Regional, Rural and Remote Physician Strategy

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Executive Summary

Populations living outside metropolitan areas have poorer health outcomes. The 28% of Australian and 16.3% of Aotearoa New Zealand populations that live in regional, rural, and remote areas have higher rates of hospitalisations, deaths, injury and have poorer access to, and use of, primary healthcare services, than people living in metropolitan areas.

Currently, 11.4% of our Australian Royal Australasian College of Physicians (RACP) members (Fellows and trainees) are working in outer regional, remote, and very remote (Modified Monash Model 2-7) and 0.5% of our Aotearoa New Zealand members are working in small urban or rural settlements[1].

In 2021–22, the College Council embarked on an initiative to explore what strategies might be used to expand access to specialist services to better support these underserved populations, and to examine the role the RACP can play in such endeavours.

Regional and Rural Physician Working Group (RRPWG)

Following the development of a vision statement by the College Council (Council) in March 2020, subsequently approved by the RACP Board (Board) in July 2020, the Council initiated the development of the regional and rural physician project.

The regional and rural physician project's aim was to develop a strategy that the RACP could use to (a) advocate for change and (b) guide activities to support equitable health outcomes for Australians and New Zealanders living in regional, rural, or remote locations.

A Regional and Rural Physician Working Group (RRPWG) was established in late 2020 and, following an expression of interest process, membership was approved at the July 2021 Council meeting. The RRPWG brought together members with knowledge and expertise in living, training, and working in regional, rural, and remote areas. In addition, they had an ongoing commitment and desire to develop the RACP's regional, rural, and physician strategy to not only improve outcomes for the community where they live and serve but to promote the positives of living, training, and working in these settings.

The Regional and Rural Physician Strategy (the Strategy)

The RRPWG met eight times between September 2021 and July 2022. The inaugural meeting focused on broad member issues—including identification of priorities for the regional, rural, and remote workforce to achieve equitable health outcomes, which formed the theme for subsequent meetings. Subsequent meetings addressed topics such as barriers to training, supervision accreditation issues, models of care, changing perceptions of working as a physician in regional, rural, and remote areas, and the recently released Australian National Medical Workforce Strategy 2021–2031. Specific issues have been recorded, along with recommendations for the RACP to consider.

Principles, developed by Ostini, O'Sullivan, and Strasser (2021) [1] guided the development and structure of the RRPWG strategy and recommendation. These principles include:

1. Grow your own "connected to" place.
2. Select trainees invested in rural practice.
3. Ground training in community need.

[1] 2.3% of Aotearoa New Zealand members' location is unknown.

4. Rural immersion — not exposure.
5. Optimise and invest in general medicine.
6. Include service and academic learning components.
7. Join up the steps in rural training.
8. Plan sustainable specialist roles.

The recommendations are grouped within the following focus areas:

1. Prioritise regional, rural, and remote (RRR) healthcare at the RACP.
2. Build capacity and capability to provide physician training in RRR areas.
3. Improve the attraction and retention of RRR physicians.
4. Collaborate to improve RRR healthcare provision.
5. Respect, promote and acknowledge Indigenous peoples.

These recommendations endeavour to provide a roadmap for the RACP to challenge the inequitable status quo and to reverse what is perceived as an outdated and culturally traditional metrocentric model of physician training and employment. In turn they provide a blueprint to a more inclusive and well-rounded system of training and mechanisms for growing and supporting current and future physicians in all communities.

1. Purpose

This strategy provides a background to inform strategic priorities and actions to be undertaken by the Royal Australasian College of Physicians (RACP) to address physician workforce imbalances that in turn contribute to health outcome inequities for Australians and New Zealanders living in regional, rural, or remote (RRR) locations.

2. Introduction

The RACP College Council (Council; the RACP's peak advisory body to the RACP Board) identified RRR physician workforce planning as a key focus to allow positioning of the RACP to best meet the needs of Australian and Aotearoa New Zealand communities and the RACP membership. Initial steps in this process were establishing a membership-based working group to provide initial guidance and advice regarding the status of knowledge and directions for future RACP RRR activity, and limited consultation and review by a range of peak bodies within the RACP. This paper summarises the outputs of this regional and rural physician project and consultation process and provides recommendations to guide the activities of the RACP in this area.

3. Strategic Alignment

This Strategy aligns with RACP and national strategic and policy areas. These include:

- RACP 2022–2026 Strategic Plan – Focus area 3, *Physician and practice of the future* and focus area 4, *Equitable and healthier communities,* where RRR communities are identified priorities.
- RACP Indigenous Strategic Framework 2018–2028 – this Strategy also aims to embed principles endorsed by the Indigenous Strategic Framework.
- Australia's National Medical Workforce Strategy 2021–2031 – currently being implemented.
- Aotearoa New Zealand Home / Kāinga | Future of health – at the time of drafting, Aotearoa New Zealand is undertaking transformation of its health system to create a more equitable, accessible, cohesive, and people-centred system.
- Manatū Hauora | Ministry of Health is also developing its Health Workforce Strategic Framework.

3.1. The Regional and Rural Physician Project

The regional and rural physician project aims to develop a strategy that the RACP can use to advocate for change and guide activities to support equitable health outcomes for Australians and New Zealanders living in RRR locations.

3.1.1. Vision statement

The following vision statement was developed by the Council following a workshop in March 2020 and subsequently approved by the Board in July 2020:

> "*The RACP commits to achieving equitable health outcomes for Australians and New Zealanders living in regional and rural locations by prioritising, advocating and supporting regional, rural and remote workforce and training initiatives.*
>
> *One means of achieving this will be to facilitate collaboration between governments, employers and the College to increase the number of high quality, well-resourced and attractive accredited training settings and training positions in regional and rural locations so that trainees competitively seek these and consider remaining in these settings following the completion of their training."*

3.2. RACP Regional and Rural Physician Working Group

The Council established the Regional and Rural Physician Working Group (RRPWG) to develop recommendations to achieve the vision of achieving equitable health outcomes for Australians and New Zealanders living in regional, rural, and remote locations.

The role and responsibilities of the RRPWG were to:

1. Consider options for strategies to advance the College Council's vision statement; and
2. Develop a project plan to advance the College Council's vision statement; and
3. Ensure appropriate consultation with relevant external and internal stakeholders such as, but not limited to, the College Education Committee and the College Trainees Committee, in developing the project plan; and
4. Present recommendations to the College Council for endorsement prior to presentation to the College Board for approval.

