



NATIONAL RURAL  
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ALLIANCE INC.

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ABN: 68 480 848 412

PO Box 280 Deakin West ACT 2600

Phone: (02) 6285 4660 • Fax: (02) 6285 4670

Web: [www.ruralhealth.org.au](http://www.ruralhealth.org.au) • Email: [nrha@ruralhealth.org.au](mailto:nrha@ruralhealth.org.au)

## **Plan for a greater number of interns for rural, regional and remote settings in 2012**

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### **Summary**

If adopted by governments and professional bodies, this proposal has the capacity:

1. to provide the opportunity for young doctors to gain some of their early medical experience in a rural setting and thus motivate them to work in rural and remote Australia in the long-term;
2. to contribute to short-term and ongoing solutions to workforce shortages in rural and remote Australia;
3. to achieve a more even geographical distribution of the Australian medical workforce and, over time, contribute to a steady supply of Australian trained doctors to rural and remote areas; and
4. to contribute to a rebalancing of medical care from acute (hospital) to primary care.

### **Funding to implement this plan**

There is a total rural health deficit in rural and remote areas of at least \$2.1 billion a year. This equates to a shortage of 25 million services, and it includes the rural Medicare deficit which has now reached \$1 billion a year<sup>1</sup>.

A small proportion of this health underspend would be sufficient to fund this plan for a greater number of interns for rural, regional and remote settings would be. The long term impact of this plan could be expected to significantly reduce the rural primary care deficit by increasing access to general practitioners and medical specialists.

Implementation of this plan will increase Australia's self-sufficiency in providing home grown doctors in the bush, reducing the need to fund the recruitment of overseas trained doctors.

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<sup>1</sup> *Fact Sheet 27 The extent of the rural health deficit*, National Rural Health Alliance, March 2011

### **A program for 2012 and thereafter**

This proposal relates mainly to the medical graduates due to complete their studies at the end of 2011, and the immediate action which can be taken to increase internships – especially in rural remote areas – for 2012.

However the program that is modelled in this specific proposal could later be extended with great benefit to support young doctors in their second and third postgraduate years (PGY2 and PGY3). The internship year (PGY1) is in effect an extension of medical training; the individuals undertaking PGY1 do not gain full registration until they have completed their internship. This means that the PGY1 year is heavily regulated and structured – which is part of the reason why rapid remodelling of the year is practicable for 2012, given the support of the professional agencies involved.

Many of the innovative or ‘non-traditional’ internships trials to date have been in medium and smaller hospitals in regional settings rather than in large teaching hospitals. They are, nevertheless, hospital-based, and involve interns moving rapidly through rotations, some of which may be in rural settings. However working in a hospital emergency department for a few weeks is unlikely to expose individual interns to the realities of rural life.

Interns in PGY1 require substantial supervision and provide a limited amount of medical service. While such service would be valued in rural areas, if the proposal were expanded to support rural placements for registrars in PGY2 and PGY3, the net gain for rural health services would be substantial. The health services taking interns in PGY1 would be providing a service to the Australian community by assisting with the training of doctors but would get only modest benefit for their own community in the first year. Providing PGY1 internships is for the greater good and should be provided by institutions that have larger resourcing capacity.

However once doctors have completed their internship there is more flexibility in the curriculum requirements. With full registration (although not yet access to a provider number) they do not need quite as much supervision, and have enough experience to make a real difference to the workload of the health service in which they work. In rural settings where there is limited supervision available but a significant demand for workforce, these later year placements could represent a real workforce asset. These young doctors can also stay in one place for a longer period of time – working in a rural town with the local general practice and/or as a VMO in the local hospital. This could be the basis of a six-month generalist rotation with a general practice or as a VMO in a rural town, with the opportunity to get a real taste of life in that community.

For all of these reasons, the Alliance believes that, in the longer term, the proposal should be refocused on PGY2 and PGY3. After their internships, junior doctors need a further one or two years of generalist experience. This means that both the threat (of too few places) and the opportunity (of regionalisation of training) will shift with this year’s cohort to those later years.

