

Policy Document

Regional, Rural, and Remote Health (2026)



Executive Summary

This policy concerns the 7 million Australians – approximately 27% of the national population – residing in regional, rural, and remote areas (Modified Monash 2–7). This population experiences the most acute health inequities in Australia. First Nation's peoples experience a disproportionate burden of disease, particularly in rural and remote communities. These inequities cannot be understood through remoteness alone, but must also be understood in the context of colonisation, systemic racism, intergenerational trauma, and limited access to culturally safe, community-led healthcare.

The core issue is a systemic failure of health equity, manifesting as a \$6.55 billion annual funding deficit and a life expectancy gap of up to 13.6 years in remote communities. Rural Australians receive \$848 less in healthcare funding per person annually than metropolitan residents, leading to an "Avoidable Mortality Gap" where residents in very remote areas die from preventable causes at nearly four times the rate of those in major cities.

The persistence of these health inequities is driven by multiple intersecting systemic failures:

- **First Nations Equity and Leadership:** Addressing rural health inequities must include a focus on improving health outcomes for Aboriginal and Torres Strait Islander peoples through culturally safe, community-led healthcare. This requires not only engagement, but genuine partnership with Aboriginal Community Controlled Health Organisations (ACCHOs), First Nations health professionals, and communities in the design, delivery, and evaluation of healthcare.
- **Social & Environmental Determinants:** Adverse conditions in which people are born and age lead to a higher prevalence of Neglected Tropical Diseases (NTDs), coronary heart disease, and mental health disorders. Burden of disease rises with remoteness, with remote areas experiencing 1.4 times the DALYs of major cities.
- **Digital Exclusion:** Geographic remoteness is a primary driver of digital inequity. Lower Digital Inclusion Index (ADII) scores in remote areas (62.5 vs 75.1 in cities) create a "connectivity tax" that prevents the equitable delivery of telehealth and modern health literacy, further isolating vulnerable populations.

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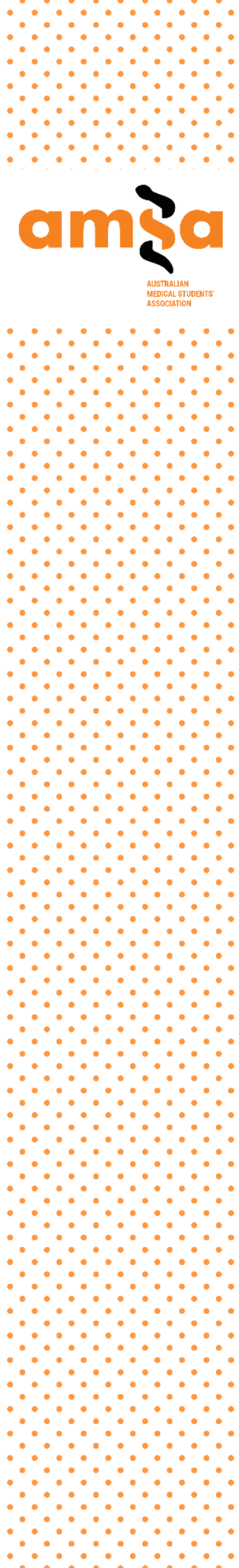
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- The Diagnostic & Specialist Gap: Extreme specialist maldistribution – with remote access being only a fraction of metropolitan levels – creates a diagnostic lag for high-burden chronic conditions like Chronic Kidney Disease (CKD) and Rheumatic Heart Disease (RHD).
- Workforce Attrition & Governance: High clinical loads and professional isolation lead to rapid burnout, while "Closed-Loop" governance models in small health districts lack the independent oversight necessary to ensure clinical safety and systemic accountability.