3.2.1. Membership

The composition of the RRPWG included RRR-practicing clinicians and trainees, as well as academics, consumers, and Indigenous voices from across Australia and Aotearoa New Zealand. In so doing, this strategy provides an invaluable perspective on RRR physician workforce issues in Australasia.

The membership of the RRPWG is provided in Table 1.

Table 1 – Members of the RRPWG

Name	Representative
Professor Nick Buckmaster	Chair
Dr Evelyn Bowles-Funk	Paediatric and Child Health Division member
Dr Lauren Bradbury	Adult Medicine Division member; regional, rural, remote
Dr Jeremy Christley	Australasian Faculty of Rehabilitation Medicine member
Dr Marianne Gillam	Australasian Faculty of Public Health Medicine representative; regional, rural, remote
Dr Kirsty Macfarlane	Aotearoa New Zealand member; trainee
Dr Annabel Martin	Adult Medicine Division member
Ms Ngāpei Ngatai	Consumer, Māori voice
Dr Simon Quilty	Regional, rural, remote; ATSIHC voice
Dr Peter Sharman	Australasian Faculty of Occupational and Environmental Medicine member
Dr Sarah Straw	Adult Medicine Division member; regional, rural, remote
Dr Janaka Tennakoon*	Paediatrics and Child Health Division member
Professor Martin Veysey	Adult Medicine Division member; College Education Committee member
Dr Peter Wallis	Paediatric and Child Health Division member
Associate Professor Aidan Foy	Co-opted member

** resigned in early 2022*

4. Defining 'Regional, Rural, and Remote'

For this paper, the following definitions are used to define RRR in Australia and Aotearoa New Zealand.

4.1. Australia

In Australia, this strategy refers to the Australian Government Department of Health and aged care's Modified Monash Model (MMM; refer to Table 2). This model classifies metropolitan, regional, rural, and remote areas according to geographical remoteness, as defined by the Australian Bureau of Statistics (ABS), and town size. A map showing MMM 2019 can be viewed at doctorconnect.gov.au.

Table 2 – Modified Monash Model (MMM)

Classification	Inclusions
MM 1	All areas categorised ASGS-RA1.
MM 2	Areas categorised ASGS-RA2 and ASGS-RA3 that are in, or within 20km road distance, of a town with a population greater than 50,000.
MM 3	Areas categorised ASGS-RA 2 and ASGS-RA 3 that are not in MM 2 and are in, or within 15km road distance, of a town with a population between 15,000 and 50,000.
MM 4	Areas categorised ASGS-RA 2 and ASGS-RA 3 that are not in MM 2 or MM 3 and are in, or within 10km road distance, of a town with a population between 5,000 and 15,000.
MM 5	All other areas in ASGS-RA 2 and 3.
MM 6	All areas categorised ASGS-RA 4 that are not on a populated island that is separated from the mainland in the ABS geography and is more than 5km offshore. Islands that have an MM 5 classification with a population of less than 1,000 (2019 Modified Monash Model classification only).
MM 7	All other areas; that being ASGS-RA 5 and areas on a populated island that is separated from the mainland in the ABS geography and is more than 5km offshore.

4.2. Aotearoa New Zealand

In Aotearoa New Zealand, urban/rural locations are defined by the Geographic Classification for Health (GCH). The five-level GCH has two urban categories (U1, U2) and three rural categories (R1, R2, R3), as illustrated in Table 3[2, 3]. The GCH map can be found via the GCH StoryMap website.

Table 3 – Geographic Classification for Health (GCH)

Urban		
U1	Major urban areas and places within 25 minutes of major urban areas.	
U2	Large urban areas and places within 20 minutes of large urban areas	
Regional		
R1	Medium urban areas	0-25 minutes from medium urban areas; 25-60 minutes from major urban areas; 20-50 minutes from large urban areas
R2	Small urban areas (1,000-9,999 residents)	0-25 minutes from small urban areas; 60-90 minutes from major urban areas; 50-80 minutes from large urban areas; 25-60 minutes from medium urban areas
R3		More than 90 minutes from major urban areas; More than 80 minutes from large urban areas; More than 60 minutes from medium urban areas; More than 25 minutes from small urban areas

5. Background

5.1. Rural Snapshot

Australia and Aotearoa New Zealand are highly urbanised countries. Almost three-quarters of the Australian population lives in major cities; however, 28% still live outside the major cities in RRR areas. The proportion of Australians by area of remoteness in 2021 [2] was:

- 72% in Major cities (MM1)
- 18% in Inner regional areas (MM2-3)
- 8.0% in Outer regional areas (MM4-5)
- 1.1% in Remote areas (MM6)
- 0.8% in Very remote areas (MM7)

In Aotearoa New Zealand, most New Zealanders live in urban areas (U1-2), while only 19% of the population live in rural areas (R1-3) [3].

5.1.1. Proportion of Indigenous peoples living in RRR areas

The health and healthcare needs of Indigenous peoples is a priority for both Australia and Aotearoa. It is particularly relevant when considering the RRR physician workforce.

The proportion of the total Australian population who are Aboriginal and Torres Strait Islander peoples is generally higher in remote areas (from 1.8% in Major cities, to 32% in Remote and Very Remote areas) [4].

In Aotearoa New Zealand, the Māori population are estimated to account for 17.1% of the population (in June 2021), with 25% of the Māori population living rurally [3, 5].

5.1.2. Rural, regional, and remote health challenges

RRR areas are diverse locations and communities. Diversity can include community resources, demographics, educational attainment, housing, health resources and teams, as well as jurisdictional variation. Although people living in rural and remote areas are, on average, younger than those living in larger centres this does not mean they have lesser healthcare needs. Indeed, certain vulnerable populations, including Indigenous Australians and Māori have both well described health disadvantage and poor life expectancy and are over-represented in rural and remote populations. The mortality outcomes and inequities that exist have additional challenges associated with living rurally [5, 6, 7].

These populations face shared and distinct challenges in healthcare access, including that relating to specialist healthcare. Overall, this is illustrated by poorer health outcomes compared with those living in metropolitan/major urban areas. For example, data show higher rates of hospitalisations, mortality and injury, and poorer access to, and use of, primary healthcare services compared with those living in metropolitan areas [8].

