Rural recruitment and training promotes rural practice by GPs, but is it enough to retain them?

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Challenges to keeping general practitioners in the bush remain

The findings reported by McGrail and colleagues in this issue of the *MJA* support the effectiveness of Australian government incentives for recruiting and training general practitioners in rural areas as a strategy for reducing rural medical workforce shortages.[1] The study found that rural origin of trainees and rural vocational training of GPs were each strongly associated with their practising in rural areas in the early years after completing vocational training. However, their findings also suggest that these effects had started to diminish by 4 years post-training.[1] This finding is consistent with another recent Australian study, which found that the effects of rural recruiting and training diminished over time.[2]

As evidence emerged in the early 1990s that a rural background and a positive rural training experience promoted the subsequent uptake of rural practice by trainees, the Australian government introduced several initiatives for recruiting and training medical students in rural areas. The Rural Undergraduate Support and Coordination Program (RUSC) was in 1993 among the first of these initiatives, followed by the Rural Clinical School (RCS) and the Rural Clinical Training and Support Program (RCTS). These initiatives required that 25% of the intake of students by federally funded medical schools be from a rural background; that all federally supported medical students undertake a 4-week structured rural placement; and that 25% of students undertake at least 12 months' clinical training in a rural location.[3] Initiatives such as the Australian General Practice Training Program followed, ensuring that at least 50% of general practice vocational training placements are in rural or remote areas.[4] These training initiatives have contributed to the success achieved in increasing the number of GPs who adopt rural practice: it was recently reported that the rural and remote GP workforce increased by 23% between 2010 and 2014, compared with a 3.5% increase in the rural and remote community population, and a 10% increase in the metropolitan GP workforce over the same period.[5]

It is now timely to consider whether an increase in the number of rural and remote GPs necessarily translates into a sustained and well supported workforce which can deliver quality health care that meets the needs of rural communities. Factors that motivate practitioners to remain in rural areas include access to training, professional development and career development opportunities.[3] While I focus in this article on the role of training and education in rural retention, other factors known to be important include peer and professional support, assistance with heavy workloads and on-call requirements, locum relief,[3] access to infrastructure (such as information and communication technology and electronic health data systems), housing, and family support.[6]

In addition, being a principal of the medical practice has been identified as significantly increasing the likelihood of a doctor remaining in a rural location (by 72%), while being a salaried or contracted employee significantly reduces the likelihood (by 20–30%).[7] GPs in rural and remote locations work longer hours than their metropolitan counterparts, increasing steadily from an average of 38 hours per week in metropolitan locations to 45.8 hours in very remote locations.[5] Such demands, and the need to travel, make it more difficult for rural or remotely located practitioners to participate in professional development and to take up training opportunities. Innovative business and work model solutions are needed to support the rural GP workforce.

It should also be noted that the proportion of GPs practising procedural skills increases with remoteness (from 8.0% in inner regional areas to 13.8% in outer regional and 20.9% in remote and very remote locations).[5] Recognising that rural and remote practitioners must have procedural skills in general surgery, obstetrics, anaesthesia, radiology and endoscopy, the Royal Australian College of General Practitioners has incorporated procedural skills training into their curriculum.[8] Additional training is provided through the General Practitioner Procedural Training Support Program. Nevertheless, the period 2010–2013 saw a drop in the proportion of GPs practising procedural skills;[5] the decline was greatest in outer regional areas (4.1%), followed by remote (3.9%), inner regional (1.9%) and very remote locations (0.6%). Reasons for this decline are not clear and need further exploration, especially given a recent finding that undertaking hospital work significantly increases the likelihood that rural and remote GPs remain in rural locations (by up to 40%).[7] As exercising one's skills contributes to increased job satisfaction, motivation, commitment and retention,[9] there is a need to provide the infrastructure and opportunity for these practitioners to enhance and practise the procedural skills that have been identified as an important aspect of rural practice.

The early training initiatives are having positive effects on recruitment, but they must be reviewed and updated as new evidence emerges. Accordingly, in light of consistent support for the influence of longer term rural clinical placements on the likelihood of choosing rural practice, the initial requirement that all federally supported medical students undertake a 4-week rural placement has been reduced to 50% of students, but with no change to the proportion required to undertake a year-long rural clinical placement.[10] It will be another 5–10 years before the effect of these revised funding parameters on the recruitment and retention of the rural medical workforce will be apparent.

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