#MillennialsGoRural: preparing for the new generation of health professionals

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Context: investments in the rural health workforce

There has been, and continues to be, significant investment in programs to align the health workforce with community need in regional, rural and remote Australia. These include increases in undergraduate student numbers (particularly medicine), rural origin student quotas, rural clinical schools, university departments of rural health, scholarships, financial incentives, rural teaching infrastructure and so on. There's enough to fill a book and the 2013 Review of Australian Government Health Workforce Programs did just that.[1] But will these investments and reforms align with the generational changes occurring in our broader society and workforce? Are they appropriate to achieve the desired outcomes into the future?

To take one example, researchers and stakeholders in the rural workforce sector are familiar with the term 'rural pipeline' or 'rural pathway'. Briefly, this term refers to an integrated, more streamlined career path for health professionals from their undergraduate studies through to rural practice. Quite correctly, research has continually identified the lack of coordination between key stakeholders and institutions and complex training pathways as deterrents to rural practice. However, even the terms 'pipeline' and 'pathway' imply a logical, linear progression from high school to university to professional training to practice that may be of less relevance to the upcoming generation of health professionals.

The growing millennial influence

By the year 2020 – just five years away - it is estimated that 50% of the global workforce will comprise millennials.[3] That is, people reaching adulthood in the early years of the new millennium (ie born from the early 1980s to around 2000). In Australia the comparable figure is 46%.[4] As the Baby Boomers move closer to retirement – perhaps delayed a little due to dismal interest rates and the urgings of the Department of the Treasury to keep working - businesses, community and health service employers are looking at a potential talent pool that is vastly different to that of 10 or 15 years ago. Also bear in mind that in Australia – unlike any other G20 country – the millennials have never lived through a recession or a period of double-digit unemployment. The millennial generation has a new perspective, new expectations and a more elaborate skillset in the way of technology, this latter of particular importance in health.[5] Are we ready for the millennials? Are we – particularly in rural – offering them training, careers and workplaces that are appealing, reflect their experiences and are professionally satisfying? Let's briefly review some broad traits of emerging health professionals.

Instant feedback

Millennials have a strong desire for ongoing feedback and encouragement.[3] They are in constant contact with peers and friends and expect instant responses to queries (or at least within minutes, not hours or days). When a millennial posts a photo of themselves presenting at a conference they expect that post to be 'liked' by your friends and colleagues within the next couple of hours. By the next day that post is history. Tweets are favourited and retweeted within 30 or so minutes – after that they are lost amongst the hundreds of other tweets that have popped up in that time.

Think about this in terms of some current mentoring and supervision frameworks. Telling a junior doctor following you on ward rounds (making notes on their iPad) that you will meet them tomorrow or next week to discuss is likely to elicit the response "Why can't you tell me now?" or "Skype me later tonight".

Continuously connected

Millennials' daily worlds are full of technology and social media. As stated, they are in 24/7 contact with friends, peers and the broader world. Telecommunications 'black spots' in the bush and second rate technology are unlikely to be acceptable to this new generation of health leaders. While civic-minded, they can be questioning of authority and detached from social institutions.[6] Millennials are less afraid to challenge senior colleagues. Through constant online interactions with peers they are aware of how things are done in other workplaces and institutions and will not accept a "this is how it's always been done" explanation. Just to be clear, these are not negatives – indeed unquestioning acceptance of others' clinical decisions for example should not be encouraged - but they are different to how many of our institutions, procedures and - dare we say - some of us, operate. This may challenge some traditional health service leadership approaches.

