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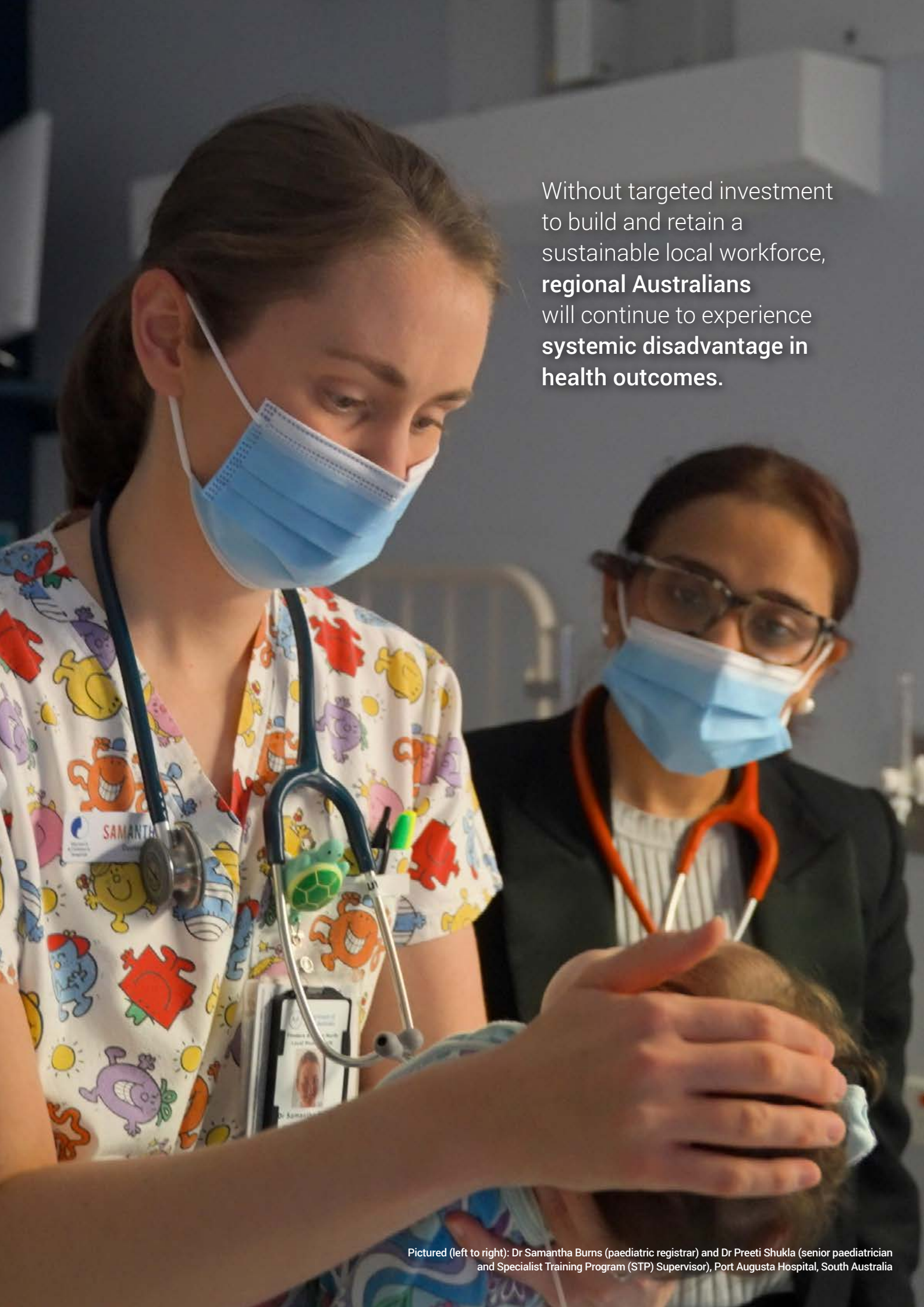
AUSTRALIA'S REGIONAL, RURAL AND REMOTE HEALTHCARE CRISIS

A snapshot analysis of the physician workforce and five-point plan to improve access to specialist care in regional, rural and remote Australia.



Without targeted investment to build and retain a sustainable local workforce, **regional Australians** will continue to experience **systemic disadvantage in health outcomes.**

Pictured (left to right): Dr Samantha Burns (paediatric registrar) and Dr Preeti Shukla (senior paediatrician and Specialist Training Program (STP) Supervisor), Port Augusta Hospital, South Australia

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OVERVIEW

Australians living in regional, rural and remote areas face significant health inequities in comparison to their counterparts in metropolitan areas. These inequities are driven by several factors, with one of them being significant medical workforce shortages.

Despite this being a longstanding issue, as a nation, we are yet to solve the problem of attracting and retaining a robust regional, rural and remote medical workforce, particularly physicians.

We lose too many doctors to the cities not because they want to leave, but because the system leaves them no choice. The city-country divide is embedded into the training pathway from the very beginning, limiting the future supply of physicians to regional, rural and remote communities.

The shortage of doctors in regional, rural and remote Australia is not only a workforce issue. It is also a health equity problem.

Communities outside major cities experience higher rates of preventable disease, injury and premature death, and face longer travel times and wait times to access care.[1]

People die from potentially avoidable causes at higher rates the further away they reside from major cities. When compared to the rate in major cities, potentially avoidable deaths in very remote parts of Australia are 2.5 times higher in men and 3.7 times higher in women.[2]

These gaps place additional pressure on already stretched hospitals, contribute to poorer chronic disease management, and limit economic participation in rural areas.[1]

Without targeted investment to build and retain a sustainable local physician workforce, regional Australians will continue to experience systemic disadvantage in health outcomes.

The reality is that many aspiring rural doctors want to serve their local communities, but are forced to relocate to cities to complete their training and often don't return.

To begin to address the critical task at hand, governments, medical colleges, universities, health departments and hospitals must do two things:

- break down the barriers that are currently preventing and discouraging doctors from working in regional, rural and remote areas.
- build genuine, supported pathways for medical students from regional areas to study, train, work, and ultimately stay, in their local communities.

