Policy Document

Rural Clinical Schools (2026)

Executive Summary

The Australian Medical Students' Association (AMSA) believes that:

1. Rural Clinical Schools play a dynamic role in the clinical education of medical students and provide a pathway to future rural workforce retention.
2. Rural Clinical Schools must receive sufficient financial and academic support to incentivise, encourage, and mitigate barriers to accessing Rural Clinical Schools.
3. Attracting medical students towards Rural Clinical Schools is dependent on lifestyle factors including liveability of communities, economic considerations, and social opportunities provided by the Rural Clinical School environment.
4. All students, regardless of status of their enrolment, should be provided the opportunity to attend Rural Clinical Schools and expressions of future rural intent should be considered when selecting students to attend Rural Clinical Schools.
5. Rural Clinical Schools should not be used as a substitute in the Commonwealth government's funding towards other rural medical initiatives for medical students.
6. Student-led evaluation and monitoring frameworks should be incorporated at both Commonwealth government and university levels to ensure consistent and cohesive experiences between all Rural Clinical Schools.
7. Rural Clinical Schools provide important opportunities to strengthen First Nations health learning within medical education. AMSA believes that any placements involving First Nations communities must be culturally safe, community-informed, and grounded in self-determination. Such placements must occur through formal, ongoing partnership with local First Nations communities and Aboriginal Community-Controlled Health Organisations (ACCHOs), and must not impose unintended burden on communities, services, or staff.
8. First Nations students studying at Rural Clinical Schools regardless of if they are away from their own Country or not should be supported through culturally safe local orientation that fosters connection, respect, and belonging.

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Policy Points

AMSA calls upon:

1. The Commonwealth Government to:

a. Ensure that Rural Clinical Schools are adequately funded to:
    i. Deliver high quality medical education through robust Rural Clinical School programs and rural end-to-end medical school programs; and
    ii. Provide a high standard of financial subsidies for students to support:
        1. Relocation costs;
        2. Accommodation;
        3. Transport for the duration of their placement; and
        4. Living expenses (e.g. food).
b. Support more extended rural placements at Rural Clinical Schools;
c. Support doctors doing rural clinical school teaching via continuing medical education, professional development points, and practice incentive payments;
d. Implement the recommendations of the Rural Health Multidisciplinary Training Program Evaluation (2020);
e. Employ accountability frameworks and monitor each Rural Clinical School's expenditure, placement quota targets, and overall quality;
f. Ensure that Rural Clinical School funding structures incorporate Commonwealth Performance Payments, with accountability frameworks that link funding to student outcomes and equitable access; and
g. Collect longitudinal data regarding the career outcomes of students who attend Rural Clinical Schools.

2. The Australian Medical Council to:

a. Assess universities on their promotion of rural health careers to graduates;
b. Develop additional standards to assess the quality of Rural Clinical Schools as part of the medical school accreditation process; and
c. Establish standardised monitoring and evaluation procedures through which students can provide feedback at Rural Clinical Schools.

3. Australian Medical Schools to:

a. Employ strategies to attract medical students to rural clinical schools such as:
    i. Providing clear and consistent financial subsidies for students during their entire placement, regardless of duration, including subsidies for:
        1. Relocation costs;
        2. Accommodation; and
        3. Transport.

ii. Ensure subsidies cover a minimum proportion of costs consistent across RCS;
iii. Ensure that Rural Clinical School students have structured opportunities for metropolitan clinical experience during their program, including short-term feasible placements (e.g. 6-week placements), to maintain breadth of training and exposure to diverse patient populations; and
iv. Ensure that metropolitan medical students have structured opportunities for rural clinical placements, including short-term feasible placements (e.g. 6-week placements), to encourage interest in and exposure to rural health practice.