Flexible careers paths into fixed pipelines

For this generation, life does not necessarily follow a straight path in the way it may have for their parents or grandparents - graduate, get a job, marry, buy a house, have kids, retire. They are more affluent (or at least have grown up accustomed to relative affluence), want to travel, do not look at a job as a lifetime commitment, and with both partners working can afford to take 'sabbaticals', 'career breaks', or have periods of part-time work to devote more time to family or other pursuits. One global survey found that over 70% of millennials wanted to work outside their home country during their career.[3] How prepared are our services, workplaces, training colleges and other institutions to meet this emerging demand for flexibility? Are we taking it into consideration in the ongoing development of rural pathways to practice? A study undertaken by the Royal Australasian College of Surgeons Trainees Association in 2010 found 34% of trainees expressed an interest in part-time training.[7] The same survey reported that 0.3% of surgical trainees were actually completing their training part-time. A subsequent report noted that while College policy allows part-time training, in practice such training must be organised by individuals and trainees are frustrated by barriers at the trainee, College, Specialty Board, hospital administration and medical organisational levels.[8] To the College of Surgeons' credit they have recognised this as a significant issue and recently established a Flexible Training Working Party to tackle it.[9]

Career progression

Perhaps one of the most important characteristics of this generation in relation to the future workforce is a finding from a study undertaken by PwC entitled "Millennials at work: reshaping the workplace".[3] When asked about the attributes that make an organisation an attractive employer, 'opportunity for career progression' was the biggest drawcard. The report states that "once again, the ambition and optimism of this generation comes through." While we set standards for registration, accreditation, supervision and CPD, what do we really offer through our policy and program settings for career progression in a rural setting for a young doctor or allied health professional?

Competitive, career focused

Finally, closer to home, a recent study commissioned by RHWA explored the decision-making process to relocate rural amongst Australian-trained urban medical students and junior doctors.[10] A total of 25 medical students and 41 junior doctors took part in focus groups and indepth interviews in Melbourne, Brisbane and Adelaide. The research found that these millennials see themselves in a competitive environment – competing with around twice as many medical graduates than around a decade ago for hospital placements and preferred rotations and specialist training places. They are likely to have larger undergraduate higher education debts than their predecessors (and may be concerned about these increasing significantly in the near future). They are highly career-focused (as identified in the PwC data[3)] and the report highlights the need to promote the "professional advantages" of rural placements and rural practice more generally. The following verbatim comments from students and junior doctors illustrate:

> "I think as a general rule, medical students are really concerned about getting the best marks they can get. They're concerned about getting an inch over other medical students and getting more opportunities for more practical hands on stuff." [PGY1]

> "What they've told us is that the results have shown that the students who go to the rural program consistently perform well as a group and it's hard for those students to go under the radar. They'll pick up if you're not - if you're struggling early on and give you remediation. They get good results." [PGY2]

The study's authors advised that:

> "a crucial, modifiable motivator [to go rural] is the quality of professional skill development in rural exposure experience. Students are motivated by the evaluation of a non-metropolitan clinical experience as more advantageous than an equivalent metropolitan clinical experience. In addition, some students are motivated by the opportunities to practice in ways that are diverse, holistic and offer continuity of care, all of which are generally associated with work in non-metropolitan settings." [10]

What motivates millennials to go rural?

Following this qualitative research emphasising the important of positive rural experiences, RHWA undertook to quantify some key themes uncovered about what motivates the millennial healthcare student to undertake rural for clinical placements. For an organisation such as ours, we see this as critical to ensuring a sustainable future health workforce. Importantly, the scope of the research was expanded to non-medical students. While GPs remain at the centre of primary healthcare in Australia, this is not always the case in rural (and particularly remote) Australia. By virtue of necessity as much as design, multidisciplinary health service delivery is a major strength of rural and remote health.[11] Further, millennials prefer and expect to work as part of teams.[12]

Methods

A questionnaire reflecting key themes identified in the qualitative research was administered through SurveyMonkey and sent to the NRHSN database (approximately 17,000) of the National Rural Health Student Network (NRHSN) during March 2015. The NRHSN is a multi-disciplinary network of students who belong to the 28 Rural Health Clubs at Australian universities. Funded by the Department of Health and managed by RHWA, the NRHSN promotes rural health careers to students and provides a voice for students who are interested in improving health outcomes for rural and remote Australians.

