RRIPM
Rural and Remote Institute of Palliative Medicine

# The RRIPM Roadmap: 2025-2028


RRIPM is a program of ANZSPM

anzspm
Australia New Zealand Society of Palliative Medicine

# Acknowledgement of Country

ANZSPM acknowledges and pays respect to the Traditional Custodians of the lands and waters across Australia on which our members live and work, and to their Elders, past, present and emerging.


***The RRIPM Roadmap*** was prepared by Jo Risk, RRIPM Program Manager, on behalf of the RRIPM Steering Group.

Citation: The RRIPM Roadmap:2025-2028. ANZSPM / RRIPM, Canberra ACT, 2024.
rripmproject@anzspm.org.au

# Contents

# Foreword

*Werte,* from beautiful Arrernte country in Central Australia!

I want to commend this project to my palliative care colleagues all around the country, to prospective trainees who may be wondering whether to explore the road less travelled, and – perhaps most importantly of all – to the health sector, whose support we are seeking so that we can nurture the future development of rural palliative medicine.

Last year we published and consulted on our scoping review, *Beyond the Burbs*. It identified many barriers to progressing rural training, and some huge challenges, but it also made clear that none of them are insurmountable. This *Roadmap* is the product of a collaboration between rural palliative care doctors from every jurisdiction in Australia and is our response to those challenges. It grew out of a real and urgent need, for us to be able to sustain our services and secure a future for rural palliative care. ***We need to be able to train more rural specialists to work in the amazing services we have helped build*.** And we need to train them right here, in the places where they will work, not in the city.

The clinicians who are in the RRIPM steering group and who lead these services have, between them, an amazing depth of clinical experience. I thank them for their collegiality, good humour and wisdom, and their persistence. Likewise, the trainee doctors who spend time in our services are also amazing – adventurous, curious, clinically courageous, and so much wanting to make a real difference in the places where they work. They are the inspiration for this project. We look forward to working with many more such trainees in the future, and to being able to offer them a joined-up rural training pathway that will meet their needs, and the needs of our communities.

To the State and Commonwealth funders who, by each providing a very small quantum of funding, can take the RRIPM project forward - I remind you of what we are calling *the RRIPM effect*. The value add that is provided by each rural specialist is about so much more than just direct patient care (important though that is) – it can catalyse real change and system improvement, can support the capacity and development of local services, and can provide mentoring, training and education for so many other clinicians who will then go on to care for rural patients. It's gotta be worth it.

Truly, and literally, a little goes a long way out bush.

**Dr Christine Sanderson**

Clinical Lead, RRIPM project
Specialist in Palliative Medicine
Territory Palliative Care – Central Australia / Alice Springs Hospital
30th July 2024.

# Acknowledgements

The RRIPM team would like to acknowledge the support received from the Department of Health and Aged Care. Funding provided through the Flexible Approach to Training in Expanded Settings [FATES] grant process allowed this important work to begin. We also acknowledge:

- ANZSPM Council and CEO for ongoing support
- RACP College Dean, Training and Education Committees, for being receptive to change
- Assoc Professor Chris Schilling, University of Melbourne, for health economics advice
- Reference group members / organisations- for sector support and willingness to partner.
- Katherine Economides, RACP NT/SA office, and Janice Besch, former CEO of ANZSPM – for helping wrangle the FATES grant application – and thus creating the possibility of RRIPM
- Dan Curley for being a true rural palliative care legend… (and coming up with our name)
- Arron Veltre for testing our thinking and active support
- Matthew Coleman for generously leading the way

*RRIPM Steering Group and contributors*

| | |
|---|---|
| **Dr Chi Li** | Victoria |
| **Dr Chirag Patel** | SA – Advanced trainee |
| **Dr Christine Sanderson** | NT – Project Lead |
| **Dr Kane Vellar** | NT –AIDA representative |
| **Dr Lea Currie** | ACT |
| **Dr Louis Christie** | NSW |
| **Prof Kirsten Auret** | WA |
| **Ms Nicole Willico** | RACP |
| **Dr Odette Spruijt** | Tasmania |
| **Dr Sally Banfield** | WA -Advanced trainee |
| **Dr Sophia Lam** | QLD – RACP Training Committee, Palliative Medicine |
| **Dr Susan Haynes** | SA |
| **Dr Suzanne Rainsford** | NSW / Rural Remote Special Interest Group ANZSPM |