We need to keep aspiring medical students from the country, in the country, and attract and support doctors who want to make their home in a rural community.

Aboriginal and Torres Strait Islander leadership and expertise are essential to ensuring reforms are effective and culturally safe. Investing in and supporting First Nations trainees will help grow the Aboriginal and Torres Strait Islander physician workforce, strengthen community-led care, and improve health outcomes.

Compared with major cities, rates of potentially avoidable deaths are **2.5 times higher for men** and **3.7 times higher for women** living in very remote areas of Australia.[2]

Greater investment in end-to-end regional training pathways, pilot programs, training hospitals and support programs would allow more students to study and stay local.

Ensuring regional hospitals have adequate funded positions, supervision and training capacity is also critical so trainees can progress and remain in these communities. Creating and strengthening the regional training pipeline is key to improving access and reducing health inequities across Australia.

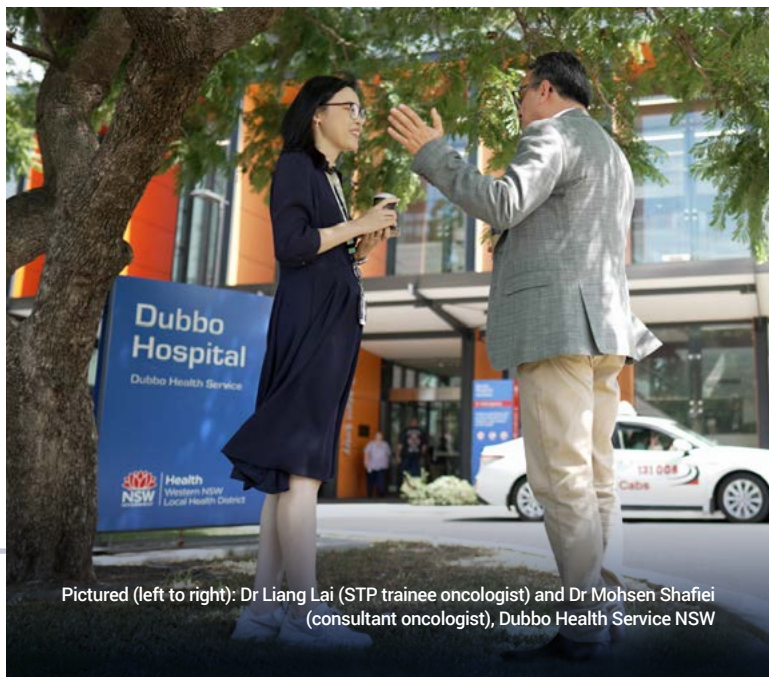
This report provides a snapshot of the physician workforce crisis facing regional, rural and remote areas and sets out a plan to attract, train, retain, and support a greater physician workforce in these areas.

For the purposes of this report, 'regional, rural and remote' refers to locations classified under the Modified Monash Model as MM 2–7.[3] 'Physician' refers to a medical specialist who has completed specialist training and Fellowship with The Royal Australasian College of Physicians (The RACP) and includes those working in adult internal medicine (general medicine physicians) and paediatrics and child health medicine (general paediatricians).

[1] Australian Institute of Health and Welfare, 2025, Rural and remote health. Accessible via https://www.aihw.gov.au/reports/rural-and-remote-health

[2] National Rural Health Alliance, Rural health in Australia - snapshot 2025. Accessible via https://www.ruralhealth.org.au/wp-content/uploads/2025/02/NRHA-Rural-Health-in-Australia-Snapshot-2025.pdf

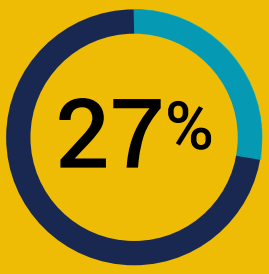
[3] Department of Health, Disability and Ageing, 2025, Modified Monash Model. Accessible via https://www.health.gov.au/topics/rural-health-workforce/classifications/mmm?language=en



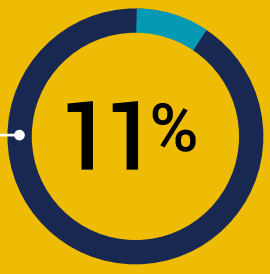
Pictured (left to right): Dr Liang Lai (STP trainee oncologist) and Dr Mohsen Shafiei (consultant oncologist), Dubbo Health Service NSW

THE CRISIS FACING OUR REGIONS

Around seven million Australians, or 27% of the population, live in regional, rural and remote areas,[1] yet according to RACP member data, only 11% of RACP trainees and Fellows practice in regional, rural and remote areas.[4]



of the population are in regional, rural and remote areas



of RACP trainees and Fellows are in regional, rural and remote areas

In some regions, patients travel hundreds of kilometres for specialist care and face months-long waiting times.

Without urgent, targeted action to create local training opportunities and reduce the barriers that prevent physicians and physician trainees from practising in regional areas, these inequities will continue to widen.

Regional, rural and remote health challenges are often invisible to those shaping policy. From the outside, these pressures can be reduced to workforce numbers and funding lines, yet the lived experience is far more complex.

Behind every data point in this report are families navigating long waits, clinicians stretched across enormous catchments, and communities adapting to gaps that have become commonplace over time.

While the workforce data the RACP presents in this report is critical in revealing structural inequities, it is also important to remember that these figures represent real people, real delays in care, and real consequences for health outcomes.

Making regional, rural and remote health visible in policy, planning and investment decisions is essential if Australia is to deliver equitable care regardless of postcode.

[4] Royal Australasian College of Physicians, 2025, RACP Member Statistics and Insights. Accessible via https://www.racp.edu.au/docs/default-source/secured-documents-library/2025-racp-member-statistics-and-insights-report.pdf?sfvrsn=31fad1a_4

People in remote and very remote areas are **1.5 times more likely** to die prematurely and have **2-3 times the rate of potentially avoidable deaths** compared with those in major cities.[1]

Pictured: Dr Anna Birchley, paediatric registrar, Mount Isa Hospital, Queensland

NATIONAL SNAPSHOT:

THE CITY-COUNTRY DIVIDE

Across Australia, most RACP members live and/or work in metropolitan areas

In Victoria, approximately 92 per cent of Fellows and over 95 per cent of trainees are concentrated in metropolitan areas. Similarly, in New South Wales, around 90 per cent of Fellows and about 95 per cent of trainees are based in metropolitan areas, with only limited regional spread.