It is recognised that the NRHSN database is not a representative sample of health students at Australian universities. In addition to being heavily skewed towards medicine students (approximately 50%), NRHSN members have, by virtue of their membership, an expressed interest in rural health. Approximately 50% of the NRHSN membership is comprised of students from a rural background. Nevertheless, the NRHSN is a large, national, multi-disciplinary database and it is planned to replicate this study amongst a more representative national sample at a later date.

Results

Completed surveys were obtained from 1,203 NRHSN members, representing a 7% response rate.

Table 1 Key characteristics of the sample obtained

Base: all respondents	Sample (n=1203) %	NRHSN Database (n=16,898) %
Gender		
Male	24	29
Female	76	71
Age		
18-25 years	64	59
26-35 years	26	33
36+ years	10	8
Where currently living		
Major cities (ASGC-RA 1)	52	N/A
Regional and remote (ASGC RA2-5)	48	N/A
Rural origin		
Yes	64	N/A
No	36	N/A
Discipline		
Allied health	21	30
Medicine	60	50
Nursing and midwifery	17	20
Undertaken rural placements		
Yes	78	N/A
No	22	N.A

For the purposes of further analysis, 90% of the sample was defined as millennials (ie those born from 1980 onwards).

Future intent to practise rurally

Respondents were presented with 5 statements regarding future intention to practise rurally for a period of at least 5 years. Given that the NRHSN is a body of students with an interest in rural health, it is of little surprise that the vast majority indicated a positive disposition to practise in rural – almost half the sample indicated that they had already decided to do so. Even amongst this sample, students with a rural background have a significantly higher disposition to rural practice than their urban counterparts (Table 2).

Table 2 Future intent to practice rurally (for at least 5 years)

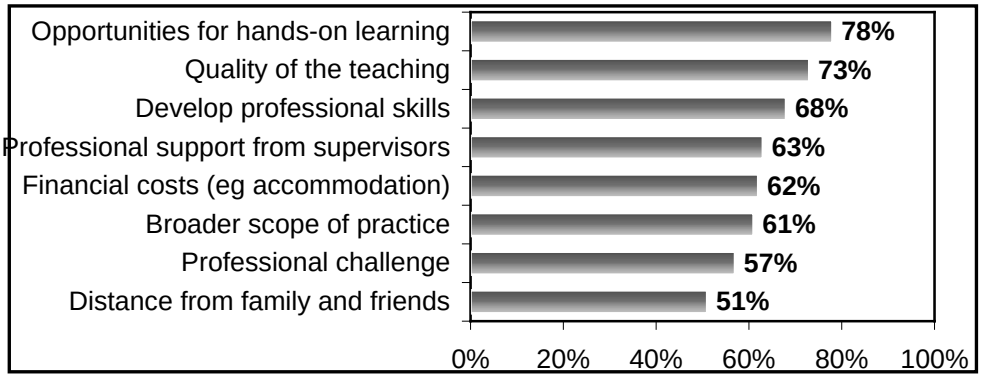
Which of the following statements best reflects how you feel about living and working in your chosen health profession in a regional, rural or remote area of Australia for at least 5 years?	All respondents (n=1077) %	Rural background (n=672) %	Non-rural background (n=405) %
I would definitely not consider it	1	1	2
I am unlikely to consider it	5	2	11
I might or might not consider it	10	5	18
I would consider it	42	39	46
I have already decided that I would like to	42	54	26

Factors of importance in considering clinical placements

From a list of 31 factors that might be considered when deciding to undertake a clinical placement in either a rural or metropolitan setting respondents were asked to nominate which were more important to them (the order in which these factors were presented was randomised). The 8 factors nominated

by at least 50% of participants are summarised in Figure 1 (each participant nominated 13 factors as important to them on average).

Figure 1 Factors considered important when deciding to undertake a clinical placement (n=1056)



When asked to nominate their top 3 considerations from the same list of factors, the results are similar. By discipline, it is evident that financial costs are a significant issue for nursing and allied health students (Table 3). The issue of distance from family and friends for medical students is likely due to medical students in the sample being significantly more likely to come from an urban background than the nursing and allied health students (42% of the medical students were from an urban background compared to 30% of the nursing and 25% of the allied health students).

