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Regional, Rural and Remote Physician Strategy

Table of Contents

1. 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, 11.6% 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 0.6% 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 College Board (Board) in July 2020, the College 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 College Council meeting. The RRPWG brought together members with knowledge and expertise in living, training, and working 'out bush'. In addition, they had an ongoing commitment and desire to develop the RACP's regional and rural 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 draft recommendations for the RACP to consider.

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

1. Grow your own "connected to" place.

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

2. Select trainees invested in rural practice.
3. Ground training in community need.
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 draft 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.

2. Purpose

This report 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.

3. Introduction

The RACP College Council (the RACP's peak advisory body to the Board) has 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 provides recommendations to guide the activities of the RACP in this area.

It is important to note that while the paper focusses on the physician workforce, physicians do not work in isolation and require collaboration with Primary Care, other medical specialties, Allied Health and Nursing services to provide effective care to their communities. Workforce shortages across these other areas must be addressed in coordination with the suggested strategies to improve access to RACP specialties for Regional. Rural and Remote communities.

4. Strategic Alignment

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

- RACP 2022–2026 Strategic Plan – Focus area three, *Physician and practice of the future* and focus area four, *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.

4.1. The Regional and Rural Physician Project

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

4.1.1. Vision statement

The following vision statement was developed by the College 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."

4.2. RACP Regional and Rural Physician Working Group

The College 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.

4.2.1. 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 report provides an invaluable perspective on RRR physician workforce issues in Australasia.

The membership of the RRPWG is provided in Table 1.

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 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

Table 1 – Members of the RRPWG

5. Defining 'Regional, Rural, and Remote'

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

5.1. Australia

In Australia, this strategy refers to the Australian Government Department of Health and aged care's Modified Monash Model (MMM). 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.

The classification divides Australia into seven classes:

- MM1 – Metropolitan
- MM2 – Regional centres
- MM3 – Large rural towns
- MM4 – Medium rural towns
- MM5 – Small rural towns
- MM6 – Remote communities
- MM7 – Very remote communities.

5.2. Aotearoa New Zealand

In Aotearoa New Zealand, urban/rural locations are defined on a population basis as follows:

- Major urban area – 100,000 or more residents
- Large urban area – 30,000 to 99,999 residents
- Medium urban area – 10,000 to 29,999 residents
- Small urban area – 1,000 to 9,999 residents.

Rural areas represent land-based areas outside urban areas and are classified as rural settlements or other rural (Stats NZ, 2022).

6. Background

6.1. 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 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)

(Australian Institute of Health and Welfare, 2022)

In Aotearoa New Zealand, most New Zealanders live in the urban areas, while only 16.3% of the population live in rural areas or small towns (Ministry for Primary Industries, 2018).

In 2018, the proportion of New Zealanders by urban/rural area was:

- 51.2% in the major urban areas

- 14.1% in large urban areas
- 8.4% in medium urban areas
- 10.0% in small urban areas
- 16.3% in rural areas.

(Environmental Health Intelligence New Zealand (EHINZ), Massey University, Wellington, 2018)

6.1.1. 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.

While Aboriginal and Torres Strait Islander peoples (Indigenous Australians) are more likely to live in urban and regional areas than remote areas (33%, 44%, and 18%, of the Indigenous populations respectively) the proportion of the total population who are Indigenous is generally higher in remote areas (from 1.8% in Major cities, to 32% in Remote and Very Remote areas) (Australian Institute of Health and Welfare, 2021).

Māori also comprise a higher proportion of the population living in small urban areas (14.7% of the Māori population) and rural areas (18.0%), compared with the total population (10.0% and 16.3% respectively) (Environmental Health Intelligence New Zealand (EHINZ), Massey University, Wellington, 2018).

6.1.2. 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. While 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 with onset of chronic disease and morbidity often occurring at a younger age. 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 (Australian Institute of Health and Welfare, 2022) (Ministry for Primary Industries, 2018) (Crengle S, 2022 Aug 18;).