Queensland stands apart for their stronger regional and remote presence, with 82 per cent of Fellows in metropolitan areas. About 18 per cent of Fellows and over 18 per cent of Basic Trainees are located outside metropolitan centres.

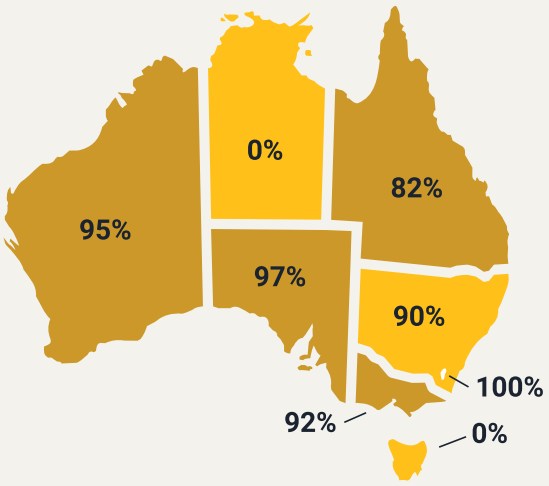
Western Australia is notable for its reach into very remote areas while still retaining 95 per cent of Fellows in metropolitan areas. South Australia's physician workforce is highly concentrated in Adelaide, with 97 per cent of Fellows and nearly all trainees in metropolitan areas.

Tasmania's members are entirely located in regional and rural settings, while the Northern Territory has one of the most regionally and remotely distributed workforces in the country. It is important to note that neither Tasmania nor the Northern Territory has a metropolitan classification (MM1). This means all Fellows and trainees in these jurisdictions are counted within regional, rural or remote categories with most still working in larger regional centres.

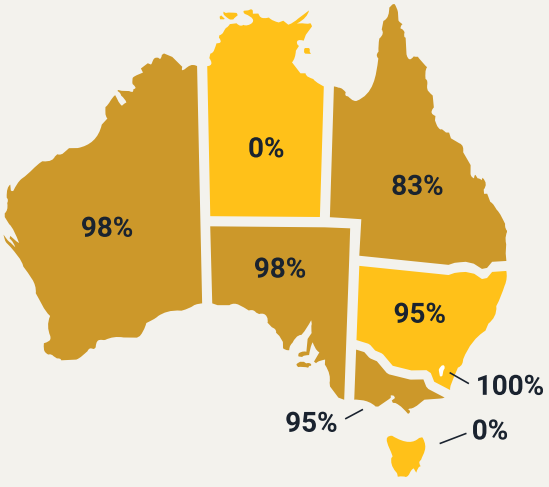
While there are variations between jurisdictions, most states and territories experience underlying imbalances in workforce distribution. This is a systemic, nationwide issue driven by how we fund, train and support the health workforce.

Without coordinated national action to rebalance investment and strengthen regional training and service models, the city–country divide will continue to widen, leaving communities outside metropolitan centres with poorer access to care and greater health inequities.

Proportion of Active Fellows in MM1 areas



Proportion of trainees in MM1 areas



Source: RACP membership data (refer to Appendix)

THE CITY-COUNTRY DIVIDE IN NUMBERS: GENERAL PAEDIATRICS

Paediatric workforce gaps leave regional children behind

The RACP's workforce data paints a concerning picture when it comes to access to specialist care for children living outside of metropolitan Australia: that children outside of major cities are far more likely to experience longer wait times, delayed diagnosis, and fragmented care.

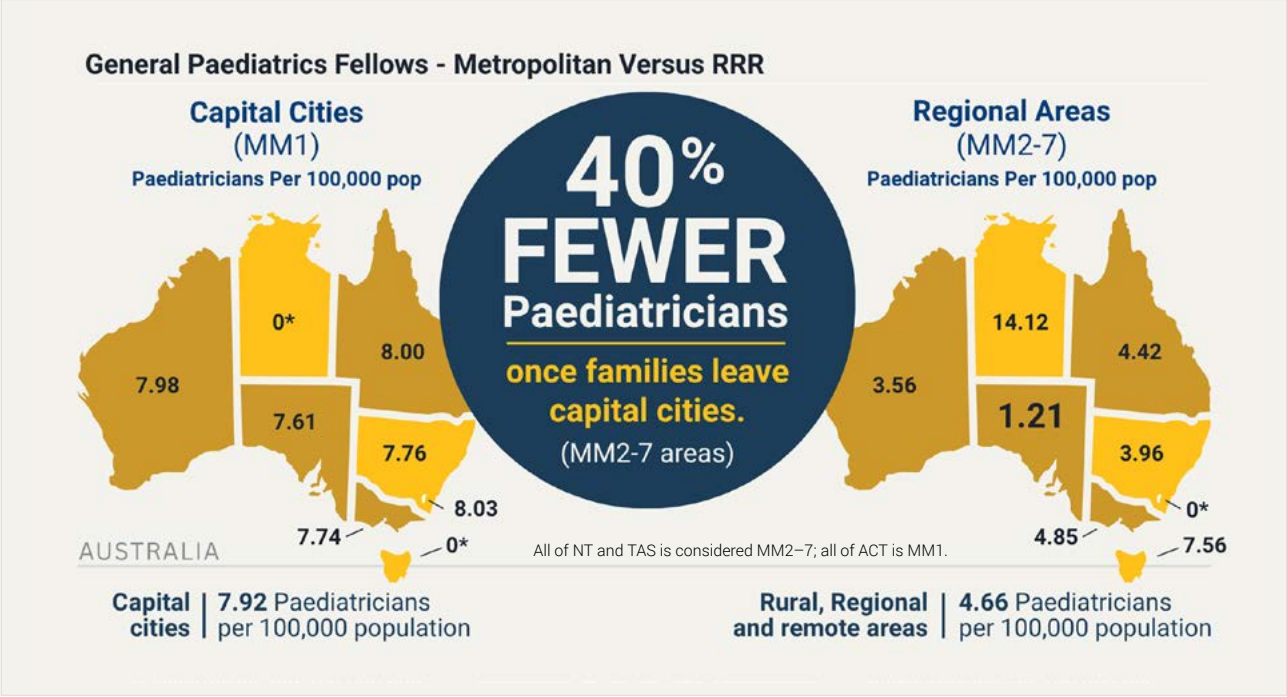
Nationally, there are 7.92 general paediatricians per 100,000 people in metropolitan areas, compared with 4.66 per 100,000 people in regional, rural and remote areas. This means that there are 40 per cent fewer general paediatricians per 100 000 people once families leave capital cities.