The Australian Medical Students' Association (AMSA) calls for a fundamental transition toward Structural Health Reform:

- National Standardised Subsidy Framework: Implementation of a permanent, CPI-indexed subsidy model to remove financial barriers to regional practice, ensuring the health workforce reflects the socioeconomic diversity of the Australian public.
- Digital Equity Mandates: Recognising high-speed internet as a social determinant of health and mandating subsidised infrastructure investment in MM 6–7 zones to ensure universal access to virtual care.
- Specialist Access Parity: Redefining healthcare standards to guarantee rural residents the same access to in-person specialty consultations and diagnostic pathways as metropolitan residents.
- Independent Governance & Safety: Establishing anonymous, external reporting pathways for all regional health services to ensure patient safety and professional standards are independent of local hospital hierarchies. These pathways must also be culturally safe, trusted, and accessible, recognising that low reporting rates in First Nations communities may reflect barriers to reporting rather than assuming safe systems.



Policy Points

AMSA calls upon:

1. Australian Federal Government to:

- a. Fund permanent, CPI-indexed National Rural Health Subsidy Framework replacing ad-hoc grants to offset regional practitioners and trainees costs;
- b. Mandate that regional health districts demonstrate "Specialist Access Parity," as a requirement for federal health funding, ensuring that rural residents have the same access to early-stage screening (e.g., echocardiography, renal biopsy) as metropolitan residents;
- c. Increase Commonwealth Supported Places (CSPs) for First Nations Australians from regional, rural and remote areas in Medicine;
- d. Partner with Aboriginal Community Controlled Health Organisations (ACCHOs), First Nations health professionals, and communities in the design, implementation, and evaluation of rural and remote health reforms affecting First Nations;
- e. Invest in high-speed, subsidised telecommunications infrastructure, including reliable Internet connection and electronic devices, for MM 2-7 communities, improving telehealth delivery and equitable access to digital health services;
- f. Expand Medicare Benefits Schedule (MBS) funding for critical telehealth services provided by general medical and allied health practitioners in rural areas;
- g. Fund additional accredited speciality training positions in rural regions for high-burden specialities; and
- h. Direct the National Health and Medical Research Council (NHMRC) to prioritise funding for rural health outcomes research, Neglected Tropical Diseases (NTDs) in remote Australia.

2. State and Territory Governments to:

- a. Fund and deliver easily-accessible and tailored education, training and support for all healthcare professionals on the effective use of technology in healthcare;
- b. Create anonymous, external reporting pathways for all regional health services, ensuring that patient safety and staff professional standards are not compromised by local hierarchies. These pathways must be culturally safe, accessible, and trusted by First Nations patients, families, and staff;
- c. Standardise and fund aeromedical stabilisation training for rural-based healthcare providers to mitigate the "Distance Decay" effect on mortality rates for acute trauma and obstetric emergencies; and
- d. Partner with rural community councils to co-design culturally appropriate health literacy activities and social engagement for healthcare workers.

3. Australian Universities and Medical Schools to:

- a. Increase and promote opportunities for placements in rural regions and provide additional support for students to be able to attend rural placements;
- b. Promote graduate selection at regional internship centres;
- c. Include rural health into the curriculum with emphasis on the importance of Rural Generalist Pathways (RGPs);
- d. Provide information and resources on Rural Generalist Colleges such as ACCRM and RACGP-RG Colleges and regional internship centres; and
- e. Embed ongoing, locally informed, First Nations-led cultural safety education across medical training, with clear links to clinical safety, patient outcomes, and professional accountability.

4. Specialty Medical Colleges to:

- a. Increase additional specialty training positions in rural regions, especially for specialties with increased demand in the region due to increased burden of disease;
- b. Incentivise metropolitan-based specialists to provide in-person clinical outreach and supervision within regional hubs to address;
- c. Formalise RGPs and ensure funded regional rotations that focus on high-acuity diagnostic skills relevant to rural pathology; and
- d. Embed the limitations of rural health care into relevant education and training programs.