Health inequalities in rural and remote areas are due to myriad of factors that may be within and outside the scope of healthcare delivery. These include challenges in accessing healthcare or health professionals, such as specialists; social determinants such as income, education, and employment opportunities; higher rates of risky behaviours such as tobacco smoking and alcohol use; higher rates of occupational and physical risk, for example from farming or mining work and transport-related accidents [8].

Populations in remote areas were more likely to report barriers accessing general practitioners (GPs) and specialists than residents of metropolitan/major urban. For example, in Australia, the proportion of people reporting not having a specialist nearby, as a barrier to seeing one, increased from [9]:

- 6.0% in Major cities
- 22% in Inner regional areas
- 30% in Outer regional areas
- 58% in Remote and very remote areas

5.2. Mortality and Burden of Disease

People living in rural and remote areas are more likely to die at a younger age than those in metropolitan/major urban areas. They also have higher rates of potentially avoidable deaths.

In 2020, Australian age-standardised mortality rates increased as remoteness increased for males and females. Males had a higher mortality rate than females in all remoteness areas, with the highest difference in remote areas (1.5 times higher). In addition, 17% of all deaths were potentially avoidable, with the rate increasing with remoteness (Table 4) [2].

Table 4 – Median age at death, mortality rate and rate ratio, by sex and remoteness area (2020)

	Major Cities	Inner Regional	Outer Regional	Remote	Very remote
Median age at death (males)	79.6	78.7	76.8	73.1	65.7
Age-standardised rate (deaths per 100,00) (males)	545.9	630.7	668.1	703.3	712.7
Rate ratio (males)	0.94	1.09	1.15	1.21	1.23
Median age at death (females)	85.2	84.3	82.7	78.3	66.2
Age-standardised rate (deaths per 100,00) (females)	388.6	435.9	461.0	468.7	569.5
Rate Ratio (females)	0.95	1.07	1.13	1.15	1.40

Burden of disease (and injury) is a term referring to the quantified impact of a disease or injury on a population, using the disability-adjusted life years (DALY) measure [10].

The burden of disease rate in Australia differs across states and territories, with the Northern Territory being the highest. Based on AIHW data, remote and very remote areas burden of disease is 1.3 and 1.7 times as high as major cities and there are noticeably higher burden rates in remote and very remote areas for kidney and urinary diseases, injuries, infectious diseases, endocrine disorders, and cardiovascular diseases [11].

The geographic impediment to care access co-exists with financial barriers. Whilst disease burden increases by remoteness, activity data indicates that not only do services decrease, but also out of pocket costs increase. For example, Medicare statistics show from 2016–2017 that the number of services per capita in major cities is 6.3 which steadily declines to 3.6 in very remote areas whilst average out of pocket costs for non-bulk billed services was $38.37 in major cities decreasing in inner regional to $34.73 and steadily increases to $40.59 in very remote areas.

For Aotearoa New Zealand, recent research has found that, compared with non-Māori, Māori experience higher mortality rates in all five levels of the GCH. Rural Māori experience greater mortality rates than their urban peers. Both Māori and non-Māori mortality rates increased as rurality increased [6].

5.3. Rural Medical Workforce – Current State

Getting skilled medical workforce into RRR areas is critical in delivering high quality health care services to these populations. AIHW data shows that remote areas have seven times fewer specialists compared with major cities [8].

Since 2007, when there was an undersupply of doctors in Australia and Aotearoa New Zealand, there has been an increase in medical training places, bringing with it an increasing number of junior medical graduates in both Australia and Aotearoa New Zealand (see Figures 1 and 2 [12]).

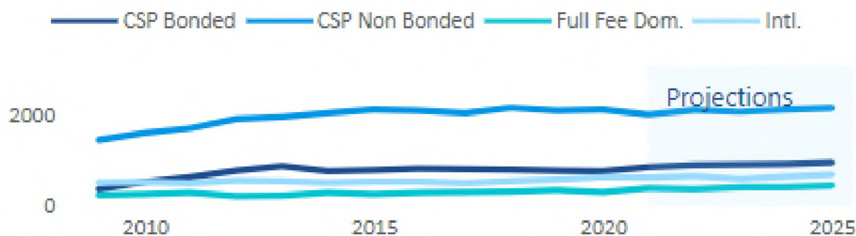


Figure 1 – Medical School Graduates in Australia 2009 to 2025

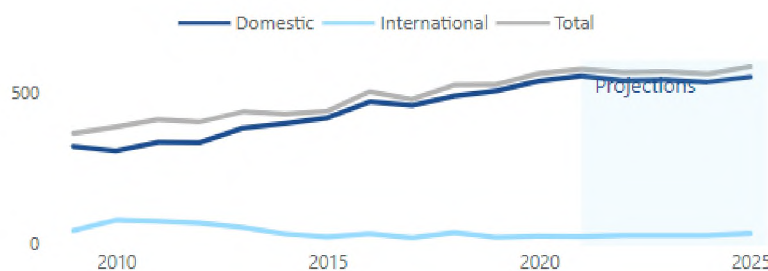


Figure 2 -Medical School Graduates in Aotearoa New Zealand 2009 to 2025

Of the Australian medical school graduates commencing in 2022, 32.4% had a rural background (an increase from 29.2% in 2014). In Aotearoa New Zealand 19.6% had a rural background in 2022 (17.3% in 2014) [13].

Recruitment of international medical graduates (IMGs) is another way of filling workforce gaps. IMGs make up a large proportion of both the Aotearoa New Zealand and Australian medical workforce (41% in 2021 and 31% in 2018 respectively) [14, 15].

Despite this significant increase in supply there remains a significant workforce shortage in regional, rural, and remote areas. This can be seen in the wide geographical variation/maldistribution in the access to medical practitioners, including specialists, for those living in rural and remote areas.

Since 2015, the number of employed FTE clinicians across all Ahpra registered professions in Australia decreased with increasing remoteness. In 2020, there were more registered clinical FTE health professionals in major cities (386,000 FTE) than in all regional and remote areas of Australia combined (132,000 FTE).

Relative to the populations, Major cities had a greater number of working FTE clinicians than each of the other remoteness areas [14]:

- Major cities—2,077 clinical FTE per 100,000 people
- Inner regional areas—1,890 FTE per 100,000 people.

- Outer regional areas—1,761 FTE per 100,000 people.
- Remote areas—1,959 FTE per 100,000 people.
- Very remote areas—1,833 FTE per 100,000 people.

Workforce structures vary from urban centres, with staffing increasingly supplied by non-medical practitioners and with allied health shortages also present.