In some jurisdictions, the disparity is even greater. In South Australia, for example, there are 84 per cent fewer general paediatricians per 100,000 people outside metropolitan Adelaide, according to RACP membership data analysis. While South Australia's health system is highly centralised with most specialist services in Adelaide, this pattern of substantially fewer specialists outside metropolitan areas is also evident in other states. In Australian eastern states, the data shows that general paediatrician rates in regional, rural and remote areas remain well below metropolitan levels.

There are **40 per cent fewer** general paediatricians per-capita availability once families leave capital cities.

It is important to recognise that the data described here does not capture geographic scale, travel times,

Figure 1 General Paediatrics Fellows in metropolitan areas vs regional, remote and rural areas



Source: RACP membership data (refer to Appendix)

part-time roles, or reliance on visiting and outreach services, all of which disproportionately affect families in rural and remote communities. For example, the figures for general paediatricians in New South Wales and Western Australia are similar but Western Australia covers a far greater land area, meaning greater distances for patients to travel.

This data makes it clear that workforce shortages in regional Australia are not isolated or incidental; they are structural.

Without targeted investment in regional training pathways, collaborative models of care, and greater incentives that enable paediatricians to work and live sustainably outside metropolitan areas, inequitable access for children and families will persist.

> “A child’s postcode should not dictate their access to a paediatrician. Failing to address these gaps now will have long-term consequences for the health of our population.”
>
> **Dr Niroshini Kennedy** President of the RACP Paediatrics and Child Health Division

Pictured: Dr Ingrid Els, paediatrician, Launceston

THE CITY-COUNTRY DIVIDE IN NUMBERS: GENERAL MEDICINE

General medicine: a fragile workforce supply for regional and rural health

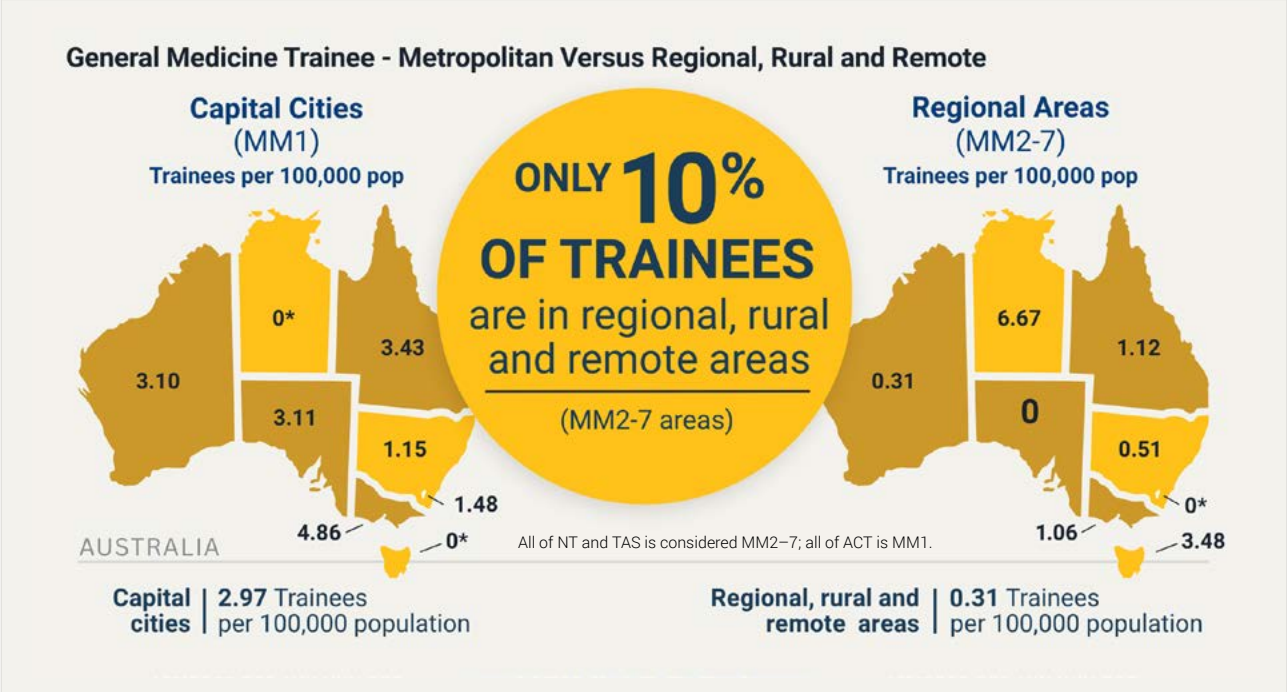
General medicine physicians provide a broad scope of health care,, support smaller hospitals, and underpin collaborative models of service delivery. They are the backbone of many country hospitals, providing expert, life-saving care to regional, rural and remote patients with complex illnesses and enable access to specialist care locally. They also play a central role in managing the growing burden and complexity of disease. Although regional, rural and remote communities benefit significantly from a strong general medicine workforce, most general medicine physicians and trainees continue to live and train in metropolitan settings.

According to RACP membership data, 77 per cent of general medicine physicians were metropolitan-based, with Queensland the only state (with an MM1 classification) with more than the national average of general medicine physicians based in regional, rural and remote areas (27 per cent; as at June 2024). Note, both the Northern Territory and Tasmania are classified as MM2–7.

