



**RURAL DOCTORS  
ASSOCIATION  
OF AUSTRALIA**

# **RURAL HEALTH MATTERS: ELECTION PRIORITIES 2025**

**23 JANUARY 2025**

## About RDAA

The Rural Doctors Association of Australia (RDAA) is the peak national body representing the interests of doctors working in rural and remote areas and the patients and communities they serve. RDAA is committed to ensuring rural and remote communities have access to a range of medical services aligned with their needs, and access to 24/7 emergency care is essential.

RDAA's election priorities focus on the health issues that matter most to people living in rural and remote Australia. They want:

- Better access to medical services;
- More health services available locally; and
- Less waiting time.

Delivering health care in 'real rural' communities (those classified by the Modified Monash Model (MMM) 3-7) is significantly different to delivering health care in metropolitan or large regional centres (MMM1-2), and require targeted initiatives. Investing in 'real rural' health provides benefits that extend beyond the local community; when rural and remote Australians receive care locally it reduces pressure on health services in larger regional towns.

## Summary

Rural health matters. Access to health care is a primary cause of poorer health outcomes for rural and remote Australians. RDAA's election priorities are aimed at increasing access to medical and other health services in the short term, as well as laying the foundations for longer term investment to improve the sustainability of rural and remote health services.

RDAA has developed a five-point plan to address both the most urgent issues, and longer-term solutions for issues affecting access to health care in rural and remote Australia:

1. Train more rural doctors
2. Get more specialists
3. Build more work spaces
4. Help parents stay in the workforce
5. Plan for the future

## **1. Train more rural doctors:**

### **Continue investing in Rural Generalist Training**

Recent investment and developments in rural generalist training have been highly successful. The number of rural generalist training positions needs to increase by 200 FTE, and additional investment is required to facilitate quality supervision of current and future trainees. Continuing support for incentives and employment reform must be maintained, and recognition of rural generalism within the Medicare Benefits Scheme (MBS) and Pharmaceutical Benefits Scheme (PBS) must be prioritised and progressed.

## **2. Get more specialists**

### **Increase support for rural and remote Consultant (non-GP) Specialists**

Greater access to specialist care outside of major cities is essential. Rural consultant specialists need access to support from Primary Health Networks (PHNs), recruitment and retention support through the Workforce Incentive Program (WIP) Medical Stream, and a reformed Specialist Training Program (STP) that actually delivers on the intent of the program.

## **3. Build more workspaces**

### **Infrastructure grants for rural and remote general practices and hospitals**

The investment required to expand infrastructure so as to increase training capacity and ability to deliver multidisciplinary care is simply unaffordable for many small facilities. Rural general practices and rural hospitals need access to grants to facilitate expansion of service.

## **4. Help parents stay in the workforce**

### **Pilot program to increase access to childcare for essential workers in rural areas**

A lack of access to childcare is a significant barrier to the medical workforce in rural areas. RDAA proposes a pilot program of commercial childcare facilities on hospital grounds.

## **5. Plan for the future**

### **Development of a National Rural Health Strategy**

This strategy would enable the outcomes from recent reviews to be considered in the rural context and progressed appropriately for the rural and remote context

Investment into these key targeted areas will alleviate the more urgent need as well as build the foundation for longer term sustainable investment to increase access to medical and other health services for people living in rural and remote Australia.

## 1. Continue investing in Rural Generalist Training

**Further development of the rural generalist workforce is needed to increase access to medical services for people living in rural and remote Australia.**

The recent investment in the National Rural Generalist Training Pathway, the progression of recognition of Rural Generalism as a sub-specialty of general practice, and the increased Rural Generalist (RG) training positions has generated a significant increase in interest in and uptake of RG training. This has been an exciting development for rural patients and the recent and current investment in rural generalism needs to continue, along with additional investment, so this pathway delivers on its promise to provide the medical workforce that rural and remote communities need.

There is no ongoing commitment to continue current investment into many of these highly successful programs, incentives and initiatives. Long term commitment to rural generalist training and the development of the rural generalist workforce is needed.