These, then, are the directions in which the plan might be developed in the out-years. But for the immediate future – and for the remainder of this paper – the focus will be on changes this year (2011) for next year’s interns

### **This year's plan**

A greater number of medical students will graduate from Australian universities at the end of 2011 than there will be internships available. This creates a challenge that needs urgent attention and provides an opportunity for immediate reform.

The National Rural Health Alliance (NRHA) proposes a program that will rapidly increase the number of internships available for medical graduates from the beginning of 2012. It will also provide some much-needed extra medical services for rural areas; encourage young doctors to focus on primary care rather than hospital settings; and take pressure off hospital budgets in the future.

Work to accommodate increased domestic medical graduate numbers through expansion of internship capacity has already occurred, with the work impacting on jurisdictions in different years. Central to the success of the early stages of the program would be agreement by all necessary Commonwealth and State/Territory agencies to increase still further the number of 'non-traditional' internships for first year medical graduates (PGY1s), including in community health and medical specialist settings. Having a greater number and proportion of internships in settings other than major hospitals would make it possible for a greater number of them to be in rural, regional and remote areas – albeit most would still be in hospital settings.

The Australian Health Ministers Advisory Council (AHMAC) has recognised this urgent need for greater numbers of internships and meeting this need can maximise the advantage to the nation from the current 'bubble' of new medical graduates. It is a once-in-a-lifetime opportunity to revitalise rural medicine and to address the longstanding medical workforce imbalance that prejudices the health of people living in rural and remote areas of Australia. Having a greater number of internships in rural areas would result in an increase in the number of doctors wanting to work in those areas after PGY1.

Medical students need greater clarity about the next steps after their medical degree and this plan has significant potential to address this. Regionalisation of medical training and promotion of the associated opportunities will support clearer and more streamlined and more immediate pathways for those interested. This should include the development of well-supported pathway for international students who would like to go rural.

### **A national approach**

There needs to be a national approach to this opportunity, with all jurisdictions sharing both the costs and the benefits. The path to rapid action may be:

- Health Workforce Australia to confirm the shortfall in internship places and put the plan to Federal, State and Territory Ministers for Health;
- Ministers to agree on the resourcing formulae for the additional infrastructure and supervision that will be required for the extra internship places;

- Ministers to agree about carriage of the work to be done and the timelines for its completion.

With top down support and engagement from interested agencies, and bottom up involvement of health entities willing and able to take on interns, it will be possible to get rapid results. Some jurisdictions are already using non-traditional settings for internships and rotations such as Aboriginal Medical Services, Multi-Purpose Services, smaller rural hospitals, group general practices and the Royal Flying Doctor Service.

Opportunities for effective internships in non-traditional settings will increase with the rapidly-growing capacity of e-health to provide support and mentoring. It will become increasingly possible and acceptable to maintain professional and social networks online, and not just through the intranet systems in State public hospitals that are already well-developed.

In increasing the number of new internship places, the agencies with a key role include the Postgraduate Medical Education Councils of each jurisdiction. It would be desirable in the medium term for there to be a national approach to promoting rural and regional rotations, and the Confederation of Postgraduate Medical Education Councils (CPMEC)<sup>2</sup> could play a key role in this.

To complement the actions proposed in this plan, a range of other jurisdictional initiatives could be extended. For example, the Rural Preferential Recruitment Scheme managed by the Clinical Education and Training Institute (CETI) in NSW for graduating medical students could be implemented in all jurisdictions. This recognises the need to encourage more trainee doctors to live and work in rural Australia by allowing graduates with rural intentions to apply directly to their rural location of choice instead of participating in a state-wide allocation process.

### **Existing resources and activities on which to build**

The Australian Health Ministers Advisory Council (AHMAC) has recognised the urgent need for greater numbers of internships for new medical graduates who expect to be employed from 2012. AHMAC can be instrumental in gaining agreement among Federal and State authorities and professional bodies to establish non-traditional, community based, internships in rural and remote areas to address both the shortage of internships and to reduce the serious shortage of doctors in rural and remote areas.