5. Rural Healthcare Services to:

- a. Continue integration and improvement of continuous telehealth services in rural and remote areas:
 - i. Ensure that core in-person health services are not replaced with telehealth services; and
 - ii. Improve accessibility and ease of use for consumers with limited digital health literacy skills.
- b. Ensure staff are sufficiently trained in culturally safe practice, particularly for First Nations peoples through ongoing, locally informed education and accountability mechanisms that address unsafe care and improve patient outcomes; and
- c. Partner with local ACCHOs, Elders, and First Nations community representatives to support culturally safe, community-informed models of care.

6. Rural and Remote Community Councils and Leadership to:

- a. Liaise with health care professionals and services to:
 - i. Deliver culturally appropriate, community-tailored health promotion and health literacy activities; and
 - ii. Provide opportunities for social activities to actively engage healthcare workers with rural communities.

7. AMSA Rural Health, National Rural Health Student Network, and Student Rural Health Clubs to:

- a. Continue raising awareness of the challenges faced in rural healthcare to medical students, government and other stakeholders; and
- b. Continue advocating for positive change to meet the demands of rural healthcare.

8. National Health and Medical Research Council to:

- a. Support research into Rural health outcomes and NTDs which disproportionately affect the morbidity of remote Australians and First Nations people; and
- b. Support evidence-based interventions to improve community digital health literacy, ensuring that virtual health tools are culturally and socio-demographically appropriate.

9. University Medical Societies to:

- a. Promote engagement and involvement with rural specialist colleges RACGP and ACCRM:
 - i. Co-design events to generate interest and increase student participation; and
 - ii. Provide mentorships and scholarships for those with interest in rural practice.

Background

Defining Remoteness.

Equitable healthcare access remains a challenge across rural, regional, and remote Australia. The Australian Government uses the Modified Monash Model (MMM; MM1-MM7) to classify areas by remoteness and population size. Introduced in 2015, the MMM guides workforce distribution and incentive eligibility, with MM2-MM7 considered regional, rural, or remote.

SOCIAL DETERMINANTS OF HEALTH

Overview of Regional, Rural, and Remote Health in Australia.

In 2021, around 27% of Australians (over 7 million people) lived in rural, regional, or remote areas.[1] These populations experience poorer health outcomes than metropolitan residents due to limited services, workforce shortages and adverse social determinants of health, disproportionately affecting First Nations peoples who are more likely to reside in regional and remote areas and experience a greater burden of disease.[2]

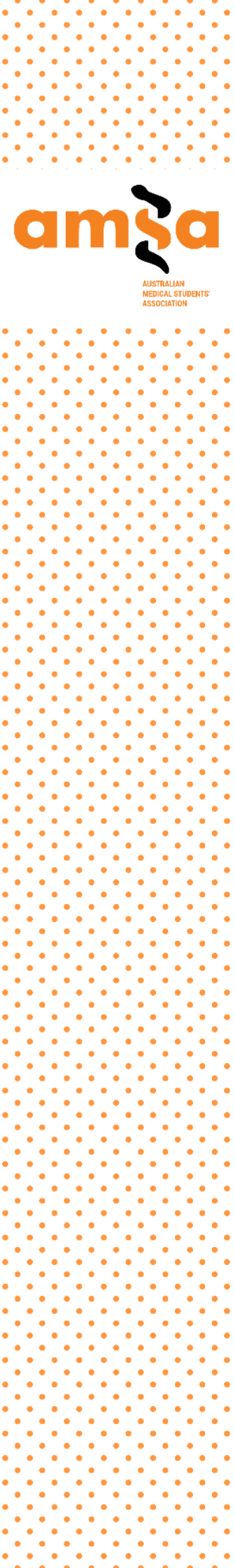
Social Determinants of Health.