In Aotearoa New Zealand, the Medical Council of New Zealand's (MCNZ) *The New Zealand Medical Workforce in 2021* report [15] states key demographics:

- 18,780 doctors
- 4.6% Māori doctors
- 2.2% Pasifika doctors
- 47.4% female doctors (in 1980 this figure was < 20%).

MCNZ is reviewing the methodology used to estimate whether doctors are working in a rural area and thus data regarding this were not published [15].

5.4. Disruptions Contributing to the Rural Workforce Shortage

Living and working in RRR settings offers numerous personal and professional benefits. These include [16]:

- More relaxed lifestyle in a more natural environment
- Greater professional autonomy and responsibility
- Working in a multidisciplinary team
- Diverse patient mix
- Range of financial benefits.

However, there remains a preference for metropolitan areas.

The Australian National Medical Workforce Strategy [17] highlights the following causal and contributing factors for this:

- *"Limited exposure to rural and remote settings during medical school and training*
- *Training programs and curricula that are heavily influenced by metropolitan health settings*
- *Perceptions that clinical practice in rural and remote areas is less prestigious and intellectually satisfying, and that practitioners in these areas are inferior to metropolitan counterparts*
- *Lifestyle requirements, including appropriate employment for partners and schooling for children*
- *Concern that work in a rural or remote setting will be career limiting and restrict an individual's skill acquisition or ability to return to clinical practice in a metropolitan setting*
- *High community-based demands, autonomy, and isolation compared to practice within a larger local workforce*
- *Less sophisticated clinical infrastructure to support clinical practice and other career interests such as research, teaching and new technology."*

Buykx et al [18] highlight further factors that have impacted the rural workforce in recent years. These include:

- Inadequate workforce policies guiding the number of doctors in training
- Changing patterns of employment of doctors as new graduates (with an increased feminisation of the workforce) seeking better work-life balance e.g., decline in hours worked
- Rationalisation of rural health services and changes in rural practice

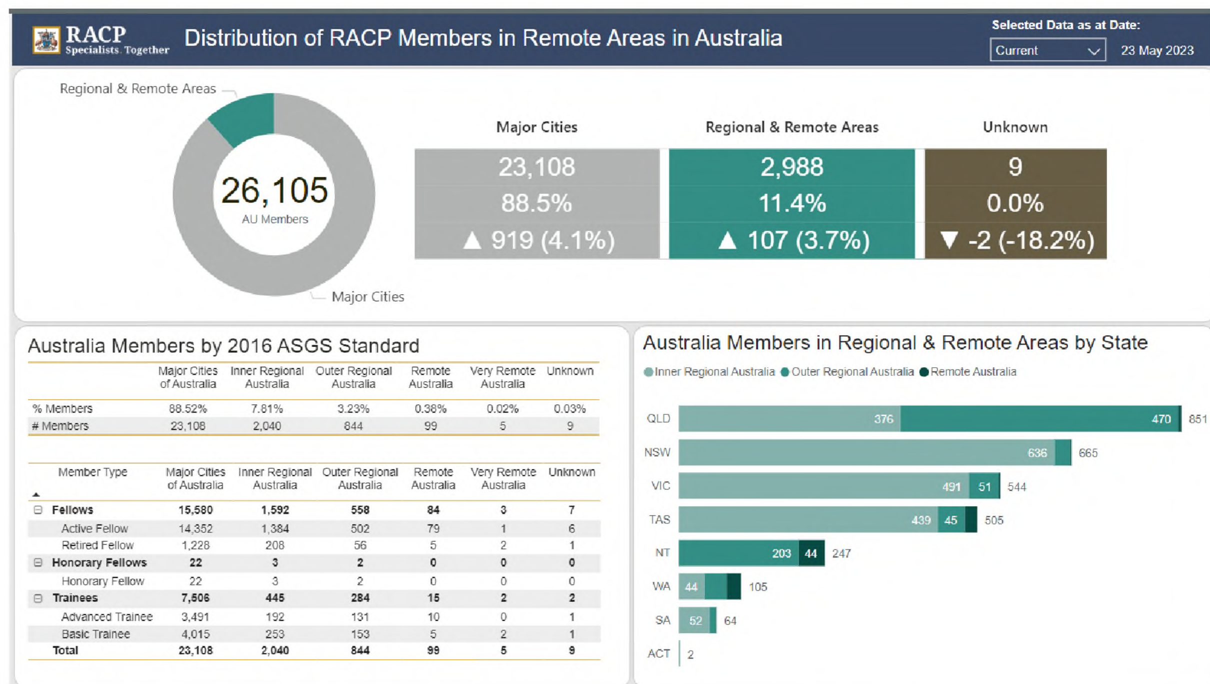
- Increased mobility of the workforce.

Other disruptions include the diversion of trainees from the medical student pipeline, with trainees choosing not to go down rural or other underserved training pathways, and the increase of those choosing highly sub-specialist over generalist training and career pathways.

It is important to note that gaining parity of all types of specialist physicians to the population, across all settings, is not a realistic aim or financially viable or sustainable due to geography, population density, limited infrastructure. Nonetheless the current stark geographic disparities in workforce distribution, healthcare needs and health outcomes mean maintaining and accepting existing disparities is inequitable, will lead to downstream healthcare costs and is likely to have an economic impact both regionally and nationally.

5.5. RACP Snapshot

As of May 2023, 11.4% of Australian RACP members are in regional and remote areas and in Aotearoa New Zealand 0.5 % of RACP members work outside an urban area (refer to Figures 3 and 4).