# Executive Summary

The cycle of rural disadvantage in healthcare, particularly in palliative medicine, is a critical issue that needs urgent attention. Around 7 million Australians (28% of the population) live in rural or remote areas. (AIHW, 2023) However, only 16% of specialists work in rural areas so there are significant disparities in the kind of palliative care that is available to people in different geographic locations across Australia as they near the end of life.

This roadmap outlines a three-year plan to develop the Rural and Remote Institute of Palliative Medicine. It details achievable solutions to address rural palliative medicine workforce challenges, leading the way for rural workforce sustainability.

The Rural and Remote Institute of Palliative Medicine (RRIPM) is a virtual program supported by the Australia New Zealand Society for Palliative Medicine (ANZSPM) with the specific purpose of building rural workforce capability by strengthening access to, and support for, palliative medicine training in rural and remote communities within Australia.

Operating virtually as a coordinating body, RRIPM builds capability, advances specialist palliative medicine training in non-metropolitan settings, and will increase the rurally based palliative medicine workforce over time. RRIPM has the potential to **double** the number of palliative medicine fellows in rural areas by 2035.

RRIPM applies principally to people completing the Advanced Training in Palliative Medicine (36 months) through the Royal Australasian College of Physicians (RACP) or Chapter Fellowship. A secondary benefit will be setting up structures that support the Clinical Foundation in Palliative Medicine (6 months) and foster alignment with both Royal Australian College of General Practitioners (RACGP) and the Australian College of Rural and Remote Medicine (ACRRM) rural generalist and GP Advanced Specialised Training (AST) in palliative medicine programs offered by these Colleges. (12 months).

### *Building capability*

In addition to fostering a network of rural palliative care services, over the next three years (2025-2028) this collaboration of rural 'training-ready' providers will pilot a model of rural palliative medicine training.

RRIPM has identified 21 rural locations across Australia that could sustain advanced palliative medicine training. We conservatively estimate these sites, once accredited could add 10 new rural advanced trainee places in the short-term, an increase of 67% over today, and more than 20 places over the longer term (133% increase from today).

The pilot will demonstrate how a more equitable and sustainable rural palliative care workforce is achievable, with collaborations that can nurture both rural specialists and generalists.

### *Partnering for outcomes*

RRIPM will seek to partner with key stakeholder groups including the Royal Australasian College of Physicians, The Royal Australian College of General Practice, the Australian College of Rural and Remote Medicine, Palliative Care Australia, the National Rural Health Alliance, Australian Indigenous Doctors Association and others, to deliver rural workforce results.

*Funding required*

RRIPM has significant support across the sector. Critical elements for collaboration and progress are in place with the *critical exception* of **program funding**, required for the period, July 2025 - June 2028.

RRIPM offers a targeted and cost-effective way to increase the number of specialist palliative care clinicians in rural areas. Considering the strong health economic arguments supporting this rural training initiative, there is strategic value in funding RRIPM as an investment in improving healthcare outcomes, reducing disparities and supporting rural communities.

The initial project phase has been funded by the Department of Health and Aged Care through a Flexible Approach to Training in Expanded Settings (FATES) grant administered by the Royal Australasian College of Physicians [RACP] through until June 2025. This grant funding is not recurrent.

**New funding of $600,000 per year is required to support pilot activities from July 2025 – June 2028.**

Potential funding entities are invited to consider the benefits and how their support will translate into meaningful and sustainable improvements in rural palliative care, as part of a national approach that is leading real change.

RRIPM, as it develops, will directly improve the experiences of people living and dying outside of our metropolitan centres and out to the furthest part of the country. The outcomes of this project will make that a reality.