Rural, regional, and remote Australians face a higher disease burden driven by adverse social determinants of health. The World Health Organization (WHO) defines social determinants of health as “the conditions in which people are born, grow, live, work and age, and people’s access to power, money and resources”. [3] Health outcomes are shaped by a social gradient, whereby declining socioeconomic status is associated with progressively poorer health. Limited access to safe housing, quality education, stable employment, transport, health services and strong social support networks increases risk of chronic disease, preventable illness and premature mortality.[4]

In regional, rural and remote communities, these social determinants interact with geographic and infrastructural challenges. Upstream factors, including limited public service funding, digital exclusion and poor educational opportunities, reduce health literacy and employment prospects.[5] Midstream factors, such as limited healthcare infrastructure, telehealth barriers, and workforce shortages, impede timely diagnosis and chronic disease management. Downstream effects include higher preventable hospitalisations, poorer disease control and increased psychological distress, especially among elderly, First Nations, and other vulnerable populations. Collectively, these factors perpetuate a cycle of disadvantage in rural and remote communities, resulting in higher healthcare costs, reduced quality of life and persistent inequities relative to metropolitan-based Australians.

Rural Health Inequities.

Burden of disease increases with remoteness, with remote areas experiencing approximately 1.4 times the disability-adjusted life years (DALYs) of major cities.[1] Coronary heart disease (CHD), chronic kidney disease (CKD), type 2 diabetes, chronic obstructive pulmonary disease (COPD) and suicide



disproportionately affect these communities.[6] Notably, CHD and CKD impose two to three times the burden observed in metropolitan populations.[1]

Neglected tropical diseases (NTDs) are endemic within remote Australian communities. These conditions particularly affect Aboriginal and Torres Strait Islander peoples, due to overcrowding, inadequate housing and limited access to clean water and sanitation.[7] Despite their impact, NTDs remain under-recognised in research and funding priorities, showing the need for targeted public health investment. Trachoma, for example, remains an important indicator of preventable health inequity in some remote First Nations communities in the Northern Territory, Western Australia and South Australia, while it has been eliminated from metropolitan areas for over a century. Conditions such as Rheumatic Heart Disease also represent a substantial and ongoing burden, contributing significantly to morbidity, premature mortality and long-term healthcare burden in First Nations communities.

Greater geographical remoteness is also associated with higher rates of self-harm and suicide.[8] Individuals experiencing suicidality are more likely to have coexisting mental health disorders compared with the general population. Although overall mental health incidence appears similar nationwide, affecting approximately one in five Australians, this statistic may mask untreated or undiagnosed conditions in rural and remote communities.[9,10] Mental health service provision is significantly lower in these areas, with remote regions having approximately 2.7 times less access to mental healthcare services.[11] Residents also face distinct social determinant challenges, including social isolation, limited access to support services and socioeconomic disadvantage.

Furthermore, access to healthcare declines with remoteness, often requiring travel or temporary relocation to obtain specialist care. The majority of specialists and allied health professionals are concentrated in metropolitan centres, leaving smaller rural towns understaffed.[1] Although GP availability in very remote areas may appear comparatively high, they often assume expanded scopes of practice and responsibilities, inflating apparent service capacity.[12]

Climate change further exacerbates rural health inequities. Extreme weather and natural disasters strain healthcare systems, increase food insecurity, elevate vector-borne disease risk and intensify pressures on rural health workers and services.[13]

First Nations Rural Health.

First Nations peoples comprise approximately 3-4% of Australia's population and are disproportionately represented in rural and remote areas, accounting for around 6% of outer regional populations and 15% of remote communities.[14] Some First Nations communities are geographically isolated, with limited infrastructure and service access. Hospitalisation rates are approximately 1.9 times higher than for non-Indigenous residents, reflecting a 2.3-fold greater overall disease burden.[15]

These inequities must also be understood within the broader historical and structural context of colonisation, dispossession, systemic racism, and intergenerational trauma, which continue to influence the social determinants of health and access to healthcare for First Nations peoples in Australia.[16] These disadvantages intersect with geographic remoteness, compounding barriers to healthcare access that differ from those experienced by non-First Nations rural populations. As such, improving rural and remote health outcomes for First Nations peoples requires not only improved service access, but culturally safe, community-led care and genuine First Nations leadership in health system design and delivery.