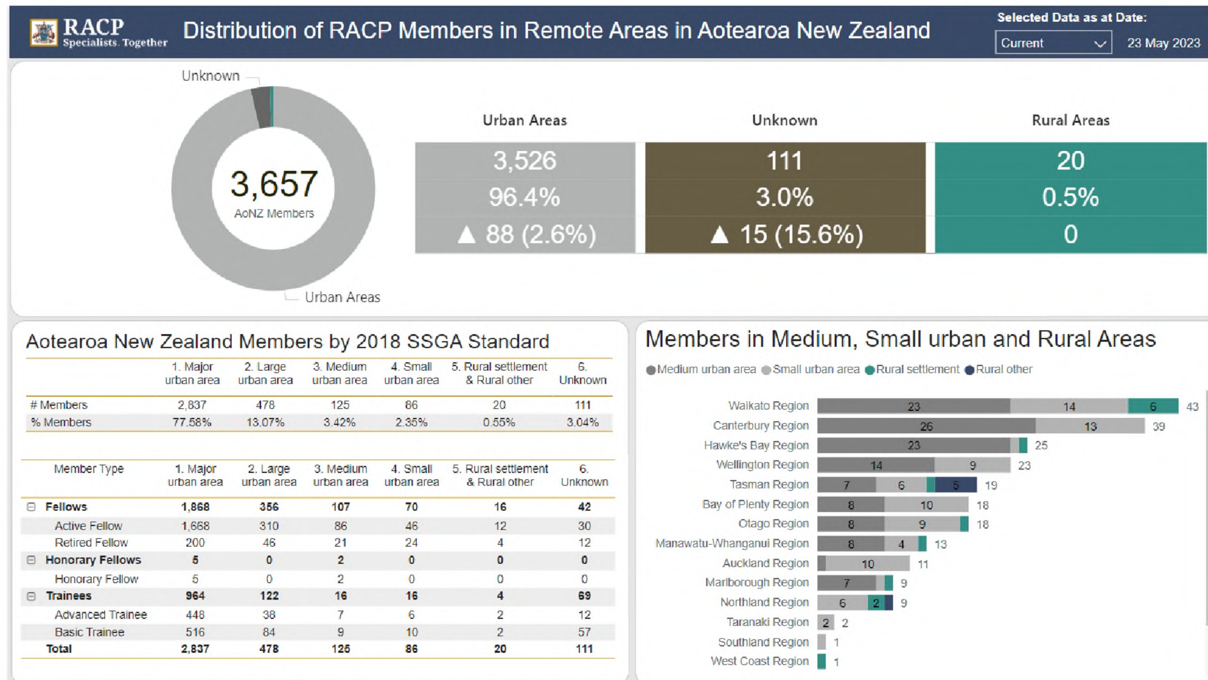


Australia Members by 2016 ASGS Standard

	Major Cities of Australia	Inner Regional Australia	Outer Regional Australia	Remote Australia	Very Remote Australia	Unknown
% Members	88.52%	7.81%	3.23%	0.38%	0.02%	0.03%
# Members	23,108	2,040	844	99	5	9

Member Type	Major Cities of Australia	Inner Regional Australia	Outer Regional Australia	Remote Australia	Very Remote Australia	Unknown
Fellows	**15,580**	**1,592**	**558**	**84**	**3**	**7**
Active Fellow	14,352	1,384	502	79	1	6
Retired Fellow	1,228	208	56	5	2	1
Honorary Fellows	**22**	**3**	**2**	**0**	**0**	**0**
Honorary Fellow	22	3	2	0	0	0
Trainees	**7,506**	**445**	**284**	**15**	**2**	**2**
Advanced Trainee	3,491	192	131	10	0	1
Basic Trainee	4,015	253	153	5	2	1
Total	**23,108**	**2,040**	**844**	**99**	**5**	**9**

Figure 3 – Distribution of Australian RACP members in remote areas (2023)



Aotearoa New Zealand Members by 2018 SSGA Standard

	1. Major urban area	2. Large urban area	3. Medium urban area	4. Small urban area	5. Rural settlement & Rural other	6. Unknown
# Members	2,837	478	125	86	20	111
% Members	77.58%	13.07%	3.42%	2.35%	0.55%	3.04%

Member Type	1. Major urban area	2. Large urban area	3. Medium urban area	4. Small urban area	5. Rural settlement & Rural other	6. Unknown
Fellows	**1,868**	**356**	**107**	**70**	**16**	**42**
Active Fellow	1,668	310	86	46	12	30
Retired Fellow	200	46	21	24	4	12
Honorary Fellows	**5**	**0**	**2**	**0**	**0**	**0**
Honorary Fellow	5	0	2	0	0	0
Trainees	**964**	**122**	**16**	**16**	**4**	**69**
Advanced Trainee	448	38	7	6	2	12
Basic Trainee	516	84	9	10	2	57
Total	**2,837**	**478**	**125**	**86**	**20**	**111**

Note: Gisborne and Nelson regions are captured as null.

Figure 4 – Distribution of Aotearoa New Zealand RACP members in remote areas (2023)

When comparing RACP members to the general population, Australia has a higher number of RACP members per 100,000 than Aotearoa New Zealand. Within Australia, the ACT has the highest and WA the lowest (see Figure 5).