In most states, **more than 90 per cent** of general medicine trainees **are metropolitan-based.**

Trainee distribution reflects a similar pattern, with the majority of general medicine trainees concentrated in metropolitan areas with Queensland again having the largest share for an MM1 region outside metropolitan areas (16 per cent), while Victoria and New South Wales remain strongly metro weighted.

Figure 2 General Medicine Trainee – Metropolitan Versus Regional, Rural and Remote (per 100,000)



Source: RACP membership data (refer to Appendix)

> “The rural training pathway for general medicine is dire. We must invest now to change the trajectory of general medicine in regional Australia to secure the future rural general medicine physicians our regional communities deserve. Only by doing this can we ensure rural Australian residents can access the care they need, when they need it, as close to home as possible.”
>
> **Professor Graeme Maguire**
> General Medicine physician, Western Australia.

Given the fundamental role of general medicine physicians in delivering high-quality care in regional, rural and remote settings, this imbalance is a significant workforce concern. Building a sustainable, well-supported general medicine physician workforce for these communities is critical.

While the Australian Government's Specialist Training Program (STP) has been an important enabler of rural specialist training, its funding has not kept pace with rising employment costs which has limited its ability to address current rural workforce shortages.

To improve equity and access, the RACP has secured funding through the Australian Government's Flexible Approach to Training in Expanded Settings (FATES) program to strengthen training visibility, improve distribution and support regional, rural and remote general medicine and general paediatric training pathways.

Without targeted investment in regional training pathways specifically for specialities like general medicine, regional workforce shortages will continue to be entrenched.

BUILDING THE RURAL PHYSICIAN WORKFORCE THROUGH PLACE-BASED TRAINING

The Western Australia Rural Physician Training Pathway, led by the WA Country Health Service (WACHS) and supported through the Flexible Approach to Training in Expanded Settings (FATES) program, highlights what is possible when governments invest in supporting early career doctors to train in rural communities.

Developed in partnership with the RACP, the initiative has established Australia's first fully accredited basic physician rural training network. The pathway embeds trainees within regional communities rather than relying on short-term metropolitan rotations, supporting workforce retention, continuity of care and service delivery tailored to local need.

The pathway achieved RACP network accreditation, including flexible training arrangements that allow extended physician training in rural settings while maintaining high education and accreditation standards. Central coordination and education leadership support consistent training quality across geographically dispersed sites.

The program has now moved from a pilot to an ongoing WACHS funded service, with the model already being applied to new rural specialist training pathways, including paediatrics and emergency medicine.

> “Training in a rural community over a longer period allows doctors to build stronger connections with patients, services and communities, while showing trainees that a long-term rural career is both achievable and professionally rewarding.”
>
> **Dr Jaye Martin,** consultant physician, Kimberley Regional, Western Australia

A PLAN TO ADDRESS THE REGIONAL PHYSICIAN WORKFORCE CRISIS

The RACP's five-point plan **Support, Plan, Attract, Retain, Collaborate (SPARC)** is designed to kick-start the improvement of Australia's regional, rural and remote physician workforce.

The plan prioritises supporting trainees, improving workforce planning, attracting and retaining physicians, and enhancing collaboration..

SPARC

1 SUPPORT

Support trainee physicians from regional, rural and remote areas to train and remain there

2 PLAN

Coordinate rural workforce planning through a national regional, rural and remote health workforce planning framework

3 ATTRACT

Make it easier for physicians and trainees to relocate and remain in regional, rural and remote areas

4 RETAIN

Address heavy workloads in regional, rural and remote areas and physician and trainee burnout

5 COLLABORATE

Enhance collaboration between physicians and other health professionals

1 SUPPORT: TRAINEE PHYSICIANS FROM REGIONAL, RURAL AND REMOTE AREAS TO TRAIN AND REMAIN THERE

Training location is one of the strongest predictors of where a physician will ultimately practise. It is important rurally linked, based or interested medical students and early career doctors have the opportunity to continue their training in a regional or rural setting. Yet too many trainee physicians who want to stay in regional and rural areas are required to leave their communities and move to metropolitan areas to complete training, greatly reducing the likelihood they will return.

To build a sustainable regional, rural and remote physician workforce, governments must invest in regional, rural and remote physician training pathways that allow trainee physicians to complete the full spectrum of their training within regional, rural and remote settings. Where training must involve some time in a metropolitan setting, it is important that rural trainees are supported to undertake such training while at the same time maintaining their links to their community.

Strengthening culturally safe, training and career pathways for Aboriginal and Torres Strait Islander trainee physicians is essential to improving workforce sustainability, health equity and culturally responsive care in regional, rural and remote communities.

> “Young people who grow up here understand the community’s rhythm and challenges. We should be starting early, looking at students from when they’re at high school - identify those who have an interest in medicine, nurture them to do medical training and complete their training here in the country. Universities, governments, colleges, and health services must work together to pave this pathway.”
>
> **Dr Annabel Martin**
> Nephrologist, Albury-Wodonga NSW/VIC

ACTION

- Establish Regional Training Networks in each jurisdiction with flexible employment arrangements, single employer models and multi-year employment contracts to improve attraction and retention.
- Explore and invest in location-based models that provide training in regional areas, enabling trainee physicians to complete both Basic and Advanced Training in adult medicine and general paediatric medicine within these settings.
- Expand and fund generalist physician training positions in regional, rural and remote areas, including general and acute care medicine and general paediatrics training positions.
- Support flexible care models that blend generalist and subspecialty skills to meet the needs of regional, rural and remote communities.
- Ensure the redesigned Specialist Training Program strengthens rural workforce capacity building.
- Support the recruitment, training and retention of Aboriginal and Torres Strait Islander physicians in regional, rural and remote areas through culturally safe, training pathways, targeted scholarships, rural placements, mentorship and long-term career support.

2 PLAN: COORDINATED NATIONAL RURAL HEALTH WORKFORCE PLANNING

While national and jurisdictional workforce strategies exist, there is no dedicated, nationally coordinated regional, rural and remote physician workforce planning mechanism that consistently aligns training pathways, funding settings and long-term distribution targets across all jurisdictions.

Workforce initiatives are often developed in isolation, with limited interoperability of datasets and at times inconsistent alignment between Commonwealth and state/territory investments.