About 35% of the health gap between First Nations and non-First Nations Australians is attributed to socioeconomic factors such as lower incomes, unemployment and reduced educational attainment.[17] Systemic and interpersonal racism, lower employment rates, reduced educational attainment and income inequality limit long-term socioeconomic mobility and contribute to persistent mistrust of mainstream institutions, including the healthcare system.[18] Thus, access to culturally safe healthcare is critical to improving health outcomes for First Nations peoples. Cultural safety requires healthcare systems and professionals to recognise and address power imbalances, institutional practices, racism, and systemic barriers that may negatively impact First Nations patients. Services that prioritise culturally safe care are associated with improved trust, engagement, continuity of care and health outcomes. Cultural safety should therefore be understood as a core component of clinical safety and healthcare quality, rather than as an optional or isolated training issue.

The Aboriginal and Torres Strait Islander health workforce therefore plays a vital role in improving service accessibility and trust. Approximately 46% of First Nations GPs practise in regional and rural areas, compared with 28% of all Australian-trained GPs, enhancing culturally responsive care, though workforce shortages mean access remains inconsistent across these regions.[19] It is also important to recognise the strength, resilience, and effectiveness of First Nations community-led models of care, including ACCHOs, which should be supported and built upon in rural health policy. Collectively, these factors demonstrate that improving rural and remote health outcomes in Australia is inseparable from advancing equity for First Nations peoples.

DIGITAL DETERMINANTS OF HEALTH

The World Health Organisation (WHO) defines digital determinants of health (DDOH) as: “any factor rooted in or contingent on the digital world that can directly or indirectly influence health or well-being”. [20] The COVID pandemic has highlighted the importance of considering DDOH in healthcare policy, with these factors having the potential to both alleviate and exacerbate existing disparities. [21] By enabling the delivery of remote care, such as through telehealth or remote patient monitoring, digital technologies offer a valuable solution to the problem of distance, which afflicts rural healthcare. [22] Findings from a recent joint study conducted by WHO and the London School of Economics can be summarised under two main branches of concern: availability of technology and digital health literacy.

Availability of Technology.

The uneven introduction of basic digital technologies, including electronic devices and reliable Internet, perpetuates “digital exclusion”, seen most acutely in Australia’s rural areas. Remoteness is an indicator for digital exclusion, evident in the Australian Digital Inclusion Index (ADII) data. ADII scores consistently decreased as remoteness increased, with Major Cities scoring 75.1 and Very Remote areas scoring only 62.5. [23] A major barrier is the financial burden of supplying infrastructure required to promote digital inclusion; however, infrastructure alone is insufficient without access to appropriate devices, digital literacy support, and implementation that is responsive to individual community context. Distance of delivery sites and lower population density in rural areas increases costs for both network providers and rural consumers, resulting in persisting low-quality connectivity outside of urban areas. [24] This hinders access to crucial telehealth services, which provide timely access to medical consultations, specialists and health education resources for patients. [25] Unreliable connectivity in MM 6-7 zones is not merely a convenience issue; it represents a failure in clinical safety by preventing real-time specialist consultation during high-acuity retrievals.

Digital Health Literacy (DHL).

Health literacy is an important means of empowering individuals and communities to be more engaged in their healthcare, and is defined as “the ability to find, understand, appraise, and use information and services to make health-related decisions”. [21] Demographic factors, including old age, lower employment and poorer education levels, contribute to lower DHL levels in rural and regional communities. [26] Low individual health literacy in general is associated with higher burden on health services and poorer health outcomes. According to the Australian Commission on Safety and Quality in Health Care, education strategies to improve DHL should be tailored to their audience. [27] For Aboriginal and Torres Strait Islander communities, digital health initiatives must clearly define how training, implementation, and ongoing support will be delivered in partnership with communities, including who is responsible for delivery, how cultural safety is ensured, and how effectiveness will be monitored and reviewed over time. As the amount of health information continues to

expand, and sources continue to move online, DHL will be crucial in ensuring individuals can critically evaluate decisions regarding their healthcare.[28]

Supporting Health Professionals.