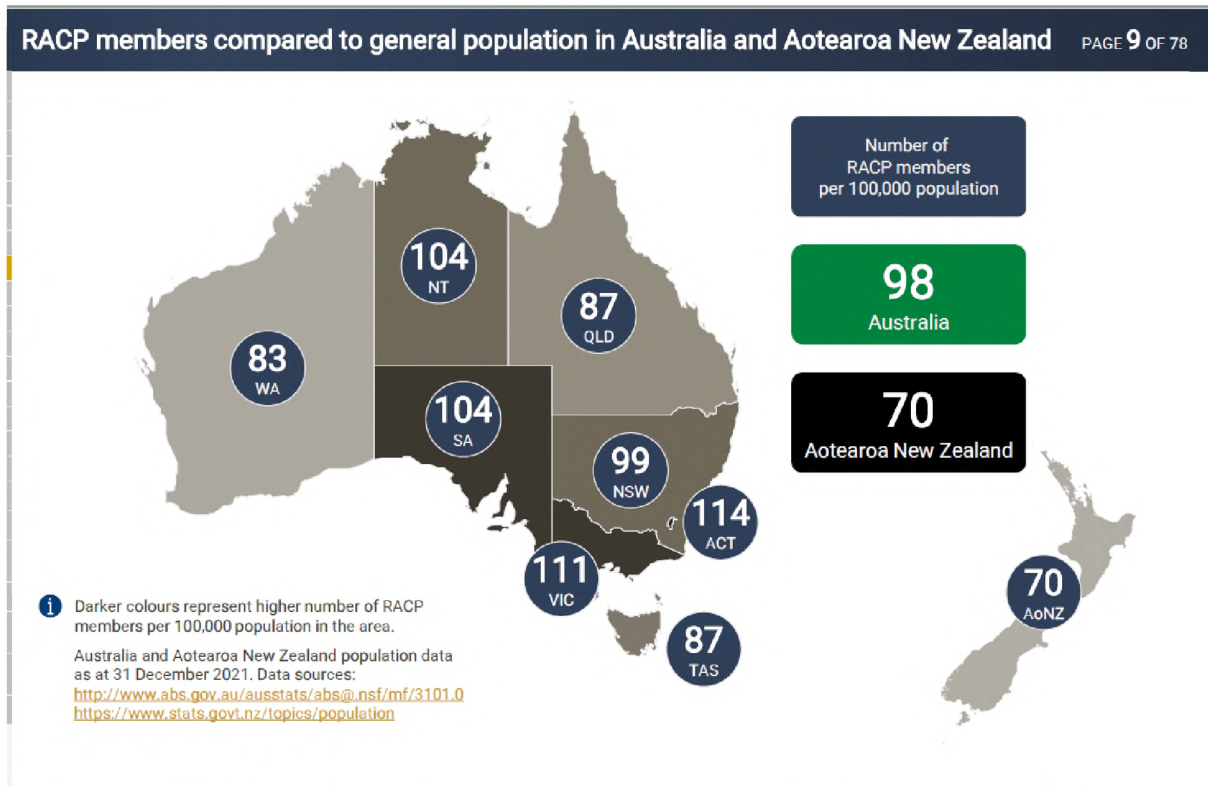


Figure 5 – RACP member compared to general population in Australia and Aotearoa New Zealand (2022)

5.5.1. Aboriginal and Torres Strait Islander and Māori RACP members

As of May 2023, there are 176 self-declared Aboriginal and Torres Strait Islander and Māori RACP members (53 Fellows, 120 trainees, and 3 Honorary Fellows) (see Figure 6).

This has increased since June 2021 where there were 135 self-declared Aboriginal and Torres Strait Islander and Māori RACP members (42 Fellows, 90 trainees, and 3 Honorary Fellows). Growing and supporting the indigenous workforce is important to the RACP.

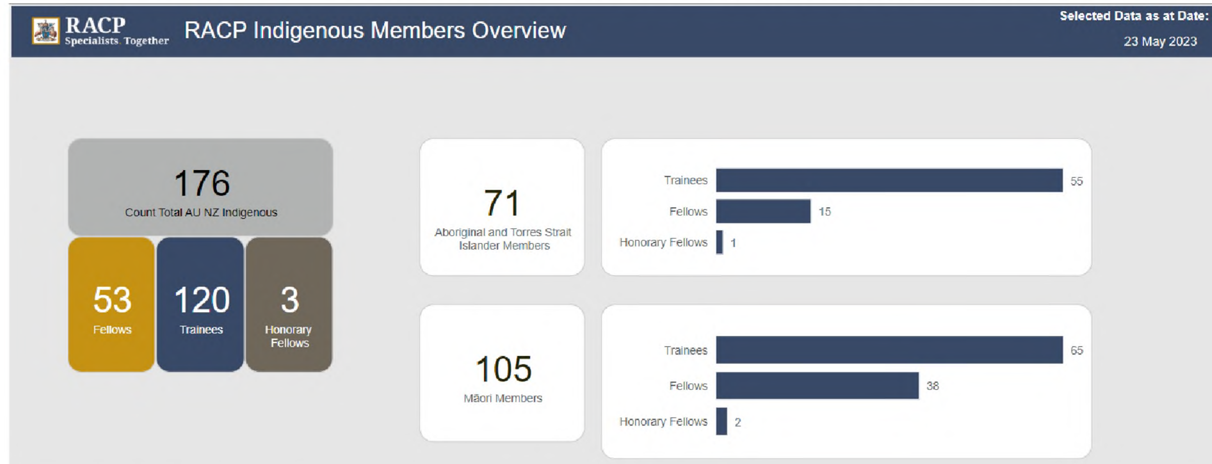


Figure 6 - RACP Indigenous Members Overview (2023)

6. Methodology

This Strategy has been developed by the RRPWG, which met eight times between September 2021 and July 2022. Their inaugural meeting focused on broad member issues including identification of priorities for the RRR workforce to achieve equitable health outcomes, which formed the theme for subsequent meetings. Subsequent meetings addressed barriers to training, supervision accreditation issues, models of care, changing perceptions of working as a physician in RRR areas, and the Australian National Medical Workforce Strategy 2021–2031. Specific issues were recorded, along with draft recommendations.

The draft recommendations and proposed strategy structure were disseminated to key RACP staff and committees for an initial internal consultation. Twenty submissions from individuals or committees with 208 comments either general or specific to individual recommendations were received.

In addition, a revised draft was circulated for external consultation (106 individuals and organisations approached and 36 responses received) and further internal consultation by way of online town hall meetings (March 2023). Over 70 members joined these online meetings.

All feedback received was collated, reviewed and, where appropriate, incorporated into this current version.

7. Building the Regional, Rural and Remote Physician Workforce

7.1. Principles

The following principles, developed by Ostini, O'Sullivan, and Strasser [1], guided the considerations of the RRPWG. A summary of these principles (Pr) is provided at Appendix 9.3:

- Pr1. Grow your own "connected to" place.
- Pr2. Select trainees invested in rural practice.
- Pr3. Ground training in community need.
- Pr4. Rural immersion—not exposure.
- Pr5. Optimise and invest in general medicine.
- Pr6. Include service and academic learning components.
- Pr7. Join up the steps in rural training.
- Pr8. Plan sustainable specialist roles.

8. Recommendations

Recommendations have been grouped within the following focus areas:

1. Prioritise regional, rural, and remote (RRR) healthcare at the RACP.
2. Build capacity and capability to provide physician training in RRR areas.
3. Improve the attraction and retention of RRR physicians.
4. Collaborate to improve RRR healthcare provision.
5. Respect, promote and acknowledge Indigenous people.

Note: Recommendations identified as high priority for the RACP have been highlighted in green.

The following recommendations endeavour to provide a roadmap for the RACP to steer away from the inequitable status quo and reverse what is perceived as an outdated and culturally traditional metrocentric way of physician training to a more inclusive and well-rounded way of training and providing future physicians to all communities.

The purpose of this strategy is to focus on the physician workforce; however, when implementing action items, certain groups such as IMGs and consumers will require specific support, in addition to collaborating with others, such as multi-disciplinary teams and rural generalists.

8.1. RACP to Prioritise Regional, Rural, and Remote (RRR) Healthcare

Rationale

There is a need for the RACP to better understand and clearly commit to the issues faced in regional, rural, and remote (RRR) regions and to support our communities and physicians working in RRR areas. This is a strategic goal of the RACP and aligns with jurisdictional and Federal government's medical workforce strategies.