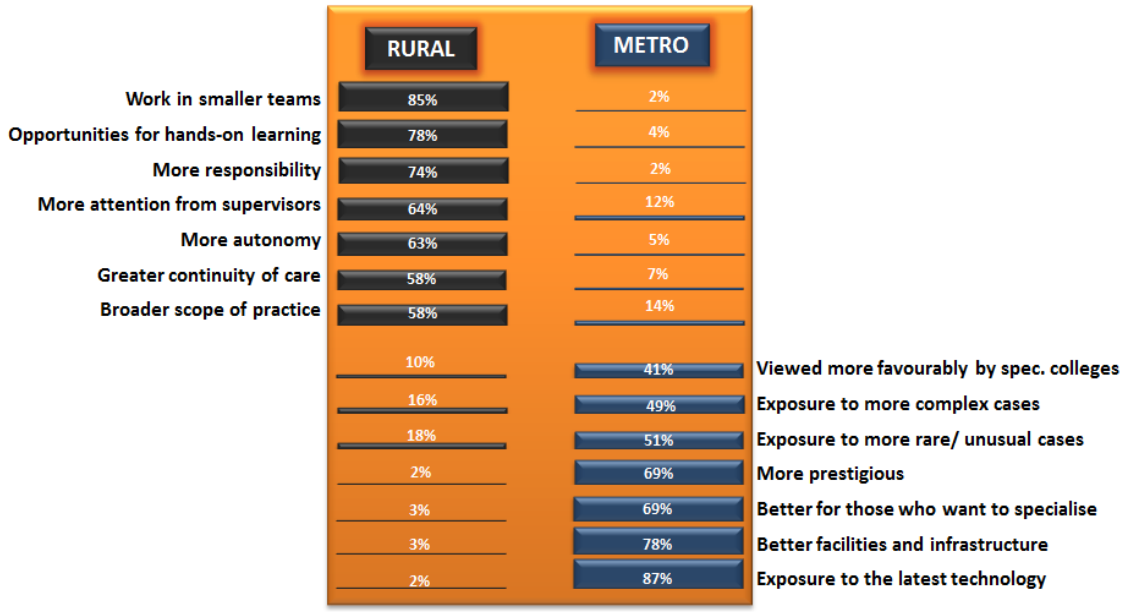
Table 3 Most important factors considered when deciding to undertake a clinical placement

Ranking	Medicine (n=641)	Nursing (n=133)	Allied health (n=217)
1	Opportunities for hands-on learning	Opportunities for hands-on learning	Opportunities for hands-on learning
2	Quality of the teaching	Develop professional skills	Financial costs (eg accommodation)
3	Distance from family and friends	Financial costs (eg accommodation)	Professional support from supervisors

Perceptions of metropolitan versus rural clinical placements

Respondents were asked whether they associated a list of 29 attributes more strongly with rural or metropolitan clinical placements (or both equally). A number of attributes that are considered important in deciding whether to undertake a clinical placement are strongly associated with rural locations, such as the opportunity for hands-on learning (particularly amongst medicine students) and attention from supervisors (Figure 2). Metropolitan placements in contrast are seen as more prestigious, better for those who want to specialise and as being more favourably viewed by specialist colleges and professional associations. Metropolitan placements are also perceived to provide more exposure to rare and complex cases.

Figure 2 Perceptions of rural versus metropolitan clinical placements



(Proportion associating each attribute more strongly with placements in regional, rural and remote or metropolitan settings; n=1077)

Discussion

The findings confirm that (in the context of considering clinical placements and rotations) millennials are looking for quality experiences that will develop their professional skills (recall career progression is the number one attribute millennials are looking for in potential employers). Opportunities for hands-on learning, quality of the teaching, developing professional skills, professional support from supervisors and broader scope of practice all figure highly in considerations. Distance from family and friends and the financial costs associated with placements (such as accommodation) are the only non-career or professional themes of note. Financial considerations are of particular importance to nursing and allied health students, consistent with anecdotal feedback that the range of incentives and scholarships available to these budding healthcare professionals is limited in comparison to those on offer to their colleagues in medicine.