To avoid placing undue responsibility on individuals to overcome what is invariably a systemic issue, it is also necessary to elevate community literacy in health personnel alongside health literacy in individuals.[29] Health literacy services across Australia are disconnected, consequently reducing opportunities for researchers, healthcare providers, healthcare organisations, consumers and policy makers to learn from each other.[27] A 2023 overview of 108 systematic reviews found that while digital health technologies could improve the performance and satisfaction of health-care employees, many barriers, including resistance to change, difficulties understanding technology and skepticism, prevented uptake. The study stresses the imperative for education tailored to the needs and skill levels of all healthcare professionals, including high-quality, live technical support and coaching.[30] This should also include locally appropriate and culturally safe support models for healthcare delivery in Aboriginal and Torres Strait Islander communities, developed in partnership with First Nations communities and services.

Regarding the adoption of telehealth among medical professionals, the introduction of telehealth items under the Medicare Benefits Schedule has been effective in incentivising clinicians to provide telehealth services. However, there is still a paucity of funding opportunities for allied health professionals, who are critical in ensuring the sustainability of medical services and for supporting specialists.[31]

STRUCTURAL BARRIERS TO RURAL POPULATION HEALTH

Specialist Maldistribution and the Diagnostic Gap.

The "Avoidable Mortality Gap" remains the most pressing equity issue in Australian healthcare, with its primary driver in non-metropolitan Australia being the extreme maldistribution of medical specialists. While metropolitan centers benefit from high-density specialty clusters, rural health systems face a "thin market" of specialised care. Residents in rural and remote areas face a potentially avoidable death rate nearly four times higher than their metropolitan counterparts.[32]

- **The Funding Gap:** Rural Australians receive \$848 less per person, per year in healthcare funding compared to those in major cities.[32] This underfunding directly sustains the "Diagnostic Gap."
- **Public Health Impact:** This disparity results in a significant "Diagnostic Gap" for high-burden chronic conditions, including Chronic Kidney Disease (CKD) and Rheumatic Heart Disease.[32] Without local specialist input, these conditions are frequently diagnosed at later stages, leading to increased morbidity and a higher reliance on high-cost emergency retrieval services. AIHW data confirms that

people in remote areas are 2.8 times more likely to be hospitalized for potentially preventable conditions.[33]

- **Systemic Failure:** Current "geofencing" of clinical capability within the medical pipeline limits the long-term diagnostic breadth of the regional workforce. To achieve population health equity, the system must shift from a "GP-only" rural model to one that mandates integrated access to tertiary specialty exposure, ensuring rural health systems can provide the same diagnostic and management capability as metropolitan centers.

Socioeconomic Filters and Workforce Representative Parity.

The sustainability of the rural workforce is threatened by the "financial deterrent" of training. A 2025 National Placement Poverty Survey found that 53% of health students have considered leaving their degree due to the financial burden of unpaid placements.[34]

- **"Placement Poverty" as a Systemic Barrier:** The financial burden associated with regional practice – including travel costs and dual-housing requirements – acts as a socioeconomic filter. This disproportionately excludes individuals from lower-income backgrounds from the regional workforce pipeline.
- **Equity Goal:** To ensure a sustainable and representative workforce, AMSA advocates for a National Standardised Subsidy Framework indexed to the CPI. Entry into regional practice and training must be based on clinical commitment and community need rather than individual financial capacity.

Safety Governance and Systemic Accountability.

The quality of rural healthcare is inextricably linked to the transparency and safety of its governance structures.