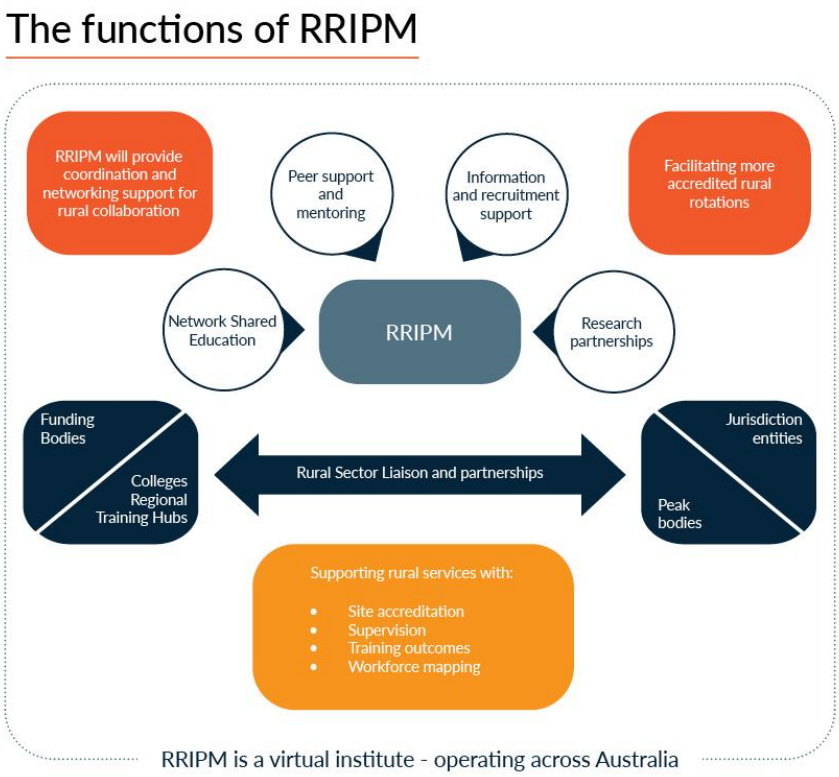
# Introducing the Rural and Remote Institute of Palliative Medicine

This roadmap outlines a three-year plan to develop the Rural and Remote Institute of Palliative Medicine. It details achievable solutions to address rural palliative medicine workforce challenges, leading the way for rural workforce sustainability.

The Rural and Remote Institute of Palliative Medicine (RRIPM) is a program supported by the Australia New Zealand Society for Palliative Medicine (ANZSPM) with the specific purpose of strengthening access to, and support for, palliative medicine training in rural and remote communities within Australia.

As a virtual coordinating body, RRIPM builds capability, advances specialist palliative medicine training in non-metropolitan settings, and will increase the rurally based palliative medicine workforce over time. RRIPM offers an integrated Rural and Remote Training experience:

- designed by rural doctors for rural doctors
- based on RACP competency-based training curriculum
- offering high-quality fully supported rural training experiences.



# Why is change needed?

Rural communities – comprising 28% of the Australian population - miss out on a range of specialist health care, and health outcomes tell the story. This disparity has been acknowledged time and again in government and peak organisation position statements and policies addressing rural health problems.

## The need for palliative care services is greater in rural and remote areas

- Older people aged 65 and over tend to make up a larger proportion of the population in regional and remote areas. This influences the burden of disease and death.
- Cancer incidence rates, for example, are approximately 5% higher in regional and remote areas than in major cities, while survival rates are approximately 3% lower[i].
- The death rate in inner and outer regional areas is consistently 13-14% higher than in major cities; in remote and very remote areas the death rate is 33% higher than in major cities[ii].
- Rural and remote residents are 64 % more likely to require palliative care in aged care facilities as assessed by the funding-based care assessment[iii]

However, access to specialist palliative care services in regional and remote areas is limited, and despite multiple policy initiatives, the vast majority of the specialist palliative care workforce practice in major cities.