These populations face shared and distinct challenges in healthcare access, including that relating to specialist healthcare. In addition access to primary care and to multidisciplinary team care is also poorer for those living in regional, rural and remote communities. 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 (Australian Institute of Health and Welfare, 2022).

Health inequalities in rural and remote areas are due to myriad 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 (Australian Institute of Health and Welfare, 2022).

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:

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

(AIHW 2019)

6.2. 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 1) (Australian Institute of Health and Welfare, 2022).

	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

Table 2 – Median age at death, mortality rate and rate ratio, by sex and remoteness area (2020) (Australian Institute of Health and Welfare, 2022)

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 (Australian Institute of Health and Welfare, 2022).

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 (AIHW, Rural and remote populations, 2018).

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, overall life expectancy is similar for both rural and urban populations (National Health Committee, 2010); however, research has found that, generally, health outcomes are poorer for those in rural areas (Steed, 2010).

6.3. Rural Medical Workforce – Current State

Getting skilled medical workforce into RRR areas is critical in delivering high quality heath care services to these populations. AIHW data shows that remote areas have seven times fewer specialists compared with major cities (Australian Institute of Health and Welfare, 2022).

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 Figure 1 and Figure 2) (MCNZ, 2021).

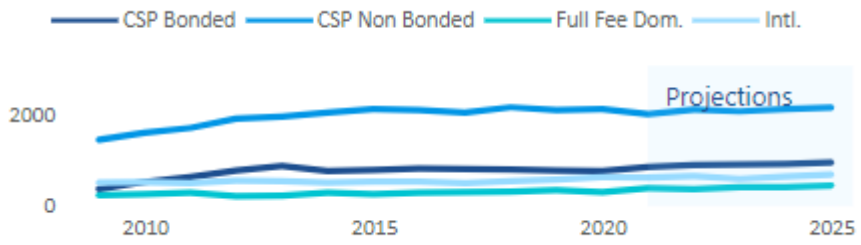

Figure 1 - Medical School Graduates in Australia 2009 to 2025

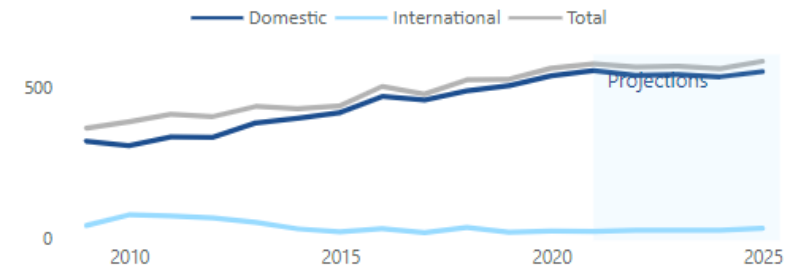

Figure 2 -Medical School Graduates in Aotearoa New Zealand 2009 to 2025

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) (Medical Deans Australia and New Zealand, 2022). 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) (Australian Institute of Health and Welfare, 2022) (MCNZ, 2021).

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, for all Ahpra registered professions, the number of employed FTE clinicians decreased with increasing remoteness. In 2020, there were also 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:

- Major cities had 2,077 clinical FTE per 100,000 people
- Inner regional areas had 1,890 FTE per 100,000 people.
- Outer regional areas had 1,761 FTE per 100,000 people.
- Remote areas had 1,959 FTE per 100,000 people.
- Very remote areas had 1,833 FTE per 100,000 people.

(Australian Institute of Health and Welfare, 2022)

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 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 (MCNZ, 2021).

6.4. Disruptions Contributing to the Rural Workforce Shortage

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

- 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.

(Queensland Health, 2020)

However, there remains a preference for metropolitan areas.

The Australian National Medical Workforce Strategy 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."*

(Australian Government, Department of Health and Aged Care, 15 March 2022)

Bukyx et al (2010) also 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 the nature of rural practice
- Increased mobility of the workforce

Importantly, these factors also result in limitations to the access to interdisciplinary team-based care required for the effective practice of many specialties.

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.

For some specialties such as Occupational and Environmental Medicine (OEM), Public Health and Sexual Health Medicine there is no training infrastructure in rural communities, predominantly as a result of their non-hospital based model of training.