b. Allow all students to preference Rural Clinical Schools via an opt-in system and;
    i. Consider other measures, such as a rural student status or First Nations students returning to Country; and
    ii. Implement measures for students to show intention to work rurally.
c. Ensure students undertake their university examinations at their Rural Clinical Schools and when unable to, allocate transport allowances and accommodation at the examination location;
d. Recognise that students may experience extenuating circumstances whilst at Rural Clinical Schools that require them to travel, e.g. to visit acutely ill family members, and that Rural Clinical School students should be supported through accommodations such as:
    i. Financial support to cover travel costs; and
    ii. Special consideration so they are not impacted academically by attendance, leave and placement requirements.
e. Work in formal partnership with First Nations communities, authority organisations and ACCHOs to co-design, implement, and evaluate First Nations health learning and placements;
    i. Teaching of First Nations health, cultural safety training and experiential learning via placements should be ongoing and embedded through all parts of the medical program, as per the First Nations Health in the Medical Curriculum policy; and
    ii. First Nations cultural health teaching must be reviewed and audited every 3 years by ACCHO's, NATSIEC, AIDA and/or First Nations educators to ensure quality teaching and cultural safety are maintained.
f. Support equitable opportunities for international students to attend Rural Clinical Schools through an opt-in system:
    i. Ensuring opportunities for Rural Clinical School allocation are equal for domestic and international students; and
    ii. Redirecting international student fees towards international student rural clinical school attendance.

g. Ensure staff responsible for the governance and implementation of Rural Clinical Schools programs are based at the Rural Clinical School;
h. Employ at least one permanent dedicated First Nations leadership position at each Rural Clinical School, responsible for things including, but not limited to:
    i. Facilitating program co-design, training delivery and partnerships between the Rural Clinical School and local First Nations communities and ACCHOs;
    ii. Escalation pathways for breaches of cultural safety; and
    iii. Pastoral care of First Nations students.
i. Provide research funding and opportunities to Rural Clinical Schools; and
j. Support the exit and intermission of students from participation in Rural Clinical Schools, with any participation hours missed being remediated in rural areas, through special consideration of factors including, but not limited to:
    i. Physical and mental health illnesses;
    ii. Caring responsibilities; and
    iii. Financial difficulty.

4. Rural Clinical Schools to:

a. Assist students with various needs that arise from relocating to a new community and environment including, but not limited to:
    i. Helping students access bulk billed medical and counselling services, and alternate in-person or virtual services to maintain a student's confidentiality, preventing them from being serviced by their medical educators and supervisors;
    ii. Supporting students to integrate into the community through facilitating participation in local community activities; and
    iii. Providing appropriate resources and escalation pathways to address the challenges faced by international students, culturally and linguistically diverse students, students with disability, First Nations students and LGBTQIASB+ students placed rurally, in line with the Racism and Cultural Diversity and Bullying and Harassment policies.
b. Provide students with opportunities to participate in both clinical and laboratory based medical research by:
    i. Establishing partnerships between Rural Clinical Schools and metro researchers and clinicians; and
    ii. Supporting small-scale community-driven research projects through;
        1. Local clinicians and faculty supervision;
        2. Community partnerships and placements; and
        3. Suitable facilities to accommodate lab-based research.
c. Provide access to study spaces, common areas, internet, and library facilities;
d. Offer wellbeing and personal development days;

e. Ensure rural placements involving First Nations communities are conducted in a culturally safe manner, grounded in partnership, accountability, reconciliation and self-determination, by:
    i. Establishing formal, ongoing partnerships with local First Nations communities, authority organisations and ACCHOs, including agreed governance arrangements such as Memoranda of Understanding or equivalent;
    ii. Ensuring that communities and ACCHOs have the authority to determine the appropriateness, scope, supervision requirements, and continuation of student placements, including the right to decline, pause, or withdraw placements without penalty;
    iii. Providing locally delivered, First Nations-led, community-informed cultural safety preparation specific to the history, context, protocols, and expectations of the placement site, as well as education on First Nations holistic approaches to health, rather than relying solely on general cultural awareness training;
    iv. Ensuring that student placements do not create unfunded workload or service burden for ACCHOs, Aboriginal Health Workers, clinicians, or community services, and providing appropriate financial and workforce support where placements occur;
    v. Establishing clear, culturally safe escalation pathways for all students, staff, and community partners where concerns relating to cultural safety or racism arise during placements, or more generally;
        1. Escalation pathways should be managed by First Nations leadership positions to maintain cultural safety, with reporter input anonymised, where possible; and
        2. Reporters should receive updates on the progress of their case whilst minimising their need to recount the event.
    vi. Embedding ongoing evaluation of placement impact on both students and communities, led by First Nations organisations, educators and local First Nations community members, including regular feedback from First Nations community partners;
        1. Cyclical improvements should be made to First Nations health placements and programs, co-designed with local First Nations communities and health services.
    vii. Being flexible in clinical school options for First Nations students who wish to undertake placements connected to Country, kinship, or community;
    viii. Providing financial support for travel, accommodation, and relocation associated with placements connected to Country or community;