- Those living in major cities are about 5 times more likely to receive MBS-subsidised palliative care services compared with those in remote and very remote areas[iv].
- Over 84 % of palliative care specialists live in major cities. There is just one palliative care physician working in a remote or very remote area[v].

| Area | Number | Per cent |
|---|---|---|
| **Major cities** | **472** | **84.3%** |
| **Inner regional** | **71** | **12.7%** |
| **Outer regional** | **16** | **2.8%** |
| **Remote** | **1** | **0.2%** |
| **Total** | **560** | **100%** |

Table 1: Distribution of Palliative Medicine Fellows by Australian Statistical Geography Standard and MMM. Source: (RACP,2023)

**Policy statements and reports describe rural inequity and the need to change**

There is strong recognition of the importance of strengthening the rural medical workforce.

National Palliative Care Strategy [NPCS], 2018

National Medical Workforce Strategy 2021-2031

Ngayubah Gadan [Coming Together] 2023

Australian Indigenous Doctors' Association

RACP Regional, Rural, Remote Physician Strategy, 2023

KPMG Final Report. Investing to save 2020

Beyond the Burbs: a scoping review 2023

- The inequity in workforce numbers persists even after adjusting for smaller populations outside the major cities. There are just 0.4 clinical FTE palliative medicine physicians per 100,000 population in outer regional areas, and 0.6 in inner regional areas, compared to 1.0 in major cities[vi].
- Things are similar for palliative care nurses. There are 5.4 clinical FTE palliative care nurses per 100,000 population in remote and very remote areas, and 9.7 in outer regional areas, compared to 11.0 in major cities[vii].

## Change is achievable

We know that rural graduates are 3 times more likely to progress their career outside of a major city relative to those from non-rural backgrounds. That makes RRIPM a particularly well-targeted and cost-effective way to increase the number of specialist palliative care clinicians in rural areas, relative to other policy options such as large incentive payments that typically cost a lot but don't deliver a sustained increase in the number of clinicians in rural and remote areas[viii]. Furthermore, policies that focus on trying to attract metropolitan doctors to move to rural areas often fail to appreciate that many of the doctors who want to train rurally are *already* living and working there, but that currently they are required to leave in order to do specialist training - a barrier that prevents many from ever pursuing that possibility.

We know that Aboriginal and Torres Strait Islander doctors are more likely than non-Indigenous doctors to be interested in a career in rural practice. The 2023 Aphra Medical Training Survey revealed that 68 % of Aboriginal and/or Torres Strait Islander trainees were interested in a future career in rural practice compared with 46% of the national response. Aboriginal and Torres Strait Islander doctors have the cultural expertise to navigate the complexities of rural and remote health.

The RRIPM program has a clear and targeted focus to drive change.

- RRIPM will support an expanded network of RACP accredited sites improving rural training options and availability
- RRIPM will pilot a new fit for purpose model of rural palliative medicine training based on the new curriculum
- RRIPM will actively seek Aboriginal and/or Torres Strait Islander candidates and other rural graduates for rotations in rural locations and will link individuals to broader cultural safety, financial and support networks. Aboriginal and Torres Strait Islander trainees will be supported to access existing RACP resources, and trainee wellbeing and professional development will be a priority focus.

# Making the changes: the RRIPM effect

The Rural and Remote Institute of Palliative Medicine is a virtual institute that crosses Australia. It is a collaborative of rural palliative care services. Participating rural services will continue to employ and train doctors, but as part of RRIPM they will collaborate with and be supported by other rural services. RRIPM's role includes:

- working with the Royal Australasian College of Physicians to remove barriers to rural training
- piloting changes to rural palliative medicine linked to the new curriculum
- growing the available network of rural training opportunities by helping more training sites to get accredited and come on board with RRIPM
- promoting rural training opportunities and advocating for its value and relevance
- mentoring and supporting rural trainees and supervisors
- sourcing and networking shared rural educational offerings
- reducing rural service isolation and duplication of effort
- providing tailored culturally safe support for rural palliative medicine trainees and the services that are training them
- building productive partnerships with key stakeholders across the rural health ecosystem, to ensure a functioning training pipeline for rural palliative care.

*RRIPM Principles*

## The three-year agenda: a new approach to training for rural palliative medicine

In addition to fostering a network of rural palliative care services, RRIPM is undertaking a 3-year pilot project (2025-2028), working with RACP to develop, trial and evaluate an inclusive approach to accreditation of rural palliative care training locations.