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.

6.5. RACP Snapshot

As of November 2022, 11.6% of Australian RACP members are in regional and remote areas and in Aotearoa New Zealand 2.9 % of RACP members work outside an urban area. See Figure 3 and Figure 4).

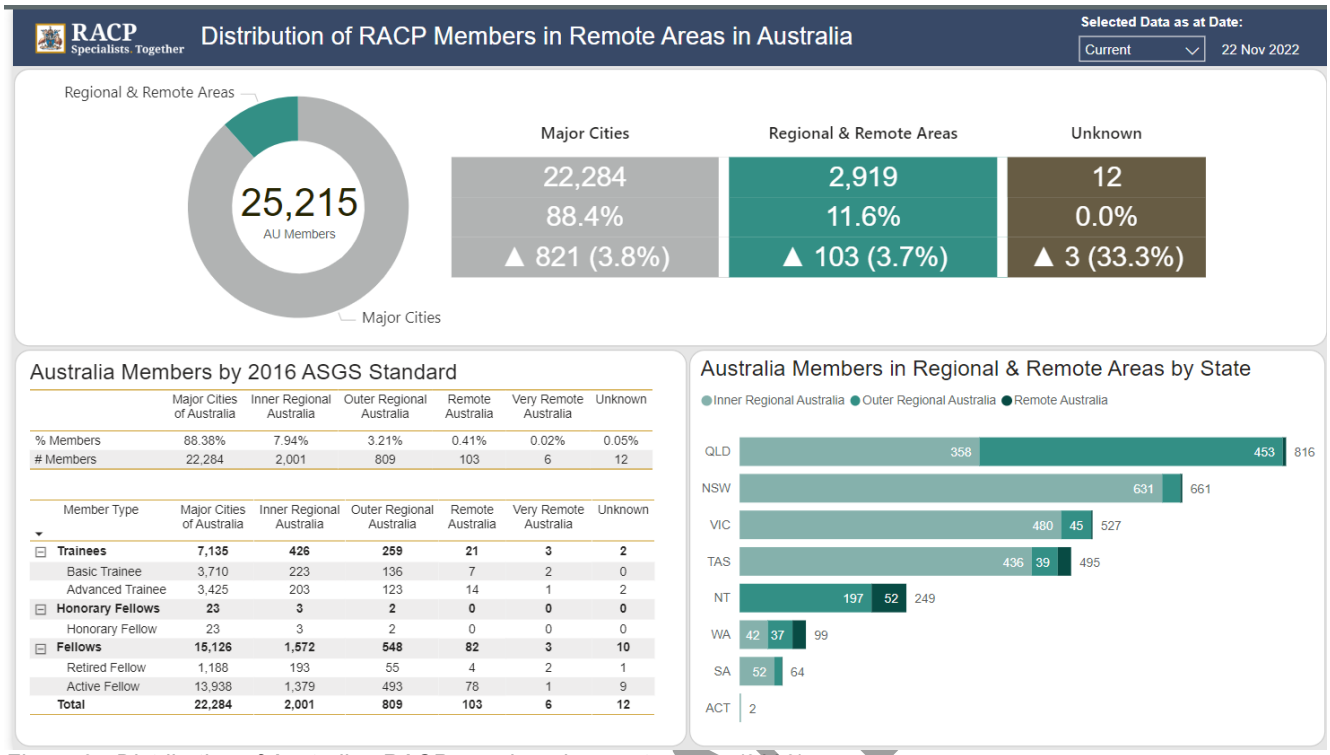

Figure 3 - Distribution of Australian RACP members in remote areas (2022)