Recommendations

1	Recognise and endorse the eight foundational principles as a basis for building a sustainable rural physician workforce (Ostini, O'Sullivan, and Strasser (2021)). ***Pr7***
2	Establish a RRR physician College body with representation from jurisdictional committees with a remit to develop a RRR workplan and to collaborate, communicate and engage with regards to RRR issues and initiatives [refer appendix 2]. ***Pr7***
3	All RACP bodies with functions affecting RRR healthcare ensure RRR physician engagement and, where possible, representation. ***Pr7***
4	The terms 'regional', 'rural', and 'remote', as used in the Modified Monash Model, are used by the RACP for the Australian context, and the relevant terminology is adapted to use for the Aotearoa New Zealand context. ***Pr7***
5	Develop RACP centralised workforce data analysis and planning capability which includes a focus on RRR. ***Pr7***
6	Participate and collaborate in research to better understand differing requirements between RRR areas. ***Pr7***

8.2. Build capacity and capability to provide physician training in RRR areas

Rationale

RACP policies, processes, curriculum, and training pathways currently favour metropolitan training sites and risk perpetuating and communicating a cultural bias that influences both existing Fellows and early career prevocational and basic trainees. For example: current accreditation rules and requirements: make it difficult for RRR sites to meet and be eligible for accreditation; can be seen as inflexible; and existing ATC curricula may not recognise the benefits that can be gained in undertaking training in RRR settings. In addition, seeking accreditation can be laborious particularly for training sites with relatively few supervisors and trainees.

Training in RRR provides richness of learning, opportunities, and experiences not available within metropolitan areas. Trainees gain exposure to a wider variety of cases and clinical experiences. This needs to be reflected in RACP training pathways to build capacity and capability to provide training in RRR areas.

The RRPWG considered a requirement that trainees work in a RRR setting for 6 to 12 months to address the inequitable supply of RACP specialist doctors to these areas, and to ensure trainees gained experience in such settings. It was favoured, as providing immersion for trainees was likely to lead to appreciable change in access to specialist physicians for rural people, and improved equity of health outcomes. Impediments included its impact on gender equity and inclusion initiatives, procedural fairness for existing trainees, and the limited capacity to provide sufficient training places for all trainees across all specialties. It was agreed by the RRPWG that RACP should move towards a process by which each trainee in every specialty and chapter will have adequate opportunity and incentive for RRR immersion, and that restrictions such as the drain of trainees to metropolitan areas, and the development of relevant RRR training positions and networks would be addressed.

Recommendations	
7	Move towards a process where each trainee in every specialty and chapter would have adequate opportunity and incentive for RRR immersion during training. ***Pr1,* Pr4**
8	Adult and Paediatrics Basic and Advanced Training pathways value and prioritise RRR training, and the curriculum and learning objectives include competencies for understanding RRR practice and allow flexible term durations. ***Pr5, Pr7***
9	Explore options to better support jurisdictions, Fellows currently practicing in RRR settings, RRR health services and RRR training sites to expand the availability of accredited training places. ***Pr7, Pr8***
10	Advocate in support of the establishment of at least one dedicated RRR training network in each jurisdiction. ***Pr4***
11	Develop selection into training procedures that prioritise the needs of RRR applicants to RACP training programs with training selection panels having RRR representation. ***Pr2***
12	Develop selection into training procedures that prioritise the needs of Indigenous applicants to RACP training programs with training selection panels having Indigenous representation where possible. ***Pr2***
13	Advocate for more equitable employment practices that prioritise the needs for RRR sites. ***Pr2, Pr4***
14	Review and expand supervision policies and mentorship models to better support RRR trainees and Fellows to collaborate by distance. ***Pr4***
15	Advocate with RRR health services to fund and support sufficient allocated time for supervisors to ensure adherence with training standards. ***Pr8***

8.3. Improve the attraction and retention of RRR physicians

Rationale

The perception of RRR training quality, career flexibility, and job satisfaction requires recalibrating to ensure RRR is perceived to be a positive and enriching career/training pathway and not an alternative for inferior trainees and specialists who will never be able to return to metropolitan areas. Ongoing myriad support initiatives for RRR physicians and their family to ensure working in RRR continues to be attractive and rewarding is required to aid retention of RRR physicians. In addition, the perception of RRR clinical practice by metropolitan/urban Fellows and trainees needs to alter to reflect the positives of RRR practice, the quality of clinical practice provided by RRR Fellows, the nature of the structural and resource limitations that characterises healthcare in different RRR settings, and the unique expertise that RRR Fellows bring to the profession and their communities.

Recommendations	
16	Commit to communicating the benefits of a career in RRR medicine including the opportunities, lifestyle, and other benefits. ***Pr1, Pr4***
17	Contribute to the evidence base regarding appropriate standards and levels of access to specialist healthcare for RRR communities. This includes strengthening research opportunities and developing targeted funding for RRR trainees and physicians.
18	Advocate for the benefits of the multidisciplinary approach to healthcare. ***Pr6, Pr8***
19	Develop support pathways for new Fellows transitioning from training to employment in RRR settings. ***Pr8***

20	Enhance and expand generalist and RRR-focussed continuing professional development programs. ***Pr5***
21	Advocate for the importance of formal referral and clinical advisory agreements between RRR generalist and highly specialised metropolitan services. ***Pr6, Pr7, Pr8***
22	Advocate for the optimisation of the STP funding model to better reflect RRR community and organisational need. ***Pr2, Pr3, Pr7***

8.4. Collaborate to improve RRR healthcare provision

Rationale

Physicians are only one part of the stakeholder puzzle of the healthcare team working in a complex healthcare system to provide high quality healthcare to RRR communities. To improve healthcare and health outcomes the RACP needs to collaborate with other healthcare teams such as nurses, GPs and other medical specialities working in RRR settings to share learnings and strengths to make the entire healthcare team more effective and efficient. This in turn addresses healthcare disparities and supports RACP Fellows and trainees.

Recommendations

23	Develop and enhance RACP curriculum resources to better support generalists. ***Pr3, Pr5***
24	Collaborate with relevant stakeholders to advocate and work together to improve services in RRR settings. This includes engaging and collaborating with RRR community members to support trainees and Fellows. ***Pr2, Pr3, Pr7, Pr8***

8.5. Respect, promote and acknowledge Indigenous peoples

Rationale

This Strategy ties into focus area four, *Equitable and healthier communities* of the RACP 2022–2026 Strategic Plan, whereby regional, rural and remote communities are an identified priority. This Strategy will embed principles endorsed within the RACP's Indigenous Strategic Framework 2018–2028 and the initiatives that are being undertaken by that body of work undertaken by the expertise working in that area.