The pilot is aligned with the introduction of RACP's new advanced training program which is a hybrid time-and-competency based training with progress and completion decisions based on evidence of trainee competence. The opportunity to implement this competency-based approach in rural locations will provide a more appropriate training experience for rural palliative medicine, with an additional educational focus on rural competencies which are not taught or gained in metropolitan training.

### *The Pilot*

Training ready rural palliative care services will participate in the pilot, working collectively to contribute to the evidence base which will demonstrate feasibility and equivalence with current training locations.

In the first year (2025), trainees in the RRIPM pilot will receive support from RRIPM including shared education and peer support activities, and the opportunity to plan their further rural training rotations.

Once the updated RACP accreditation systems are operable, in the second and third years (2026/27), RRIPM trainees will be supported to complete newly accredited rural terms, while following the new curriculum and with greater choice of rural training locations.

- Additional training ready sites will be included for accreditation from 2026
- Rural competencies aligned with the new curriculum will be defined
- Evaluation of the trial will be completed in early 2028.

Evaluation findings will contribute important implementation data, providing assurance in the change process, and demonstrating the quality of the training provided with equivalence and feasibility.

RRIPM will lead and coordinate this system improvement in partnership with the RACP.

### RRIPM Pilot Sites

as of August 2024*

Albany, WA

Albury-Wodonga, VIC

Alice Springs, NT

Launceston, TAS

Lismore, NSW

Orange, NSW

**other training-ready sites may join over the pilot period*

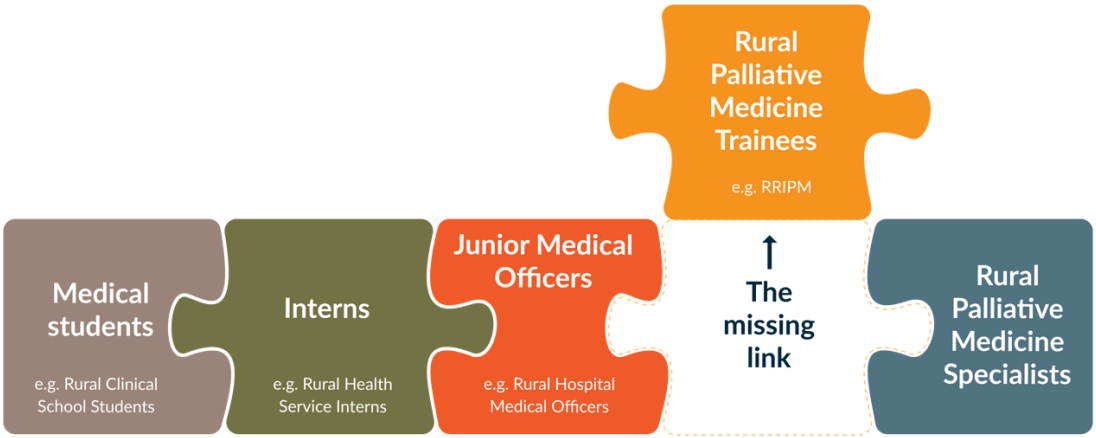
## How this will help- fixing the rural training pipeline

Within a local palliative care service, the capability to provide training is a key enabler for rural workforce retention and sustainability.

For rural medicine more generally, the medical training pipeline has been well identified, with the introduction of rural clinical schools, rural clinical rotations, the employment of rural hospital medical officers and GP colleges promoting the role of rural generalist as a specialism. For the palliative medicine workforce, the missing link in the pipeline is the ability to undertake specialist training rurally.

If the current rurally based specialists are not able to achieve accreditation of their services so they can provide rural training, then specialist training opportunities will never become available in rural settings, and the rural workforce pipeline will continue to fail to meet the needs of rural communities.