ix. Recognising cultural obligations, including Sorry Business and community responsibilities, within attendance, leave, special consideration and placement requirements, and arranging exemptions and/or alternatives for First Nations students so they are not academically impacted by said cultural obligations;
x. Ensuring access to culturally safe mentoring, wellbeing, and pastoral supports for First Nations students undertaking rural placements;
xi. Provide a culturally safe local orientation for First Nations students studying or undertaking placement away from their own Country, including appropriate introduction to the local community, cultural protocols, and the Traditional Custodians of the land on which they are living and learning; and
xii. Abide by, incorporate and be involved in updating reconciliation action plans from ACCHOs, communities and authority organisations regularly and consistently to ensure placements are improving in cultural safety.

f. Establish a student-led representative council apart from the Rural Clinical School governance.

5. The Australian Medical Students' Association to:

a. Consider Rural Clinical School students when delivering opportunities and events by reducing barriers to access including through;
    i. The provision of hybrid online/in-person events; and
    ii. Financial support to attend in-person only events.

6. Medical Student Societies to:

a. Seek comment from students studying at Rural Clinical Schools for specific inclusion in AMC review reports.

Background

The Australian Medical Students' Association (AMSA) is the peak representative body for medical students in Australia. All students should have opportunities to experience medicine in regional or rural settings to support a well-rounded education and rural workforce retention. AMSA advocates for funding towards Rural Clinical Schools (RCS), a consistent RCS experience across institutions, and consideration of lifestyle factors so all students can partake in RCS.

RURAL CLINICAL SCHOOLS

RCS are funded through the Department of Health, and are a substantial investment in mitigating rural doctor shortages.[1,2] RCS deliver significant components of medical education rurally, and are expected to meet Australian Medical Council curriculum requirements, regardless of location.[3] Studies show that RCS have positive effects on the regional medical workforce.[4] At least 25% of Commonwealth Supported Place (CSP) funded medical students must undertake placement for at least one year in a location of Remoteness Area status 2-5.[3] 50% of CSP-funded medical students must also undertake a rural training experience of at least four weeks.[5] RCS placements include regional hospitals and general practices of smaller communities.[5] There are currently no RCS requirements for international students, who are not considered within RCS funding frameworks.

Rural Health Multidisciplinary Program.

The Rural Health Multidisciplinary Training (RHMT) Program was implemented to facilitate tertiary healthcare education in rural settings, and ensure recruitment and retention of healthcare professionals in these regions.[6] The program is a major facilitator of RCS through government funding and impacts RCS longevity. An independent evaluation showed that since its implementation, RCS placements have tripled and more government-supported medical students have spent time in RCS.[6] RCS have also stimulated rural communities economically through the program.[6]

Ongoing areas for improvement include ensuring standardised experiences across program sites and consideration of program funding, particularly given that while all RCS are connected to RHMT, not all are connected to Regional Training Hubs, which support rural medical training pathways.[7] For further recommendations, please refer to the "For More Information" section below.

Student Selection.