Health Workforce Australia (HWA) has established an Expert Reference Group (Medicine) and is leading activity to address the looming mismatch between medical graduates in 2012 and the

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<sup>2</sup> The Confederation of Postgraduate Medical Education Councils (CPMEC) is an association of Postgraduate Medical Councils (PMCs) of each State or Territory in Australia and the equivalent agency in New Zealand.

CPMEC is supported by an annual grant from the Commonwealth Department of Health and Ageing which is supplemented by a levy on State Postgraduate Medical Councils members or equivalent.

PMCs are responsible for developing, supporting and implementing the education and training of junior doctors during their prevocational years (usually postgraduate years 1 and 2). PMCs also have a role in the provision of general support for this group of junior doctors and in provision of education and general support for International Medical Graduates (IMGs) working in junior medical positions in Australian hospitals.

national availability of internships and later training positions. Some of the focus of this group has been on internships for international full fee paying students. The Alliance's plan aims to ensure that the benefits of that activity extend to rural and remote Australia, contribute to better national distribution of workforce and ease the reliance on overseas trained doctors. HWA would be expected to commission specific organisations to undertake the work of the plan.

There are a number of agencies that already operate in this space and it may be possible to build on the expertise that has been developed. In the medium term, however, a single national coordinator would simplify the creation, accreditation, support and administration of training places for junior doctors.

- The CPMEC, in collaboration with its member organisations, has developed the Australian Curriculum Framework for Junior Doctors which has gained wide acceptance as a guide to the clinical experience, learning objectives and appraisal processes for intern rotations. This lays the foundation for a national approach to accreditation of internships, including non-traditional internships. National internship registration standards are the responsibility of the Medical Board of Australia.
- The Prevocational General Practice Placements Program (PGPPP) is a national program that enables hospital-employed junior doctors to do a short-term placement in rural general practice as an 'elective' rotation in their junior doctor training years. The participants work as GPs to give them a taste of what life might be like if they were to choose this career path.
- University Departments of Rural Health (UDRHs) and Rural Clinical Schools (RCSs) actively support medical students on rural and remote placements including in non-traditional settings, and the network could no doubt help provide support to an additional number of interns. They also provide education and support for clinical supervisors in rural areas. RCSs have created a rural clinical educator pathway through which clinicians can become involved in supervision.
- Rural Health Workforce Australia and its member Rural Workforce Agencies already provide a range of indirect supports for: medical students during rural placements; international medical graduates working towards professional registration; doctors relocating to a rural area; and rural doctors. This experience and expertise can assist in identifying appropriate sites for rural and remote internships and the supports that are necessary to ensure their success.

### **Non-traditional internships**

Most internships are undertaken in public hospitals and involve compulsory rotations in medicine, surgery and emergency medicine. Nevertheless, many jurisdictions have successfully introduced non-traditional internships that could be expanded in the jurisdictions where they already exist and be the models for new internships in other places. For example:

- In South Australia, interns can do rotations in rural and outer metropolitan general practices. Rotations in general practice with exposure to emergency medicine are

accredited and accepted as core emergency medicine exposure by the Medical Board of South Australia.

- In Victoria, interns can undertake at least one rotation in a rural setting; and interns can complete three of the eight weeks of their emergency medicine term in Emergency Departments which do not employ a Fellow of the Australasian College of Emergency Medicine, with 'indirect' supervision being provided (where supervision is offsite but advice is available immediately by phone and within five minutes in person).
- In Western Australia rotations are offered in remote areas such as Port Hedland and Broome Regional Hospitals, and other non-traditional clinical settings such as a palliative care rotation at the Silver Chain hospice.
- Western Australia has also provided rotations under the Prevocational General Practice Placements Program (PGPPP) which have covered disciplines of general practice, emergency medicine, palliative care and paediatrics. PGPPP provides opportunities for junior doctors who do not intend to pursue a GP career to experience working in primary care.