- **The "Closed-Loop" Problem:** Regional health settings often operate in small, insular environments where professional, supervisory, and social roles overlap. This lack of anonymity creates a "culture of silence" that prevents effective reporting of misconduct, clinical errors, and safety concerns.
- **Governance Reform:** Policy must shift toward Anonymous, External Reporting Pathways that operate independently of local hospital or regional hierarchies. This is a fundamental requirement for healthcare worker retention and, by extension, the safety and continuity of patient care in remote areas. The lack of these pathways is particularly detrimental in remote ACCHOs, where institutional power imbalances can further entrench a lack of trust in systemic accountability. Low complaint or reporting rates from First Nations patients, families and staff should not be interpreted as evidence of safe systems, particularly in rural and remote communities where fear of

repercussions, limited anonymity and mistrust of institutions may reduce reporting of unsafe or discriminatory care.

Aeromedical Retrieval and The “Distance Decay” of Acute Care.

In remote Australia, the "Golden Hour" for trauma and acute cardiac events is often structurally impossible to meet due to geographical vastness. Retrieval services are not merely a transport mechanism; they are a critical public health safety net.

- **Systemic Barrier:** Over-reliance on aeromedical retrieval is a symptom of inadequate local high-acuity infrastructure. As the "Specialist Availability Gap" widens, retrieval services are increasingly used for non-critical transfers that could be managed locally if diagnostic parity existed.
- **Public Health Impact:** High-acuity retrieval is resource-intensive and weather-dependent. Delays in retrieval for conditions like sepsis or obstetric emergencies directly contribute to higher maternal and infant mortality rates in remote zones.
- **Policy Goal:** Integration of retrieval medicine training into regional specialist pathways to ensure "first-contact" clinicians possess the stabilisation skills necessary to mitigate the risks of long-haul transport.

Allied Health and Nursing: The Multi-Disciplinary Deficit.

The sustainability of rural health is contingent on a robust "Team-Based" model. However, the current recruitment pipeline is heavily skewed toward medicine, leaving significant gaps in allied health (physiotherapy, psychology, dietetics) and nursing.

- **The "Generalist" Burden:** In the absence of a full multi-disciplinary team, rural nurses and GPs are forced to operate at the extreme edge of their scope of practice. The absolute scarcity of specialty support forces rural practitioners into a 'Compressed Scope of Practice,' where they must manage complex comorbidities – such as advanced CKD or interventional cardiology needs – that would otherwise be triaged to tertiary care. This clinical isolation is a primary driver of attrition, leading to rapid burnout and "clinical drift," where preventative health (e.g., wound care, rehab, mental health coaching) is sacrificed for acute crisis management.
- **Workforce Inequity:** Medical, nursing and allied health students often lack an appropriate level of federal subsidy for rural placements, creating a "financial deterrent" that prevents early-career exposure to regional practice.

Aboriginal and Torres Strait Islander Health Workers (ATSIHWs).

ATSIHWs are the clinical and cultural backbone of remote health delivery. They are the only workforce segment capable of bridging the "Trust Deficit" created by historical systemic failures in healthcare.

- **Structural Undervaluation:** Despite their role in improving health literacy and treatment adherence for chronic conditions (RHD, Diabetes), ATSIHWs often face "Glass Ceilings" regarding clinical autonomy and professional pay parity.
- **Systemic Integration:** Public health outcomes for Indigenous communities are directly correlated with the presence of ATSIHWs in the clinical loop. Failure to provide clear, funded career ladders for ATSIHWs into nursing or medicine represents a wasted opportunity for long-term workforce stability. ATSIHW and Practitioners should also be recognised as essential leaders in culturally safe, community-informed models of care across rural and remote health systems.

WORKFORCE RETENTION

Clinical Load and Burnout.