*The Rural and Remote Institute of Palliative Medicine offers a clear solution to address the missing link.*



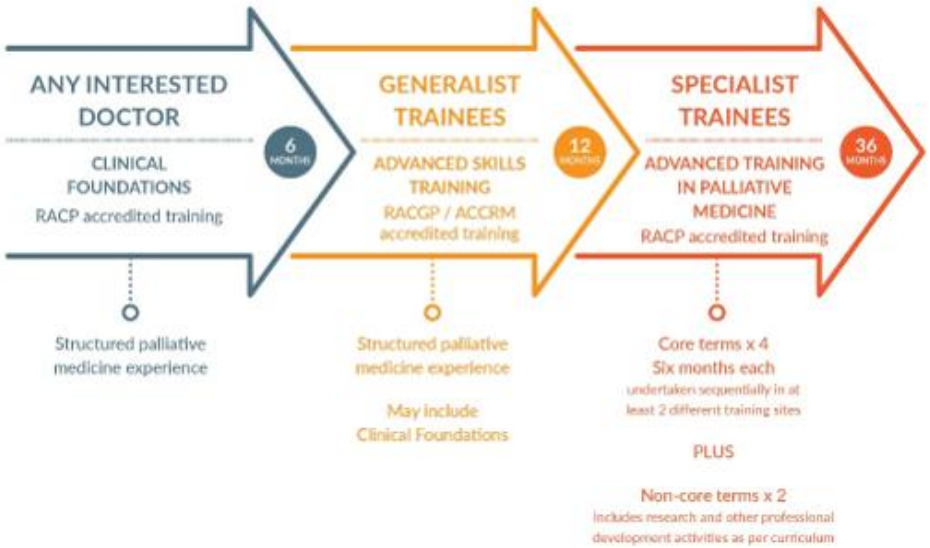

The concept of growing a place-based service and strengthening the training pipeline is multi-faceted and recognises the interdependence of specialist and generalist training in rural settings. The important elements of the training pipeline are:

- Rurally based specialists are needed for the training of both specialists and generalists in palliative medicine
- Rural communities need a balanced mix of generalists and specialists to be involved in the ongoing provision of palliative care, and to ensure the sustainability of palliative care services
- Training programs (generalist and specialist) should ideally be inter-operable, so that mutual accreditation and recognition of prior learning is supported.
- Generalists who have undertaken some palliative care training (Clinical Foundation or rural generalist AST programs in palliative medicine) may wish to continue to specialist training at some point, and that should be able to be facilitated.

*Rural training opportunities that are created by RRIPM will support both specialist and rural generalist trainees*

# The training context: training options in palliative medicine

Clinicians seeking to train in palliative medicine have a range of time-based options, each leading to a different scope of practice. While undertaking training, the clinician is employed by the participating health service and works clinically as part of the medical establishment.




## Clinical Foundation in Palliative Medicine (6 months)

The RACP Clinical Foundation in Palliative Medicine program requires 6 months of full-time equivalent (FTE) training undertaken in an accredited setting with supervision from a Fellow of the RACP or AChPM, actively practising in palliative medicine. It provides general practitioners or any other interested medical practitioners a structured program of clinical experience in palliative medicine. Completion of this course does not confer eligibility for specialist recognition in palliative care medicine.

## Advanced Skills Training in Palliative Medicine (12 months)

The Australian College of Rural and Remote Medicine (ACRRM) and the Royal Australian College of General Practitioners (RACGP) provide GP and trainees with a defined and supported pathway to gain advanced knowledge in specialist fields. GPs and Rural Generalist trainees may undertake a 12-month AST in palliative medicine, and supervision for the AST program is often supported by rural palliative medicine specialists.

## Advanced Training in Palliative Medicine (36 months)

There are two pathways for entry to RACP Advanced Training in palliative medicine.

- RACP Fellowship – after completion of Basic Physician Training
- Chapter Fellowship – with Fellowship from another prescribed College such as ACRRM or RACGP

To be recognised as a palliative medicine specialist, doctors must complete three years of supervised training and work-based assessments in an Adult (or Paediatric) setting.

## RRIPM will increase rural and remote palliative care workforce

RRIPM is specifically designed to address workforce issues by increasing training opportunities for rural clinicians. Currently, there are just 15 rural trainees enrolled in the advanced training palliative medicine 3-year course[ix].

