RACMA
Transforming
Health Leadership

RACMA Position Statement

Rural-Ready Medical Workforce: System Leadership for Equitable Care

Vision

RACMA envisions a health system in which rural, regional, and remote communities in Australia and Aotearoa New Zealand receive safe, continuous, and culturally responsive care delivered by a supported, skilled, and locally embedded medical workforce. This workforce must be shaped not only by workforce numbers but also by medical leadership, community connection, and structural reform.

Remote, rural, and regional settings are not peripheral to the health system—they are foundational. A rural-ready workforce strategy must centre on place-based leadership, population health, and the unique dynamics of rural service delivery. It must address the maldistribution of clinicians, opportunity, investment, and training.

Rural Reality

One in four Australians lives outside a major city, yet these communities experience consistently poorer health outcomes. In Aotearoa New Zealand, about one in six people live outside the seven major urban centres, with approximately 15–16% of the population living in rural areas. Health disparities persist across both countries, particularly for First Nations peoples and underserved rural communities.

Many rural hospitals and health services rely heavily on locums and fly-in-fly-out models. In some towns, general practices have closed entirely; in others, hospitals cannot safely staff on-call rosters. These service gaps compound existing disadvantages and contribute to preventable harm.

This is not simply a workforce issue. It is a governance challenge. A planning failure. A structural inequity. And it is urgent.

Place-Based Medical Leadership

RACMA Members in rural, remote, and regional Australasia are not only medical administrators. They are strategic leaders embedded in place. Their remit includes:

- Leading whole-of-system planning and service integration across hospitals, community care and primary health.
- Shaping the composition, culture, and capability of local medical teams.

- Governing credentialing systems that reflect rural scope and practice realities.
- Advocating for equitable models of education, training, and succession planning.
- Ensuring services remain clinically safe, culturally responsive, and financially sustainable.
- Strong, place-based medical leadership is the foundation of rural health system resilience.

Reform Priorities

RACMA supports a system-wide commitment to rural medical workforce reform anchored in the following priorities:

Reshape generalist pathways

Rural care depends on generalist GPs, physicians, psychiatrists, and surgeons. RACMA supports expanded rural training pipelines and reverse flow models that support training in place. Dual fellowship pathways must be better integrated, and CPD burdens must be reduced. Training should be embedded in communities and designed to meet local needs.

Embed leadership in rural generalist training

Medical leadership should be embedded within rural generalist programs. This includes formal training in HR, governance, clinical supervision, and site management—skills rural clinicians are often required to exercise without structured preparation.

Stabilise the middle tier

Service Registrars and CMOs underpin safe care in rural hospitals. RACMA calls for formalised training, credentialing, and career pathways for this workforce, including access to CPD, supervision, and equitable industrial arrangements. These roles are essential to the continuity of care in settings where procedural supervision and generalist flexibility are key.

Reform locum and FIFO reliance

Locums are an emergency measure, not a sustainable strategy. RACMA urges the creation of structured, credentialed casual pools, rate transparency, and obligations for continuity, training, and patient safety. Excessive reliance on transient staff undermines team function and places permanent staff under unsustainable pressure.

Support IMG integration and entry pathways

International Medical Graduates (IMGs) are essential to rural care across Australia and Aotearoa New Zealand. They often make long-term contributions in communities others overlook. RACMA supports structured onboarding, culturally responsive supervision, hospital-based orientation, and long-term retention strategies. Unpaid "observer" roles for IMGs raise serious safety and equity concerns. Paid roles such as Assistants in Medicine should be explored to provide a safer, fairer, and more accountable entry point into the workforce while acknowledging university placement

models and coordination with clinical schools. Supporting IMGs includes providing local mentoring, peer networks, and mental health support, especially for those placed in isolated settings.

Redesign industrial settings and funding models

Outdated awards, fee-for-service arrangements, and procedural bias disadvantage rural work. RACMA supports locality-based retention allowances, fit-for-purpose funding models, and structural recognition of generalist, non-procedural, and consultative care. Current MBS settings often fail to reflect the value of extended consultations and continuity roles, particularly in psychiatry, general medicine, geriatrics, and Indigenous health.

Invest in rural training, culture, and wellbeing

Rural communities must be training hubs, not training afterthoughts. Medical education and research must be embedded in rural settings and led by rural teams. To counter professional isolation and burnout, peer support, wellbeing, and mental health care must be prioritised in rural contexts. Rural clinicians face unique stressors, including community visibility, limited confidentiality, and overlapping responsibilities across hospital and private practice.

Governance Fit for Purpose

Rural services require governance models that reflect:

- Integration of primary care, hospital care, and population health.
- Shared leadership between clinicians, managers, and communities.
- The unique risk and privacy settings of small communities.
- Collaborative models across public, private, and virtual services.

RACMA also recognises rural services as anchor institutions. These hospitals and health networks are deeply embedded in local economies, social structures, and civic life. Their sustainability depends on community prosperity, just as community wellbeing depends on their strength. Rural health leadership must reflect this reciprocal responsibility. Strong partnerships between health services and Primary Health Networks (PHNs), Local Hospital Networks (LHNs), iwi organisations, and community-controlled services are critical to service design, legitimacy, and success.

Australasian Reach and Context

RACMA is an Australasian College. In Aotearoa New Zealand, rural health disparities particularly impact Māori and Pacific populations. Approximately one in six New Zealanders lives outside major cities, and about 15–16% live in rural areas. The challenges of geographic isolation, workforce shortages, and clinical governance are shared across the Tasman.

RACMA supports the inclusion of bicultural approaches, such as those led by Te Aka Whai Ora, and encourages reciprocal learning between systems. Innovations in clinical governance, training flexibility, and integrated rural care models should be shared across Australia and Aotearoa New Zealand.

Conclusion

Equity in healthcare access cannot be delivered without a rural-ready workforce. That workforce must be embedded, credentialed, led, and supported. Medical leaders in rural settings are already designing solutions, but need the system to back them up.

RACMA calls on governments, training organisations, employers, and policymakers to commit to systemic, long-term reform. The rural health workforce crisis is not a matter of geography. It is a test of will, leadership, and strategy.