Recommendations

25	Embed the principles endorsed by the RACP Indigenous Strategic Framework. ***Pr3***.
26	Provide training on institutional racism and how to identify and prevent it.

9. Appendices

9.1. Abbreviation Guide

Abbreviation	Meaning
Ahpra	Australian Health Practitioner Regulation Agency
AIHW	Australian Institute of Health and Welfare
AT	Advanced training
CPD	Continuing professional development
FTE	Full time equivalent
GCH	Geographical Classification for Health
GP	General practitioner
IMG	International medical graduate
MCNZ	Medical Council of New Zealand
MMM	Modified Monash Model
RACP	The Royal Australasian College of Physicians
RRPWG	Regional and Rural Physician Working Group
STP	Specialist Training Program

9.2. Glossary of terms

Physicians and paediatricians or medical specialists

In the Australasian context, physicians and paediatricians or medical specialists are doctors who have completed an extra eight years or more of training after their initial university medical training, and who have specialised in the disciplines of adult internal medicine or paediatrics diagnose and manage complex medical problems. Adult physicians manage the medical problems of adults, while paediatric physicians focus on children and adolescents. Patients are generally referred to a physician or paediatrician by a general practitioner, emergency departments, or from other specialties seeking expert medical advice [19].

For the purposes of this document the Australian National Medical Workforce Strategy's definitions of rural generalist and generalist specialist have been adopted [17].

Generalist specialists

Fellows of specialist medical colleges are registered as specialists with the Medical Board of Australia. Generalist specialists work across the full scope of their registered medical specialty. For example, generalist cardiologists care for patients with any heart condition, whereas subspecialist electrophysiologists care for patients with rhythm disorders. Generalist obstetricians and gynaecologists will care for pregnant women, intervene at delivery if needed, and provide gynaecological services such as colposcopy and managing prolapse, whereas gynae-oncologists care for women with gynaecological cancer. In some specialties, generalism has a specific training pathway, such as general medicine.

Rural generalists

A Rural Generalist is 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 [20].

9.3. Foundational Principles for Building a Sustainable Rural Physician Workforce [1]

Pr1: Grow your own "connected to" place

Rural specialist physicians and trainees need a professional identity which encompasses the distinctive scope of practice and learning of a medical professional working in a rural setting. This comes from practising and learning in the locations where physicians intend to practise, and making professional connections in these locations, which cannot occur under an urban-centric training model. Rural physician training also catalyses other rural connections that trainees may have built in rural childhood, during rural undergraduate training or from a rural spouse or partner.

Gaining wider experience relevant to the particular rural health needs of a community may also include access to alternative training settings, including other rural or urban health services, in flexible timeframes. This could include distributed or remote supervision options.

Pr2: Select trainees invested in rural practice

Trainee selection is essential to produce specialist physicians and paediatricians who are likely to take up rural practice. Rural workforce is strengthened by trainee selection practices that recognise and support doctors who have rural experience, or other demonstrated interest or commitment to practising medicine in rural settings.

Pr3: Ground training in community need

Rural regions and rural people need physicians with general medicine skills as a foundation complemented by additional advanced skills that may be community specific. As such, rural physician practice needs to be recognised as dynamic in response to community need. Physicians should be able to add to or change their advanced skills if the needs of a community change, or they move to a different community. This requires training and up-skilling opportunities accessible to rural physicians coupled with credentialing for providing these services, which provides flexibility to work in a range of locations.

Pr4: Rural immersion —not exposure

Rural immersion is much more than rural "exposure". Positive training and supervision experiences involve personal and professional elements, connected to the social and cultural aspects of a community. This requires longer rural experiences, in healthcare settings and the community, supported by appropriate employment contracts. Positive experiences also rely on supportive training and practice environments, encompassing practice sites, professional colleges, and local communities.

Short-term rotations or exposures, such as 3-month rotations to rural areas, do not support connection or exploration of the scope of learning opportunities. This is exacerbated by a lack of rural location-specific curriculum and mission.

Pr5: Optimise and invest in general medicine

Training in rural locations provides access to a broad range of presentations in a generalist healthcare team and greater responsibility due to fewer points of delegation. This is an excellent foundation not only for rural medical training but also for highly specialised training available in other locations, and it builds excellence in medical practice by encouraging trainees in formative stages to understand the spectrum of patient care. Highly specialised care is not cost-effective or comprehensive for most of the healthcare needs of the Australian population, including for older people with multimorbidity. In rural areas, it greatly escalates patient costs and travel requirements, and creates a risk of unsafe, dislocated care.

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Pr6: Include service and academic learning components

All trainees in rural areas need access to supervised training that includes health service work and academic opportunities, which inform rural service quality improvement. Rural teaching and research capabilities play a role in rural medical workforce recruitment. Support for training, service and research may require considerable flexibility in training program design, including viable rosters and time for study and research. This flexibility requires engagement by stakeholder leadership, the development of supportive governance structures, institutional accountability, and rural research capacity.

Pr7: Join up the steps in rural training

The long physician training journey involves many stakeholders operating at different times and at critical junctures. Owing to the number of stakeholders, their organisational interests and the amount of time that medical training requires, there is a high risk that medical career stages are not coordinated, with the greatest implications for sustaining a rural workforce. Stakeholder groups have different interests, goals and needs that must be met. Competing purposes can result in a misalignment of good faith efforts to support trainees and supervisors. Strong accountability by stakeholders, through leadership and governance, is needed to align individual organisational efforts, and thereby bridge gaps and align steps in rural training.

Pr8: Plan sustainable specialist roles

A responsive rural medical career pathway requires robust, future-focused workforce policy, planning and design. This requires design focused on local health systems, community needs, and dynamic work environments. It includes training a rural workforce in local, outreach and telehealth work, and enabling rural physicians to supervise trainees. Rural medical practice requires broadly connected clinical networks across locations. These will support training, upskilling and supervision for specialists with fewer co-located peers; working across medical specialties, including general practice; and interprofessional modes of practice.

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11. DOCUMENT HISTORY

Revision	Date	Summary of Changes
1.0	23/06/2023	Approved by RACP Board.
1.1	17/07/2023	Minor typographical corrections; document history added.