Each university utilises different processes to select students for RCS.[5] Factors often considered include rural background-status or bonded medical program (BMP) participation.[1] However, medical students' 'self-efficacy' - that is, belief in their own competence - has been shown to be a strong factor in decisions to train and practise rurally.[8,9] Intent to work as a generalist also increases likelihood of rural practice.[10] By contrast, students trained only in metropolitan services contribute equally to the rural workforce,[11] and rates of completing return of service for BMP students are low.[12] Thus, the impetus of each student should be a driving factor in RCS student selection, alongside rural background and BMP participation rather than being outweighed by them.

To support student selection based on rural workforce interest, popular RCS need to address potential oversubscription by increasing capacity and/or extending placements into adjacent regional areas.

To enable broader access, RCS should implement flexible and split-site placement models. A 2024 national report showed that of final year respondents, students aged 25-29 and 30-34 made up 44.8% and 8% of the cohort, respectively.[13] As mature aged student proportions increase, structural barriers to RCS participation for this demographic must be addressed. Split-site models would allow rural community immersion while easing pressure on student capacity.[12]

Rural 'End-to-End' Medical Schools.
Rural end-to-end medical school programs are programs in which medical students stay in areas of Modified Monash Model category 3 or greater throughout their entire degree, including pre-clinical years.[14,15] They evolved from the philosophy that there is a positive correlation between rural medical student immersion and selecting rural internships.[16,17] Delivery of 'end-to-end' medical schools through models like the Murray Darling Medical School Network,[16] and Regional Medical Pathway,[18] is based on studies into RCS experiences.

Many new medical school end-to-end programs are at locations which already have RCS.[19] Imposition of end-to-end medical places on access to rural placements for metropolitan-based preclinical students has not been fully evaluated,[20] but deficits in RCS clinical experiences due to increased student numbers are posited.

RCS AIMS

Rationale.
RCS were established to address persistent rural workforce shortages and health inequalities. Rural areas have higher rates of chronic disease, less access to healthcare, and poorer health outcomes.[21] Traditional urban-centric medical training fails to prepare graduates for realities of rural practice.[22] Students who undertake high-quality rural placements report broader clinical learning opportunities, which improve competence and increase intention to work rurally.[21] RCS are thus critical for better aligning training with community needs.

Future Workforce Implications.
On the AMSA Rural Student Support Report Card, 45.2% of respondents reported autonomous intention to practice rurally.[23] However, a recent Victorian study found that uptake of rural internship positions by domestic graduates is sub-optimal, with targets for building rural workforce from local graduates being unmet.[24] Strategies are urgently needed to address barriers which perpetuate rural reliance on international graduates.[25]

RCS are strongly associated with increased likelihood of rural practice for students from both rural and urban backgrounds.[26] Medical graduates with RCS experience are up to four times more likely to work rurally up to ten years after graduation.[27] Other long-term benefits of RCS include increased job satisfaction and strong academic and health service partnerships.[27] Additionally, RCS programs reduce professional isolation, improve quality of care, and equip students with adaptability and digital literacy through distributed teaching and telehealth exposure.[26]

POSITIVE RCS FACTORS

Student experiences of RCS shape interest in returning to rural areas to practise, so positive aspects of RCS experiences should be identified and amplified.[28]

Early Exposure to Hands-On Clinical Experience.

Direct, hands-on placements are a beneficial feature of RCS compared to metropolitan schools.[29] Early clinical experiences offer students value and visibility within clinical teams.[30]

Community Connections.

Community connection has been highly valued by students amongst RCS cohorts.[30] Community engagement plays a large role in RCS students' perception of what their future can look like, with many citing it as a factor for developing intent to practice rurally.[31]

ISSUES OF RCS

The quality and experiences of placements delivered by RCS are not universal,[23] and the Australian Medical Council does not currently assess RCS in isolation from hosting institutions unless they result in distinct qualifications.[32] One example of differing experiences is that University of Sydney RCS students can access obstetrics placements at Lismore Base Hospital that are not offered to Western Sydney University RCS students who share the facility.[33,34] Utilisation of a standardised report card system could mitigate some variances between RCS.

Financial Implications.