This plan is based on the belief that the key learning objectives and exposure that interns usually receive in their medical, surgical and emergency rotations in major teaching hospitals can be achieved in non-traditional settings. Its implementation will ensure that adequate supervision and senior support is available for rural rotations so they can grow a reputation as providing quality learning opportunities for junior doctors and become career destinations of choice. In 2012 internship positions should include a rotation to one or more of the newly created positions, with an 'all rural' internship available for those students who wish to pursue it.

Other settings for internships or rotations could include: AMSs; community paediatrics; MPSs; rural hospitals, general practices and other specialised rural or remote settings; and the RFDS. CPMEC is currently collaborating with the Australian Indigenous Doctors' Association (AIDA) and other bodies on ways of promoting junior medical officer rotations to AMSs.

### **Recommended actions**

AHMAC should agree on the contributions to be made by the various jurisdictions to a new funding pool to be used to support an increased number of non-traditional internships to make up the shortfall in internships for 2012. Each jurisdiction would be allocated a target for the establishment of additional intern posts. In consultation with stakeholders, each State/Territory would determine the proportion of new internships to be established in regional and rural settings, and ensure these proportions are met.

Urgent action needs to be taken to implement changes before the end of 2011. HWA will need to be funded to commission and resource a range of short-term projects, as described below. These projects are inter-related and all should commence immediately so that the results can be brought together within the next six months. Consideration should be given to utilising independent, well-resourced consulting companies for each project, largely because these companies have a greater degree of autonomy to work with individual service providers, as well

as the capacity to act quickly and with greater flexibility than many publicly funded agencies. The overall program should be conducted under the guidance of a national body such as CPMEC or the Medical Deans of Australia and New Zealand.

## Projects

- 1 **Agreement on model curricula:** the Australian Medical Council (AMC) is in the process of developing national standards for internship registration and, in conjunction with the Medical Board of Australia, this could be the basis for an approved 'bank of model curricula' for internships in non-traditional settings.
- 2 **Identification of new intern posts in rural and remote areas:** in parallel with project 1, a project to identify prospective additional settings for non-traditional internships in rural and remote areas and rapidly establish internship posts. This project would need to be coordinated nationally with much of the work being undertaken on a jurisdictional basis through collaboration with PMECs and State/Territory health departments.

Steps involved would include:

- Further analyse the successful non-traditional internships identified in Project 1, to identify factors and characteristics that are needed for a successful internship program. For example, what elements are essential (size, staffing etc) for a health service or general practice to be successful in managing internships?
- Consult with Rural Clinical Schools and University Departments of Rural Health to ensure a seamless path from undergraduate to junior doctor training.
- Develop broad criteria to guide interested health services or general practices wishing to be considered as a site for internships.
- Publicise the need for new sites for non-traditional internships and invite proposals from interested organisations.
- Identify suitable organisations and provide support for them to implement the appropriate criteria, supervision arrangements and become accredited as an internship provider.

For such additional posts to provide effective and supportive training, the interns will need access to accommodation and to facilities such as broadband and library facilities. These will need to be fully funded by State/Territory and/or Federal Governments from the scheme's commencement in early 2012.

In later years this scheme for interns will have to articulate with vocational training for general practice and other specialties.

- 3 **Increasing the number of clinical supervisors:** the third project would explore options to increase the number of available clinicians to provide quality supervision for interns (and medical students) and to establish necessary training, employment and remuneration arrangements for clinical supervisors. Activity would include:
  - development of a funding stream for the payment of supervisors;
  - finding ways and means of removing existing barriers to utilising semi-retired or retired doctors as clinical supervisors for interns; and

- working with International Medical Graduates, particularly in rural and remote areas, to enable some of them to be supervisors for PGY2 and PGY3 doctors.

A national certificate/award could be given to clinical supervisors to reward them for their teaching.

- 4 **Communication:** a communication strategy should be developed and implemented so that all stakeholders are informed and engaged. Students in their later years of medical study need to be targeted, so that they are well informed and encouraged to take up the new opportunities available. Medical Deans Australia and New Zealand may well be one of the key organisations in this respect.