A nationally coordinated regional, rural and remote health workforce planning framework would provide the foundation for more equitable and sustainable distribution of physicians and other healthcare practitioners. Such a framework needs to be informed by robust workforce data, transparent modelling and meaningful community input including through partnership with the Aboriginal Community Controlled Health Organisation (ACCHO) sector. It would align training pathways, funding mechanisms and service delivery models with local population health needs, while strengthening accountability for outcomes.

> “Right now, planning for the rural and remote physician workforce is happening in pockets, rather than through one coordinated national approach. That makes it harder to ensure doctors are trained, funded and supported in the places that need them most. A nationally aligned, data-driven framework would give governments a much clearer picture of what’s working, what isn’t, and how to build a sustainable workforce for regional and remote communities.”
>
> **Associate Professor Kudzai Kanhutu**
> Infectious diseases physician and RACP Dean

ACTION

- → Develop a national regional, rural and remote health workforce planning framework informed by robust data and stakeholder input to guide equitable workforce distribution and align training and funding with local needs.
- → Fund and coordinate a national regional, rural and remote workforce data and modelling to support health workforce planning, track outcomes, evaluate training and distribution initiatives, and guide continuous improvement.
- → Support standardised minimum datasets and interoperable reporting across jurisdictions and strengthen data governance, data sharing, and workforce modelling.

3 ATTRACT: MAKE IT EASIER FOR PHYSICIANS AND TRAINEES TO RELOCATE AND REMAIN IN REGIONAL AREAS.

Attracting physicians and trainee physicians to regional, rural and remote areas requires more than financial incentives. Decisions to relocate are shaped by practical, professional and family considerations, like access to housing and childcare, and employment opportunities for partners, transport, and the ability to integrate into the local community.

Without targeted local support, these barriers can deter physicians from relocating or contribute to early departure, undermining workforce stability and continuity of care.

To strengthen the regional, rural and remote workforce pipeline, governments must invest in comprehensive relocation support packages for physicians and trainees. These should include coordinated assistance with housing and transport, access to childcare and schooling, partner employment support, and structured community orientation and integration. Accommodation support should also be provided for rural trainees undertaking metropolitan rotations ensuring no financial disadvantage and similar support to metropolitan trainees on rural placements.

Expanding existing Medicare incentive structures to include targeted scaled payment loadings for physicians practising in regional, rural and remote areas would also work to address financial disincentives by recognising the higher costs, complexity, and general service gaps inherent in rural areas.

Addressing these non-clinical barriers is critical to making regional practice a viable, sustainable and attractive option, particularly for early-career physicians and those with families, and to improve long-term physician retention in regional, rural and remote communities.

> “Physicians and trainees are making life decisions about their families, careers and futures, and governments need to support the whole picture. We know regional Australian communities offer both fantastic lifestyle and work. What we must do is address the everyday barriers that doctors and their families face when deciding to commit to rural Australia. Practical initiatives to provide wrap around support for relocation, accommodation, community orientation, schools and childcare can be the difference between a short-term placement and long-term career.”
>
> **Dr James Dowler**
> Consultant Paediatrician, Alice Springs Hospital, Northern Territory

ACTION

- Establish a National Relocation and Retention Fund covering subsidies for travel, removal costs, bridging accommodation, childcare (including non-institutional arrangements), and partner retraining or employment support.
- Reform remote area tax concessions, such as the Zone Tax Offset, so they reflect current living costs and workforce needs and include MM3+ locations where specialist workforce shortages persist to provide a meaningful incentive to attract and retain specialists.
- Expand Medicare payment loadings for physicians practising in regional, rural and remote areas, scaled by remoteness.
- State and territory governments to provide local housing assistance, such as temporary furnished housing, rent subsidies or co-located/nearby accommodation for specialists and trainees.
- Establish a dedicated relocation and settlement support programs in Regional Health Services as a one-stop hub to actively assist with relocation needs.

Pictured (left): Dr Thomas Han (paediatrician, STP Supervisor and Head of Unit) and (right): Dr Preeti Shukla (senior paediatrician and STP Supervisor), Port Augusta Hospital, South Australia

4 RETAIN: ADDRESS HEAVY WORKLOADS AND PHYSICIAN AND TRAINEE BURNOUT

In many regional, rural and remote communities, specialist care is delivered by a small cohort of physicians who carry substantial clinical and supervisory responsibilities. When workforce numbers are limited, even routine leave can create service vulnerability for patients.

Without reliable locum coverage and time free from clinical duties for supervision and professional development, workload pressures become cumulative. These pressures affect not only physician wellbeing, but also patient access, training quality and service continuity.

Retention strategies must therefore prioritise system-level supports that reduce workload strain and enable physicians and trainees to practise sustainably in regional, rural and remote settings.

Ensuring time free from clinical duties for teaching, training, learning and research is also critical. Without this, supervision and professional development are often deprioritised in high-demand regional, rural and remote settings, undermining workforce capability and quality of care. In addition, dedicated funding and recognition for these activities would enhance the attractiveness of regional, rural and remote practice, support future workforce pipelines, and sustain safe, high-quality training environments.

> “If we want to sustain specialist clinicians in rural and remote areas, we need structured support for locum coverage. The ability to backfill roles with skilled, reliable locums is critical for wellbeing and retention. At the moment, the locum market is ad hoc and highly competitive - government investment in better system supports for doctors and hospitals could provide the certainty that regional communities desperately need.”
>
> **Dr Dan Wilson**
> Addiction Medicine Specialist, Alice Springs, NT
>
> **The hospital catchment area for Alice Springs hospital is one million square kilometres**.

ACTION

- Establish and fund a national Regional, Rural and Remote Locum and Relief System, including national rostering infrastructure and travel and accommodation support, enabling physicians to move across jurisdictions and respond to workforce gaps.
- Fund and coordinate regional, rural and remote locum recruitment and deployment locally, ensuring locums contribute to supervision and teaching alongside clinical service, not solely Fly In-Fly Out clinical care
- Guarantee funded locum backfill for planned leave to ensure regional, rural and remote physicians can take leave without compromising patient care, training continuity or workforce stability.
- Strengthen rural supervision and training capacity by supporting supervisor development and enabling flexible supervisor models.
- Ensure Fellows and trainees have designated time free from clinical duties for teaching, learning and research.
- Invest in administrative and digital support to reduce workload burden on regional, rural and remote physicians and trainees.