Many students associate the quality of rural placements with the financial support they receive.[35] Across RCS, there is significant variation in financial support offered. 48% of students report experiencing financial stress during rural placements due to limited employment options, insufficient assistance to cover living costs, and travel between placement sites.[23]

Relocation allowances, travel concessions, and subsidised accommodation are therefore key for RCS students.[3] Travel and accommodation subsidies should also be provided for any off-site examinations. Without the burden of financial stressors, students will have increased ability to focus on learning, community participation, and optimising rural placements.[34] Standardising financial support measures across universities and ensuring they are sufficient to cover real costs is critical in reducing stress, fostering equitable RCS access, and supporting the rural medical workforce.

Personal Barriers.
Many negative connotations towards RCS come from personal circumstances. Family commitments, personal relationships, housing, and employment responsibilities are major factors contributing to unwillingness to choose RCS.[36] As medical student diversity expands to include more mature aged students, parents, and second-career medical students, these issues may increase.[37]

Worries about social isolation and access to key support networks in rural areas are also prevalent.[38] Feelings of alienation amongst culturally and linguistically diverse (CALD) students in more homogenous rural locations are a specific concern at RCS. A study of rural CALD nurses demonstrated discrimination from staff, discomfort from patients, and lack of trust overall,[39] which is reflected in anecdotal experiences of medical students. It is therefore important for RCS to provide strong support structures for these individuals.

Academic and Research Opportunities.
Almost 95% of students report feeling academically isolated at their RCS.[40] Academic isolation is associated with increased stress, greater burnout, and reduced wellbeing, which decrease self-efficacy and likelihood of practising rurally.[41,42] Consequently, professional and easily accessible wellbeing information, academic support resources, as well as trained staff in student support are needed to assist students in RCS placements.[43]

Placement at RCS is perceived as a barrier to research due to lack of access.[25] Feedback from RCS students suggests that perceived academic disadvantage and limited access to mentoring detract from research engagement.[44] Additionally, lack of clinical trials, access to laboratories, and bias towards public health research in rural areas can negatively impact specialty training applications which require first author publications as part of their ranking system.[25,43]

To amend current gaps, RCS can support small-scale community-driven research projects supervised by local clinicians and faculty. RCS can also establish partnerships with metro clinicians and researchers by inviting them to conduct lab-based work within rural facilities.

Wellbeing.
According to the most recent AMSA Rural Student Support Report Card, only 27.1% of respondents felt that their wellbeing was positively impacted by RCS.[23]

Many students over 30 felt that their wellbeing and academic performance were negatively impacted by stress associated with balancing medicine, family, financial, and partner obligations while being far from home.[45] Similarly, 31.6% of students at RCS felt socially isolated due to lack of social support structures and recreational activities.[46,47] This isolation is compounded by barriers to mental health support.[48] In AMSA's Rural Health study,[23] 35.0% of respondents felt that mental health services were not readily accessible at RCS, 28.2% were unsure whether they had access to mental health services, and only

63.8% had access to a GP. Other reported barriers to mental healthcare included out-of-pocket costs (41.4%), which deterred 21.5% from seeking care; long waiting times (26.6%); discomfort with close association between mental health services and teaching sites (13.0%); and the tight-knit nature of small rural communities (22.6%).[23]

Australian Rural Clinical School Support Survey (ARCSSS) findings echo these concerns, with 58.3% of respondents expressing dissatisfaction with support services for families and spouses, and many noting scarcity of wellbeing providers.[49] ARCSSS participants also outlined a paucity of wellbeing activities organised at RCS, with 22.7% of respondents stating there was no encouragement to engage in extracurricular activities. Medical school workload was a barrier to extracurriculars in 35.4% of respondents, with students engaging in extracurriculars noting that work opportunities predominated due to financial stressors. Establishing camaraderie through shared pastimes within rural placement cohorts should be supported.[50,51]

Desire to undertake rural placement also impacts wellbeing, as students unwillingly allocated into RCS may develop negative attitudes.[23] Such attitudes cloud students' perception, increase anxiety, disengagement, and social isolation, and lead to poorer wellness and academic performance.[48] Peer-written support of RCS may help reverse negative perceptions.