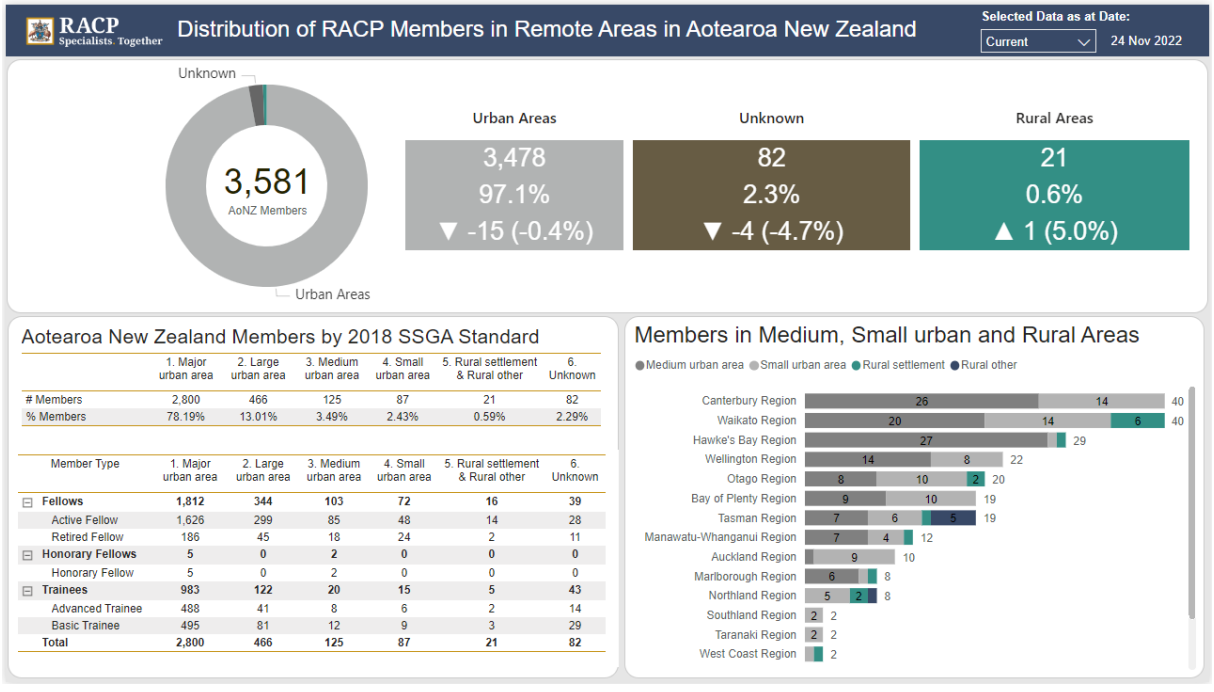

Figure 4 -Distribution of Aotearoa New Zealand RACP members in remote areas (2022)

Note: Gisborne and Nelson regions are captured as null.

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).