### 200 more Rural Generalist training positions

Increased interest in rural generalist training has created a need for more training positions with the Royal Australian College of General Practitioners (RACGP) and the Australian College of Rural and Remote Medicine (ACRRM). The current 'one off' quota increase needs converting to permanent training positions. This will enable the Colleges to develop and sustain their training capacity at the required level, as well as give junior doctors and medical students confidence in their future training and career ambitions.

200 more rural generalist training places are needed to enable the development of the future medical workforce to meet the health services needs of Australian rural and remote communities. These additional positions would ensure the rural generalist workforce continues to grow to fill the gap created the ageing rural medical workforce entering retirement, and to accommodate the growing desire/need of more health care professionals to work part time clinical hours.

### Improve support for GP supervisors

To enable the existing GP/RG workforce to train larger numbers of RG registrars, more support for supervisors is needed. Flexible supervision models need to be enabled as well additional investment to ensure that GPs providing supervision are fairly remunerated so that quality and supportive training experiences can be provided without undermining the viability of community based general practice.

## Maintain incentives, improve recognition and reform employment for Rural Generalists

Incentives paid directly to rural and remote doctors under the Workforce Incentive Program (WIP) must be retained, and the recognition of rural generalism within the Medicare Benefits Scheme (MBS) and Pharmaceutical Benefits Scheme (PBS) must be prioritised and progressed. Employment reform, such as the Single Employer Model, also needs continued support and further work.

### Invest in programs that work

Funding should be directed to the training models that actually achieve the intended outcomes of the program and/or investment. I.e. Actually, deliver on a rural generalist workforce, in MMM3-7 locations, beyond the training period.

The allocation of new and existing funding for training positions to the Colleges should not be solely based on process, but also be directed in response to measured success in delivering doctors with the right skills beyond the training years into real rural locations.

<b>Funding needed:</b>	200 more RG training positions and improved GP supervisor support	\$100 million (p.a.)
	Maintain incentives, improve recognition and reform employment	\$200 Million (p.a)

## 2. Increase support for rural and remote based consultant specialists

Consultant Specialist services are difficult to access outside of MMM1-2 locations. More needs to be done to expand the training of consultant specialists outside of the major centres, and more support is needed attract and retain the consultant specialist workforce providing care in rural and remote locations.

Enabling rural and remote Australians to access more specialist care close to home saves system and individual costs through reduced travel, and enhances quality of care when specialists work within a local integrated multidisciplinary team.

Rural Australians do not expect all specialist services to be available locally, but a near complete lack of psychiatry, paediatric, gynaecological, orthopaedic, cardiac and general surgical services impact on health outcomes and reduces the life expectancy for people living in communities without reasonable access.

**RDAA calls for three key reforms to facilitate and support greater access to consultant specialist services in rural and remote Australia:**

1. Expand the remit of the Primary Health Networks to support consultant specialists and their practices located in rural and remote Australia.
2. Expand the Workforce Incentive Program Medical Stream to support recruitment and retention of rurally based consultant specialists and registrars.
3. Reform the Specialist Training Program allocation process to deliver on the intent of the program and provide greater transparency as well as a more robust prioritisation within the program. This reform should include the provision of structured and transparent financial support (similar to the Australian General Practice Training program), the introduction of a direct payment to registrars undertaking a real rural placement, and a direct payment to the private practices that facilitate specialist training.

<b>Funding needed:</b>	WIP Doctor Stream expansions	\$50 million (p.a.)
	PHN Service expansion	\$3 Million (p.a.)
	STP reform	\$1 million (p.a.)

### **3. Infrastructure grants for rural and remote general practices and hospitals**

While a longer-term infrastructure strategy is required as part of the National Rural Health Strategy, in the short term there are urgent areas need targeted investment to facilitate an increase in the provision of multidisciplinary care, increased training across the multidisciplinary team as well as enhance the quality and safety of the medical and other health services being provided to rural and remote Australians.