Disinterest in RCS allocation at some universities contrasts with those where RCS oversubscription occurs, suggesting that inter-university collaboration and overlapping of university allocations could be considered when rural hospital teaching facilities are shared between multiple institutions. Inter-university collaboration in rural medicine currently exists amongst the Murray–Darling Medical Schools Network, and joint programs between WSU/CSU and UoN/UNE.[52]

International Students.
Although 90% of international students in an AMSA survey (n=280) were willing to work rurally,[53] significant barriers prevent them from accessing RCS training. In some medical schools, international students are ineligible for RCS bursaries and subsidies or are charged almost double for RCS accommodation.[53-56] Moreover, others only allow international students to apply for RCS after domestic students have, or do not allow them to apply for RCS at all.[53]

International students are often excluded from RCS due to lack of Commonwealth funding and RCS requirements. With conflicting prioritisation of domestic medical students for intern positions, and the ten-year moratorium which expects international students to fill districts of workforce shortages, international medical students are often left with rural positions that they were never exposed to or trained in.[57] The proportion of international students with past experience living rurally is low,[58] making transitions to Australia's regions harder.[59] Further, the distribution of foreign graduates of Australian medical schools is not positioned to meet Australia's national medical workforce goals or current rural needs.[60]

ACCESS TO FIRST NATIONS HEALTH

Student interest in First Nations health increased from 15% in 2015 to 49% in 2020.[61-65] However, many do not consider themselves prepared to work in First Nations communities.[65] As rural areas have more robust First Nations health infrastructure, RCS are well placed to deliver experiential First Nations health teaching that improves students' knowledge of racism, cultural safety, social determinants of health and culture.[64,66] However, such education must avoid pathologising stereotypes, paternalistic overtones, and reductionist explanations.[65,67] Further, it must centre First Nations holistic approaches to health, including connection to Country, community, culture and spirituality, and reflect the heterogeneity of First Nations cultures across Australia.[68] To maintain the cultural safety of placements, community partnership and appropriate preparation are essential.[66,69] Cultural safety can only be defined by the experiences of First Nations people and requires health professionals to continuously reflect on their beliefs, attitudes and behaviours, and power differentials, to create safe, anti-racist environments for patients. Clinical opportunities in First Nations health services are necessary to create culturally safe graduates.[70] RCS can also provide opportunities to shadow Aboriginal Healthcare Workers in mainstream medical services.

While Rural Clinical Schools are well placed to facilitate First Nations health learning, this must not occur through extractive or one-sided placement models. First Nations communities, health services, and ACCHOs must be recognised not merely as placement sites, but as partners with authority in determining whether, how, and on what terms student placements occur.[71,72] Placements should only proceed where community capacity exists, where the educational model is culturally safe and locally appropriate, and where adequate support is provided so that student learning does not come at the expense of community workload or wellbeing.[72-75]

EVALUATION OF EDUCATION AND DELIVERY

To continuously enhance rural placement experience, student voice should be meaningfully included in the governance of RCS. It is essential to establish a formal student-led representative council to ensure students have genuine influence on RCS development and expansion.[76] Embedding student-led processes that bring together stakeholders will enhance curriculum relevance and align clinical education with unique needs of rural populations. It is important to ensure continuous student feedback sessions, annual student-led reviews which drive yearly program evaluations. There should be explicit evaluation of equity of resources, support service access, and other key factors governing RCS placements. This could include the perspectives of sub-committees or medical societies in the evaluation process.

Student feedback on RCS experiences must also be considered, as currently, limited feedback pathways exist. Given the substantial variation in RCS delivery, implementation of a monitoring and evaluation framework is paramount.[6] Frameworks assessing program effectiveness at university and national levels would provide the highest value insight.[6]

For More Information

An evaluation of the suggested twenty-seven recommendations to improve the future of the program. The areas of recommendation broadly include measuring the success of the program through considering student experiences, program outcomes and performance as well as reviewing program funding: KBC Australia.

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