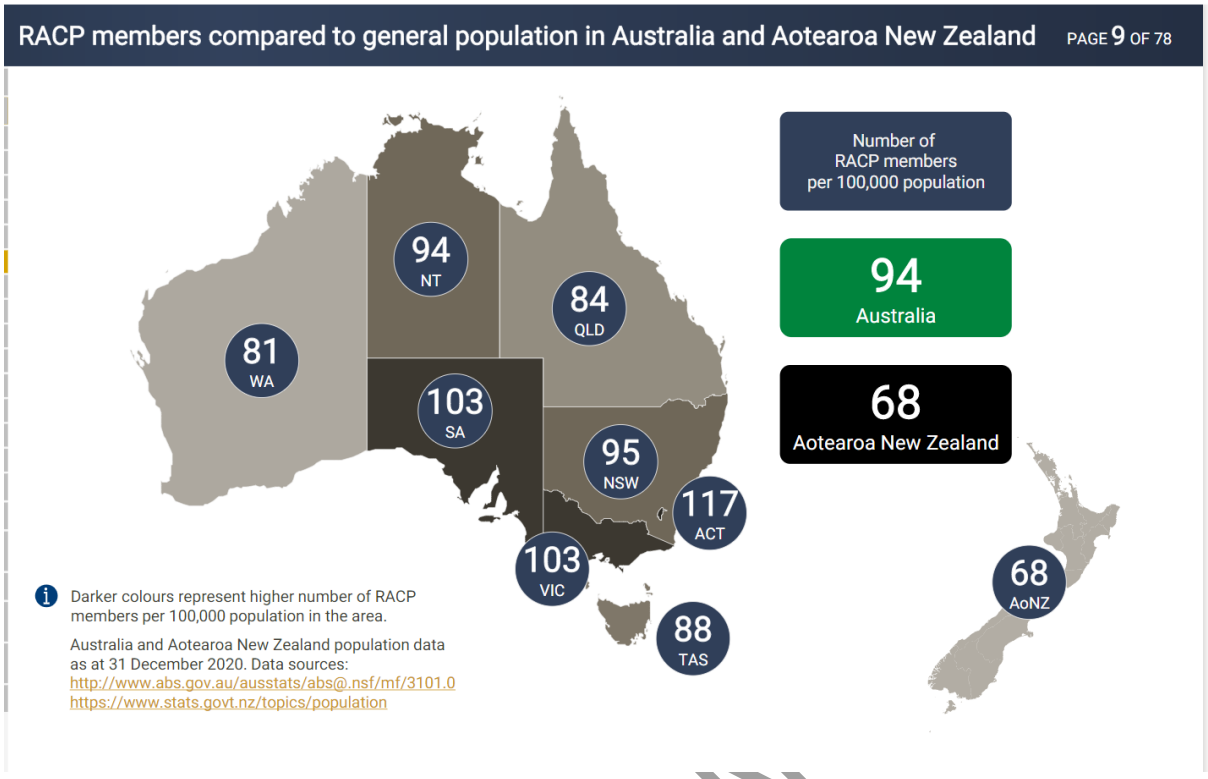

Figure 5 - RACP member compared to general population in Australia and Aotearoa New Zealand (2020)

6.5.1. Aboriginal and Torres Strait Islander and Māori RACP members

Currently, there are 150 self-declared Aboriginal and Torres Strait Islander and Māori RACP members (of which 50 are Fellows, 97 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 (of which 42 were Fellows, 90 trainees, and 3 Honorary Fellows). Growing and supporting the indigenous workforce is important to the RACP.

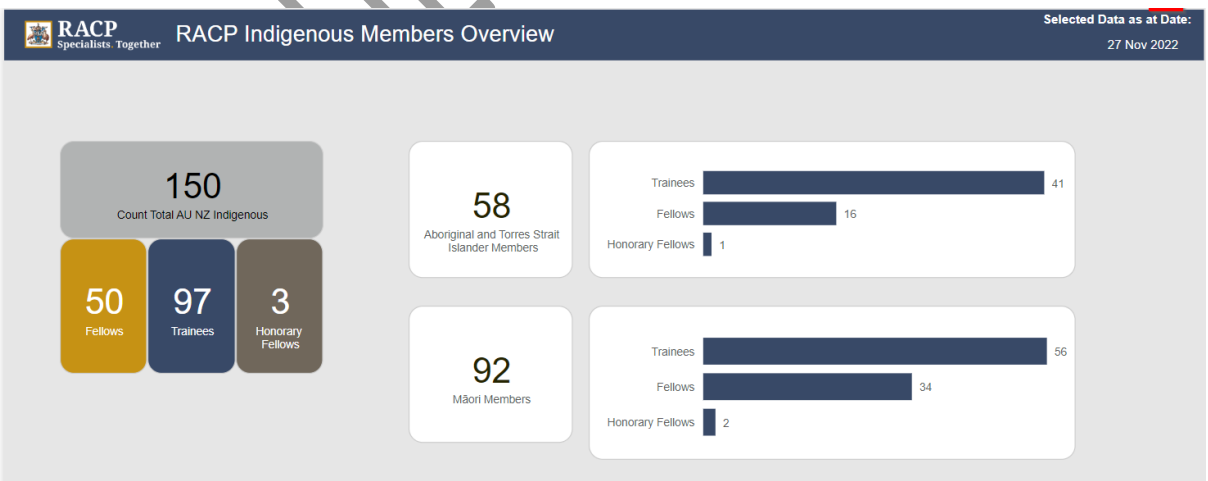

Figure 6 - RACP Indigenous Members Overview (2022)

7. 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 committees (n=24) and staff for an initial internal consultation. These included:

- College Council
- Aboriginal and Torres Strait Islander Health Committee (ATSIHC)
- Māori Health Committee (MHC)
- College Education Committee (CEC)
- College Training Committee (CTC)
- Adult Medicine Division (AMD)
- Paediatric and Child Health Division (PCHD)
- Australasian Faculty of Public Heath Medicine (AFPHM)
- Australasian Faculty of rehabilitation Medicine (AFRM)
- Australasian Faculty of Occupational and Environmental Medicine (AFOEM)
- Australasian Chapter of Palliative Medicine (AChPM)
- Australasian Chapter of Addiction Medicine (AChAM)
- Australasian Chapter of Sexual Health Medicine (AChSHM)
- Aotearoa New Zealand Committee (AoNZC)
- The seven College Australian regional committees
- Consumer Advocacy Group (CAG)
- Member Health and Wellbeing Committee (MHWC)
- Member Diversity Committee (MDC)
- Accreditation team
- Education, leaning and assessment team
- Policy and advocacy team
- Specialist Training Program team
- Overseas Trained Physician team

Twenty submissions from individuals or committees with 208 comments either general or specific to individual recommendations were received.

The feedback has been collated, reviewed and where appropriate incorporated into this current version.

8. Building the Regional, Rural and Remote Physician Workforce

8.1. Principles

The following principles, developed by Ostini, O'Sullivan, and Strasser (2021), guided the considerations of the regional, rural, and remote (RRR) physician workforce strategy: A summary of these principles (Pr) are provided in Appendix 1.

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.

9. Recommendations

The following 25 draft 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. Consider Indigenous populations.

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

These 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.

9.1. 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 governments medical workforce strategies.

	Recommendations	**Possible action items**
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***	Governance sign off the eight foundational principles.
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***	Convene as standing sub-committee of College Council with: - reporting and associated representation on College Council - secretarial support - College Council endorsed workplan
3	All RACP bodies with functions affecting RRR healthcare ensure RRR physician engagement and where possible representation. ***Pr7***	A specific regional and rural agenda item. Development of KPI for annual reporting to College Council/Board.

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***	Communication strategy and plan to inform RACP staff and College bodies.
5	Develop RACP centralised workforce data analysis and planning capability which includes a focus on RRR. ***Pr7***	Support for development of a workforce unit within the Office of the Dean.
6	Participate and collaborate in research to better understand differing requirements between RRR areas. ***Pr7***	Develop RACP RRR research strategy and formation of research alliance MOUs with research organisations (universities etc), RRR health services, jurisdictional workforce organisations and agencies (DoH, AIHW).

9.2. 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 unanimously agreed that one way to build capacity and to ensure trainees could all experience training in RRR areas would be that all RACP specialties and ATCs mandate 12 months training in a RRR setting. However, this was found to be very controversial during stakeholder consultation of the first draft of the recommendations with many RACP College committees and individuals strongly opposing this recommendation. Impediments to such an approach included its impact 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.

Recommendations	**Possible action items**

7	All 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***	Gap analysis. - curriculum review to determine which curriculum courses currently have a RRR component. - AT selection processes to determine whether factors enhancing future rural intention to practice are utilised in AT selection. - trainee survey and input regarding barriers and enablers to RRR training and RRR intention to practice. Evaluate RRR term characteristics against training curricular to highlight training and career opportunities. Reinforce the need to ensure that indigenous health is imbedded in training curricula
8	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***	Survey of RRR stakeholders to understand what is needed. Enhance processes to support settings to apply for and gain accreditation
9	Advocate in support of the establishment of at least one dedicated RRR training network in each jurisdiction. ***Pr4***	Development and implementation of a RACP policy and advocacy framework for engaging with jurisdictions and Governments including proposed structure and funding model. Collaborate with local health authorities and universities to develop bilateral high-quality regional centres of training.