Investment is needed to support established general practices to enhance and/or increase the provision of training across the multidisciplinary team as well as to increase service provision to rural patients. Infrastructure grants are needed to support projects that would increase these services, including for extending current buildings, construction of additional training facilities, improvements to IT infrastructure, expansion to enable on-site minor operation rooms, expanding services such as ultrasound facilities.

A short-term grant program is needed to support small rural and remote hospitals to address deficiencies that are impacting on their ability to provide meet current requirements for quality patient care, such as upgrades to air-conditioning, operating theatre standards, birth suite upgrades, infection control standards, and basic staff amenities such as computers to enable an efficient completion of information to electronic health records, medication management and monitoring of diagnostic results.

<b>Funding needed:</b>	General Practice grants	\$100 million
	Small rural hospitals grants (matched by state governments)	\$50 million

#### 4. Pilot program to increase access to childcare for essential workers in rural areas

Access to childcare services has a significant impact on the availability of the health workforce to participate to their maximum capacity. This affects not only doctors, but also nurses, paramedics, allied health professionals, and operational and administration staff. A lack of childcare also affects other key essential workers such as teachers and police. All these professions underpin a rural and remote communities' viability and liveability.

RDAA proposes a pilot program to develop child care services on rural hospital grounds. This arrangement is already in place in other state and commonwealth government facilities (for example, some metropolitan hospitals and the Australian Parliament House).

These child care centres would provide permanent care bookings for hospital, health and other essential workers within the community, and occasional care bookings for community members when places are available.

RDAA proposes investment into 10 pilot sites, with each site allocated up to \$3 million for the development. The application would have to show community need, as well as state government support for locations on state-owned facilities, and would be run through a private provider at a nominal rate of rent, ensuring the viability of the business model.

**Funding needed:** Development of 10 pilot sites      \$30 million

## 5. Development of a National Rural Health Strategy

Australia needs a National Rural Health Strategy for the longer-term sustainability and enhancement of rural health services. This will enable the outcomes from the recent *Review of General Practice Incentives*, *Review of After-hours Primary Care Programs and Policy*, *Working Better for Medicare Review*, and *Scope of Practice Review* to be considered through a rural lens so recommendations can be progressed appropriately for the rural and remote context.

This Strategy needs to be designed by rural Australians for rural Australians.

Rural and remote Australians need access to quality medical services, nursing and midwifery services and allied health services. To do this there needs to be more healthcare professionals across all of these services throughout MMM3-7 locations.

The context of real rural, as described by MMM 3-7 communities' health services is different from that in cities and major regional towns, (MMM 1-2). While MMM 1-2 communities enjoy a medical workforce of over 400 FTE per 100,000 population, this significantly decreases in rural and remote Australia, falling as low as 121.8 FTE per 100,000 population in small rural towns<sup>1</sup>. This trend is also evident across other health professions. This availability of workforce distinction is often inadequately considered when conducting reviews into how healthcare is delivered broadly, with exactly how recommendations will be delivered in MMM3-7 locations experiencing significant workforce shortages not considered in the design or recommendations.

Programs, incentives and funding models are needed to support multidisciplinary care, and delivery of full scope of care. This will require a cohesive strategy that includes:

- incentives targeted at individuals, to support them to relocate and remain working in rural and remote areas,

---

<sup>1</sup> <https://hwd.health.gov.au/resources/publications/factsheet-mdcl-2019.pdf>

- funding models that support the delivery of multidisciplinary care,
- funding models that support the delivery of full scope of care,
- an increase in the availability of rural and remote place-based training,
- support for consultant specialists in MMM3-7 locations, and
- maximising the rural health workforce’s capacity to deliver care in their community.

The development and design of the strategy should be allocated to the Office of the National Rural Health Commissioner which would then lead engagement with rural and remote stakeholder groups, coordinate the relevant recommendations across all reports, and develop a Strategy which draws together a workable solution for the delivery of sustainable and quality care to rural and remote patients.

**Funding needed:** Develop a National Rural Health Strategy      \$5 million