- RRIPM has identified 21 rural locations across Australia that if accredited could sustain additional advanced palliative medicine training. We conservatively estimate these sites could add 10 new rural advanced trainee places in the short-term, an increase of 67% over today, and more than 20 places over the longer term (133% increase from today).

Providing rural training opportunities is critical to growing the rural palliative care workforce. We estimate **RRIPM would double the number of palliative care medicine fellows working in rural areas by 2035.**

This makes RRIPM a particularly well-targeted and cost-effective way to increase the number of specialist palliative care clinicians in rural areas. Other policy options such as large incentive payments are costly but don't deliver a sustained increase in the number of clinicians in rural and remote areas[x].

A secondary benefit will be setting up structures that support and foster alignment with both Royal Australian College of General Practitioners (RACGP) and the Australian College of Rural and Remote Medicine (ACRRM) rural generalist and GP AST programs. Most GPs provide palliative care services, yet almost a third report lacking confidence in providing this care because of inadequate training, patient complexity and insufficient resources[xi]. In rural areas, this equates to around 2,400 GPs who could benefit from clinical training in palliative medicine.

# *What is needed to make the RRIPM collaborative work?*

RRIPM has significant support across the sector. Critical elements for collaboration and progress are in place with the *critical exception* of **program funding**, required for the period, July 2025 - June 2028.

Funding will enable the sector to commence and consolidate a robust evidence base, the findings from which will likely justify recurrent funding based on anticipated strong outcomes.

***Critical support for the RRIPM collaborative is already in place***

| | |
|---|---|
| Strong sector engagement and participation | ✓ |
| Legal entity auspice for governance and accountability | ✓ |
| Training ready services willing to participate | ✓ |
| RACP approval for trial of Integrated Rural term | ✓ [pending] |
| **Operational funding** | **?** |

## Operational funding

The FATES grant funding to scope and establish RRIPM as a national program covers project costs until June 2025. To realise the full benefits for rural communities beyond June 2025, **operational funding of $600,00 per year is needed**. (Appendix 1: proposed budget)

This funding allocation will:

- Employ a part time palliative medicine specialist as the national Medical Lead
- Employ a part time coordinator to maintain administration and communications
- Cover administrative costs including licenses, insurance, IT and employment costs.
- Fund mechanisms for peer support between trainees in isolated locations, and for supervisors, supporting workforce connectivity and wellbeing,
- Acknowledge the cultural load for Aboriginal and Torres Strait Islander trainees and representatives
- Support the work of pursuing training alignment between ACRRM, RACGP, AIDA and the specialist sector

For this 3-year pilot period, it is most likely RRIPM will need to accept contributions from several sources including state and territory governments to achieve the required funding envelope. Contributions for funding will sit within ANZSPM as the legal entity overseeing the program.

Alternative approaches to program resourcing, in the absence of a direct funding allocation, may be considered 'in kind'. A jurisdiction may opt to fund one or more of the program positions, for example the medical lead role and or coordinator role, to work operationally within the RRIPM program for a contracted period of time, while being retained fiscally through their usual jurisdictional employment. Flexible resourcing arrangements are welcome and potential funders are invited to consider how they might contribute and in return receive significant system benefit.

# The Value Proposition of RRIPM

RRIPM will yield significant benefits for rural communities, healthcare services, and society, making it a valued investment for organizations and governments concerned with healthcare equity and access.

## Palliative care makes good economic sense

- While palliative care does not aim to extend life, it does improve the quality of life for those people living with life-limiting illnesses. A recent Cochrane systematic review found specialist palliative care consistently delivers improved patient quality of life[xii].
- Further, by better understanding a person's end-of-life preferences, expensive but low-value end-of life care can be avoided. Two large Australian studies found that access to community-based palliative care has significant benefits, lowering hospitalisation admissions in the last year of life by 34%[xiii], and saving acute care costs of almost $5,500 per patient[xiv].
- In the rural setting, the hospital costs of dying patients are often blown out further by the cost of retrievals for inappropriate, low-value treatment that may occur at the end of life.

