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MEDIA RELEASE

RURAL GENERALIST PATHWAY: CONTINUOUS MEDICAL TRAINING IN THE BUSH

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TRAINING doctors through regional teaching health service networks may help deliver sustainable, high-quality health care closer to home for rural Australians, according to the authors of a Perspective published online today by the *Medical Journal of Australia*.

Emeritus Professor Paul Worley, the National Rural Health Commissioner, and colleagues wrote that inequities in access to quality healthcare for remote, rural and regional Australians meant that universal health coverage was not yet a reality here.

"We may have universal health insurance and world-class hospitals, but without a health workforce that is appropriately skilled and distributed for equitable access in rural areas, universal health care is not a reality in our country," they wrote.

"A pervasive, elusive problem, hidden within the use of averages in Australian health statistics, is that there is inequity of access to health care in many of Australia's rural communities and for many Aboriginal and Torres Strait Islander Australians.

"This problem is significantly impeding progress on national health goals and reinforcing an unrelenting gap in social and economic opportunities for many rural communities."

Emeritus Professor Worley was appointed as Australia's first Rural Health Commissioner by Parliament in 2017. His first task is to develop the National Rural Generalist Pathway – "a training program to produce more rural generalist doctors, skilled in providing comprehensive and high quality medical care specific to the needs of rural and remote Australians".

"... Rural general practitioner numbers have increased," the authors wrote. "Likewise, regional specialist hubs, outreach and telemedicine services are building regionally networked professional opportunities."

However, rural communities still rely on "the advice and care of benevolent and well intentioned city-based systems, locum services and overseas-trained doctors", they wrote.

"Although rural training opportunities have increased, rural communities are often being used as rotational outposts from city centres. This is not developing skilled rural doctors who can work across the range of comprehensive primary care and other care areas that rural communities need.

"It is not facilitating the trainee's connection to place, particularly at a time when they are setting up their lives and their families. It produces exactly what its design would suggest — city-focused subspecialists, unsuited to the breadth of specialist skills required for rural practice.

"It is time for rural communities to lead their own workforce production for doctors and other health professionals who are highly effective in their context."

Based in rural communities that need rural generalists, the National Rural Generalist Pathway can enable students, junior doctors and registrars to call rural communities home for their entire training. A rural base and a training position with secure funding are critical for allowing doctors to settle and connect with other rural people. The continuous training pathway alone has the potential to contribute at least a decade of immediate economic value to rural communities for each doctor trained.

"We can learn from the success of urban teaching hospitals and intentionally re-imagine our rural health services as locally led continuous rural teaching health service networks, developing their own doctors, creating relevant evidence for best practice, and producing high quality, cost-effective and sustainable health care," the authors concluded.

"A National Rural Generalist Pathway is good for rural communities. Healthy rural communities are productive rural communities. Productive rural communities are great for our nation as a whole."

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