5 COLLABORATE: ENHANCE COLLABORATION BETWEEN PHYSICIANS AND OTHER HEALTH PROFESSIONALS

Strengthening the regional, rural and remote physician workforce is not only about increasing the number of physicians in these areas, but also about investing in integrated, team-based models of care.

In many rural communities, health services operate across dispersed settings, with limited specialist options and significant travel distances between healthcare providers.

Improving collaboration between physicians, general practitioners (GPs) and other health professionals is essential to strengthening system resilience.

Integrated models of care including shared care arrangements, virtual multidisciplinary case conferencing, structured community outreach services and coordinated referral networks, can improve patient access to specialist input while supporting workforce sustainability.

Proven examples are already operating in parts of regional Australia, demonstrating that coordinated, team-based approaches are both feasible and effective. The priority now is scaling and expanding these models more consistently across regional, rural and remote communities.

> “Improving the regional, rural and remote medical workforce is not just about increasing the volume of doctors, but it’s also about creating smarter, more integrated ways that we deliver healthcare and optimise patient access to appropriate levels of specialist care. By enhancing access to regional, rural and remote consultant specialist services, as well as breaking down silos and developing integrated care models which support greater collaboration between specialists and GPs, we can strengthen the entire system and ensure rural patients and communities get the continuity and quality of care they deserve.”
>
> **Dr Tony Mylius AM**
> Cardiologist, Wheatbelt Region, WA

ACTION

- Provide multi-year, indexed funding to scale integrated care pilots that are proven to be effective through the National Health Reform Agreement.
- Expand and broaden Medicare telehealth items to remunerate virtual multi-disciplinary teams, e-consults, and to support tele-supervision.
- Support pilots of integrated care models that embed specialist outreach, virtual multi-disciplinary teams, and shared care pathways.
- Invest in interoperable digital health systems that support information sharing and coordinated care across hospitals, health services, primary care, community care and private health services.

THE FUTURE OF REGIONAL, RURAL AND REMOTE HEALTHCARE

The health inequities experienced by people living in regional, rural and remote Australia are well documented. They are reflected in higher rates of preventable disease, avoidable mortality, delayed diagnosis and reduced access to specialist care. Workforce maldistribution is a key structural driver of these outcomes.

But these disparities are not unsolvable. They are shaped by training pathways, employment models, Medicare funding settings and workforce planning decisions. Adjusting these levers provides a clear pathway to improving outcomes.

Evidence consistently shows that training location is one of the strongest predictors of future practice location. Strengthening regional training networks, expanding training pathways and investing in generalist physician capability are critical to improving workforce distribution over time.

At the same time, retention depends on creating sustainable conditions for practice. This includes reliable locum and relief systems, equitable access to continuing professional development, time free from clinical duties for supervision and training, and funding settings that recognise the higher cost, complexity and service demands of regional, rural and remote healthcare. Targeted Medicare payment loadings for physicians practising in MM3–7 locations would provide a practical mechanism to better align funding with service delivery.

Pictured (left to right): Dr Liang Lai and Dr Colin McClintock, Dubbo Hospital, NSW

Pictured: Dr Preeti Shukla, Port Augusta Hospital, South Australia

Improved workforce distribution also requires coordinated, data-driven planning across jurisdictions.

Aligning Commonwealth and state investments, strengthening Specialist Training Program settings in underserved areas, and supporting collaborative models of care will help ensure that specialist supply better reflects community need.

Aboriginal and Torres Strait Islander communities must be central to this reform agenda. Strengthening culturally safe training pathways, supporting Indigenous leadership in workforce development, and prioritising placements within Aboriginal Community Controlled Health Organisation settings are essential to improving equity of access and health outcomes.

The reforms outlined in this report are consistent with the objectives of the National Medical Workforce Strategy 2021-2031 and reflect The RACP's longstanding commitment to strengthening regional physician training and workforce sustainability.

With coordinated implementation, targeted investment and sustained policy attention, Australia can build a resilient, locally embedded physician workforce capable of delivering high-quality care across all communities.

Appendix

Proportion of RACP members by Modified Monash category and member type

State	Member Type	MM1	MM2	MM3	MM4	MM5	MM6	MM7
ACT	Active Fellow	99.7%	0.0%	0.3%	0.0%	0.0%	0.0%	0.0%
	Advanced Trainee	100.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
	Basic Trainee	100.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
NSW	Active Fellow	90.4%	1.7%	5.1%	0.3%	2.5%	0.1%	0.0%
	Advanced Trainee	95.1%	2.0%	1.4%	0.3%	1.1%	0.0%	0.0%
	Basic Trainee	95.9%	1.5%	1.6%	0.1%	1.0%	0.0%	0.0%
NT	Active Fellow	0.0%	79.4%	0.0%	0.0%	0.0%	20.6%	0.0%
	Advanced Trainee	0.0%	83.3%	0.0%	0.0%	0.0%	16.7%	0.0%
	Basic Trainee	0.0%	85.7%	0.0%	0.0%	0.0%	11.4%	2.9%
QLD	Active Fellow	81.9%	16.8%	0.2%	0.0%	1.0%	0.1%	0.0%
	Advanced Trainee	86.1%	12.3%	0.3%	0.0%	1.1%	0.2%	0.0%
	Basic Trainee	81.1%	17.6%	0.3%	0.0%	0.8%	0.2%	0.0%
SA	Active Fellow	96.6%	1.4%	1.2%	0.1%	0.6%	0.1%	0.0%
	Advanced Trainee	98.2%	1.1%	0.4%	0.0%	0.4%	0.0%	0.0%
	Basic Trainee	98.4%	1.0%	0.3%	0.0%	0.3%	0.0%	0.0%
TAS	Active Fellow	0.0%	86.5%	6.1%	0.0%	4.5%	2.9%	0.0%
	Advanced Trainee	0.0%	92.5%	1.5%	0.0%	6.0%	0.0%	0.0%
	Basic Trainee	0.0%	88.1%	4.5%	0.0%	4.5%	3.0%	0.0%
VIC	Active Fellow	91.6%	3.9%	2.1%	0.8%	1.5%	0.0%	0.0%
	Advanced Trainee	95.6%	2.4%	0.7%	0.5%	0.9%	0.0%	0.0%
	Basic Trainee	95.1%	3.2%	0.6%	0.2%	1.0%	0.0%	0.0%
WA	Active Fellow	95.1%	1.7%	1.6%	0.0%	0.4%	0.1%	1.1%
	Advanced Trainee	98.6%	0.5%	0.8%	0.0%	0.0%	0.0%	0.0%
	Basic Trainee	96.7%	2.0%	1.3%	0.0%	0.0%	0.0%	0.0%