One leading cause of attrition is burnout from high clinical load. To illustrate, the number of full-time-equivalent GPs per 100,000 people decreases significantly with remoteness, where MM1 has ~1 GP per 800 people, MM2-3 has ~1 per 900, MM4-5 has ~1 per 1280, and MM6-7 has ~1 per 1400.[7] If we include all medical practitioners there are ~1 per 210 in major cities in comparison to ~1 per 400 in very remote areas. Rural practitioners encounter increased burden to manage heavy workloads, often in areas outside of their expertise due to lack of specialist availability.[35]

Compared to major cities, specialist availability is roughly half for regional and remote regions, with very remote areas dwindling to only 1/7th.[36] Rural patients in need of specialist care often have delays in their diagnosis or treatment leading to poorer health outcomes, increased patient complaints, contributing further to the stress experienced by clinicians. Current arrangements depend heavily on transferring patients to metropolitan centres, a logistically difficult and often unfeasible solution, adding to the frustration of patients and clinicians.[36] In addition, reduced access to primary health care is attributable to higher rates of potentially preventable hospitalisation, up to 3 times as high in MM5+, increasing demand and complexity of treatment, pressuring rural practitioners to be competent in multiple areas – a stressful, time-consuming and exhausting process to maintain.

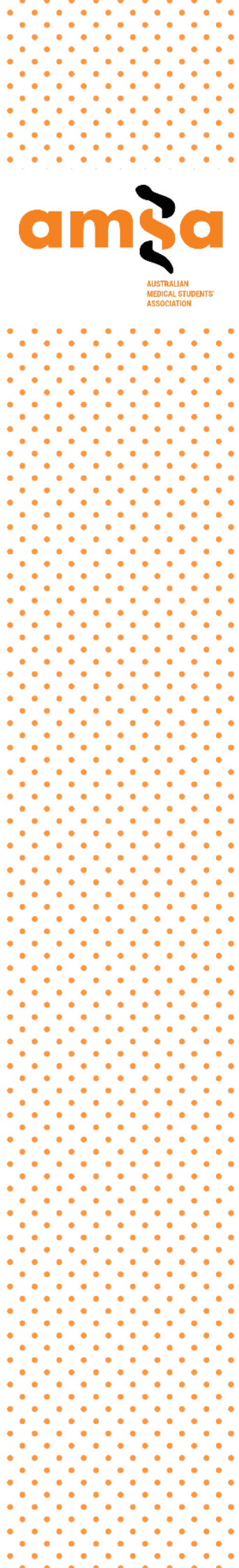
Career Development and Disengagement.

Limited rural specialist training pushes junior doctors to MM1 hospitals, fearing missed networking opportunities, perpetuating shortages and restricting access for rural patients to advanced care pathways.[37-39] Although some specialists may choose to practice in rural regions after training, urban-trained physicians may harbour fears of uncertainty towards rural practice preventing them from pursuing rural practice. This reduces rural uptake, leaving patients with potentially underdeveloped local services and increased reliance on fly-in fly-out (FIFO) specialists.[40] Hence, universities should consider mandatory rural placements and incorporation of rural health in the curriculum, increasing exposure and reducing stigma towards rural practice.[41]

Short-term staffing is frequently seen in rural and remote towns, especially in ACCHOs and health-related organisations. FIFO and high staff turnover disrupts patient continuity of care, particularly harming the relationship with First Nations people who value community and long-term relationships.[42] Patients often exhibit distrust towards transient staff and are reluctant to share their full histories.[43] The lack of loyalty may contribute to them feeling undervalued, reducing engagement and willingness to participate in healthcare. This instability may also compound existing mistrust created by previous experiences of culturally unsafe or inappropriate care, further reducing engagement with health services.

Social Isolation and Family Integration.

Social connectedness is a key social determinant of retention. For those from metropolitan backgrounds, healthcare workers may feel socially disconnected when transitioning to rural regions. Rural doctors who quickly build local social networks, either through work, schools and community groups, are more likely to stay.[38,39,44] This is especially the case when partners and children also feel integrated. Hence, policies should encourage more opportunities for active engagement of doctors with the rural community.



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