10	Develop selection into training procedures that prioritise the needs of RRR applicants to RACP training programs with training selection panels having RRR representation. ***Pr2***	Development and implementation of a RACP standardised and centrally collated and analysed data collection system for selection to advanced training. Implement processes which ensure RRR applicants are not disadvantaged
11	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***	See 10. above Development and implementation of selection to AT criteria that reflect and prioritises the lived experience and cultural expertise of Indigenous people.
12	Advocate for more equitable employment practices that prioritise the needs for RRR sites. ***Pr2, Pr4***	See 9. above
13	Review and expand supervision policies and mentorship models to better support RRR trainees and Fellows to collaborate by distance. ***Pr4***	Development of tailored mentorship resources for RRR. Development of RACP policy for remote supervision that in turn informs ATC accreditation.
14	Advocate with RRR health services to fund and support sufficient allocated time for supervisors to ensure adherence with training standards. ***Pr8***	Roundtable with relevant RRR sites to understand how much time would be required and if it is actually feasible. Feasibility study. See 9. above

9.3. Improve the attraction and retention of RRR physicians

Rationale

The perception of RRR training quality, career flexibly and job satisfaction requires recalibrating to ensure RRR is perceived to be a positive and enriching career/training pathway Ongoing multifaceted 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.

Recommendation		Possible action items
15	Commit to communicating the benefits of a career in RRR medicine including the opportunities, lifestyle, and other benefits. ***Pr1, Pr4***	Webinar on "moving to the bush". Engagement strategy with medical schools and prevocational and basic physician trainees. Development of CPD resources and cultural safety initiatives with a focus on improving the understanding of RRR healthcare by metropolitan- and urban-based physicians.
16	Contribute to the evidence base regarding appropriate standards and levels of access to specialist healthcare for RRR communities.	See 6. Above.
17	Advocate for the benefits of the multidisciplinary approach to healthcare. ***Pr6, Pr8***	Review of ATC curricula to ensure demonstration of participation in and understanding of the principles and practice of multidisciplinary care are defined learning objectives.
18	Develop support pathways for new Fellows transitioning from training to employment in RRR settings. ***Pr8***	Development of CPD resources. See 13. above
19	Enhance and expand generalist and RRR-focussed continuing professional development programs. ***Pr5***	RACP prioritises the needs of generalism and RRR Fellows and trainees when developing RACP training and CPD initiatives and in advocating for such support via jurisdictions and Governments. RACP develops systems for supporting RRR trainees and Fellows that does not exclusively focus on virtual delivery and rather seeks hybrid models that may require travel support.

20	Advocate for the importance of formal referral and clinical advisory agreements between RRR generalist and highly specialised metropolitan services. ***Pr6, Pr7, Pr8***	Development of a RACP position statement and model of care for RRR-metropolitan/urban engagement and care navigation.
21	Advocate for the optimisation of the STP funding model to better reflect RRR community and organisational need. ***Pr2, Pr3, Pr7***	See 9. Above.

9.4. 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.

Recommendation		**Possible action items**
22	Develop and enhance RACP curriculum resources to better support generalists. ***Pr3, Pr5***	Liaise with relevant specialist medical colleges (e.g.,ACRRM, RNZCGP) to ask them which curriculum resources topics they would want to see prioritised for their members.
23	Collaborate with relevant stakeholders to advocate and work together to improve services in RRR settings. ***Pr2, Pr3, Pr7, Pr8***	See 9. and 15.

9.5. 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.

Recommendation		**Possible action items**
24	Embed the principles endorsed by the RACP Indigenous Strategic Framework. ***Pr3***.	See 15.
25	Provide training on institutional racism and how to identify and prevent it.	See 15.

10. Appendices

10.1. Abbreviation Guide

Ahpra	Australian Health Practitioner Regulation Agency
AIHW	Australian Institute of Health and Welfare
AT	Advanced training
CPD	Continuing professional development
FTE	Full time equivalent
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

10.2. 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 (Royal Australasian College of Physicians, 2022).

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

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

Rural generalists are a subset of GPs.
A Rural Generalist is a doctor 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 specialty care in hospital and community settings as part of a rural healthcare team. (Australian Government, Department of Health and Aged Care, 15 March 2022)"

10.3. Foundational Principles for Building a Sustainable Rural Physician Workforce

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.

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.

Source: (Ostini R, 2021).

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