Source: RACP membership data as at March 2026

Appendix

Percentage of RACP general medicine physician Fellows and trainees in metropolitan and regional, rural and remote areas (MM1, MM2, MM3-7)

Jurisdiction	Gen Med Fellow MM1	Gen Med Fellow MM2	Gen Med Fellow MM3-7
Australian Capital Territory	100.00	0.00	0.00
New South Wales	77.18	1.68	21.14
Northern Territory	0.00	77.42	22.58
Queensland	72.58	24.74	2.68
South Australia	95.29	1.18	3.53
Tasmania	0.00	87.50	12.50
Victoria	80.67	6.09	13.24
Western Australia	88.48	4.61	6.91
Jurisdiction	Gen Med trainee MM1	Gen Med trainee MM2	Gen Med trainee MM3-7
Australian Capital Territory	100.00	0.00	0.00
New South Wales	86.90	4.76	8.33
Northern Territory	0.00	58.82	41.18
Queensland	84.03	15.97	0.00
South Australia	100.00	0.00	0.00
Tasmania	0.00	100.00	0.00
Victoria	93.88	2.88	3.24
Western Australia	97.30	0.00	2.70

Source: RACP membership data analysis (June 2024)

Percentage of RACP general paediatrics physician Fellows and trainees in metropolitan and regional, rural and remote areas (MM1, MM2, MM3-7)

Jurisdiction	Gen paed Fellow MM1	Gen paed Fellow MM2	Gen paed Fellow MM3-7
Australian Capital Territory	100.00	0.00	0.00
New South Wales	85.27	2.08	12.65
Northern Territory	0.00	72.22	27.78
Queensland	75.60	21.18	3.22
South Australia	94.59	0.90	4.50
Tasmania	0.00	72.73	27.27
Victoria	84.21	7.89	7.89
Western Australia	88.94	1.92	9.13
Jurisdiction	Gen paed trainee MM1	Gen paed trainee MM2	Gen paed trainee MM3-7
Australian Capital Territory	100.00	0.00	0.00
New South Wales	86.82	0.45	12.73
Northern Territory	0.00	64.29	35.71
Queensland	77.12	20.92	1.96
South Australia	100.00	0.00	0.00
Tasmania	0.00	91.67	8.33
Victoria	92.02	4.26	3.72
Western Australia	81.82	4.55	13.64

Source: RACP membership data analysis (June 2024)

Number of RACP general medicine physician Fellows and trainees in metropolitan (MM1) and regional, rural and remote areas (MM2-7) per 100,000

State	Gen med Fellow by MM1 per 100,000 population	Gen med Fellow by MM2-7 per 100,000 population	Gen med trainee MM1 per 100,000 population	Gen med trainee MM2-7 per 100,000 population
Australian Capital Territory	4.44	0.00	1.48	0.00
New South Wales	3.63	3.17	1.15	0.51
Northern Territory	0.00	12.16	0.00	6.67
Queensland	9.98	6.46	3.43	1.12
South Australia	11.73	1.61	3.11	0.00
Tasmania	0.00	8.35	0.00	3.48
Victoria	7.15	5.72	4.86	1.06
Western Australia	8.28	3.87	3.10	0.31

Source: RACP membership data analysis (June 2024)

Number of RACP general paediatrics physician Fellows and trainees in metropolitan (MM1) and regional, rural and remote areas (MM2-7) per 100,000

State	Gen paeds Fellow by MM1 100,000 population	Gen paeds Fellow by MM2-7 per 100,000 population	Gen paed trainee MM1 per 100,000 population	Gen paed trainee MM2-7 per 100,000 population
Australian Capital Territory	8.03	0.00	1.90	0.00
New South Wales	7.76	3.96	3.01	1.35
Northern Territory	0.00	14.12	0.00	10.98
Queensland	8.00	4.42	3.35	1.70
South Australia	7.61	1.21	2.25	0.00
Tasmania	0.00	7.65	0.00	2.09
Victoria	7.74	4.85	3.22	0.93
Western Australia	7.98	3.56	3.10	2.48

Source: RACP membership data analysis (June 2024)

Please note: State/Territory and MM classification are based on trainees' training site addresses and Fellow postal addresses. For interrupted rotations, the trainee's current billing address is used instead. Trainees/Fellows with unknown addresses are excluded.

For more information visit
www.racp.edu.au

Australia

145 Macquarie Street Sydney NSW 2000
Phone: +61 2 9256 5444
1300 697 227

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About The Royal Australasian College of Physicians (RACP)

The RACP trains, educates and advocates on behalf of over 24,400 physicians and 9,800 trainee physicians, across Australia and Aotearoa New Zealand. The RACP represents a broad range of medical specialties which work within and across the private and public health sectors, including general medicine, paediatrics and child health, cardiology, respiratory medicine, neurology, oncology, public health medicine, infectious diseases medicine, occupational and environmental medicine, palliative medicine, sexual health medicine, rehabilitation medicine, geriatric medicine, and addiction medicine. the RACP is committed to developing health and social policies which bring vital improvements to the wellbeing of patients, the medical profession and the community.

We acknowledge and pay respect to the Traditional Custodians and Elders – past, present and emerging – of the lands and waters on which RACP members and staff live, learn and work. The RACP acknowledges Māori as tangata whenua and Te Tiriti o Waitangi partners in Aotearoa New Zealand.