Rural clinical placements are strongly associated with many of the attributes students consider important – such as providing opportunities for hands-on learning and greater attention from supervisors. Conversely, metropolitan placements are perceived to be more prestigious, better for those who wish to specialise and as being more well regarded by specialist colleges and professional associations. Whether or not this is in fact the reality, this is the perception of many of today's healthcare students. Clearly, more work needs to be done, particularly by postgraduate training colleges, to remove some of the stigma attached to rural clinical placements.

Students need to be assured that a rural placement will not negatively impact on their chances of being admitted to their preferred postgraduate training college or be viewed less favourably by potential employers. More broadly, this research highlights that students need to be assured that a rural clinical placement will be a positive for their career/ professional goals as opposed to a potential negative.

Metropolitan placements are also strongly perceived as exposing students to more complex and unusual cases. It could be argued that due to the lack of specialist services in many rural locations students may obtain a **greater** exposure to more complex conditions and patients during a rural placement than they might in a metropolitan one. Similarly, the strong perception that metropolitan placements offer superior facilities, infrastructure and technology is certainly not true in all cases, and those rural areas offering cutting edge technologies would do well to promote this to potential students.

Conclusions and recommendations

Encouraging domestic healthcare students and junior professionals to consider rural practice is crucial to growing our non-urban health workforce. A key component of this is exposing students to rural practice through clinical placements and rotations during their undergraduate studies and postgraduate training. The evidence is growing that positive, well-supervised, and supportive rural placements have a positive influence on students' intentions to practise in rural locations.[13] Indeed one recent study suggests that an extended rural placement is as strong a predictor of rural practice as rural background, the authors noting the significance of this finding "given the limited pool of rural background students."[14]

This research demonstrates that today's millennial students are looking for career and professional advantages in their placements. While rural placements offer some perceived benefits, it is recommended that more is done to remove the perception that in many regards they are of inferior quality to metropolitan placements – particularly in terms of issues such as prestige, reputation and how they are viewed by training colleges and potential employers. Removing some of the financial barriers associated with rural placements for nursing and allied health students should also be a priority.

More broadly, this paper has highlighted some key characteristics of the new generation of health professionals:

- tech-savvy, they will look for technological solutions to many problems
- in constant contact with their world through social media
- competitive, career-focused, value career progression but need flexibility
- require constant and rapid feedback
- are questioning of institutions and procedures (they *know* how things are done in other places)

The impact of this generational change is already playing out. There are many recent and emerging examples of how technological solutions are being used by millennials to bypass institutions – or institutionalised processes – that have failed to change to meet their needs or expectations.

- Uber – an online/ app-based cashless alternative to taxis
- Crowd-sourcing – an alternative to traditional sources of venture capital
- Peer-to-peer lending – personal and business loan alternatives to banks

It is timely to ensure we have the settings right to encourage and support sustainable training and employment models for upcoming health professionals in regional, rural and remote Australia. The significant ongoing investment in our health workforce needs to align with the generational changes under way.

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Presenter

Greg Mundy is Chief Executive Officer at Rural Health Workforce Australia, the national body for the seven-State and Territory Rural Workforce Agencies. This network of agencies provides a range of mainly government-funded workforce programs aimed at improving access to health care services in rural and remote parts of Australia. Greg has worked in government and non-government roles in the health sector and headed the peak bodies for aged care providers and public ambulance services before taking up his current position. Greg worked for the Victorian Government in a range of senior roles in the health and community services sectors, including aged care, community health and mental health. Born in England, Greg studied in New Zealand and Australia and holds a Master's Degree from the Australian National University. Greg is a Fellow of the Australasian College of Health Services Management. Greg is a Council member and Board Director at the National Rural Health Alliance.