## Strategic Value

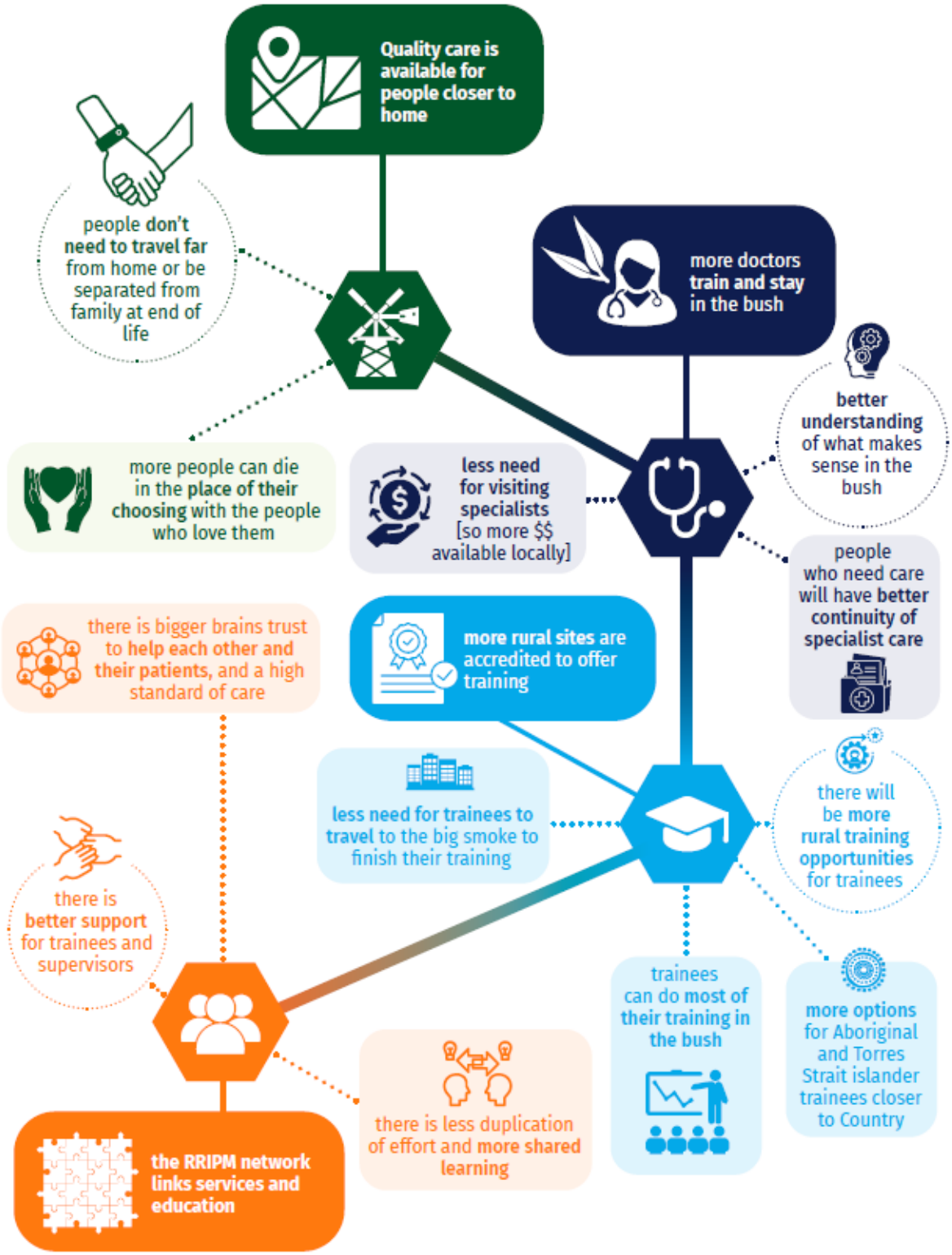
RRIPM is a strategic investment with significant benefits to be realised including:

1. **Addressing Healthcare Access Disparities**
   Rural areas often face significant healthcare disparities, including limited access to specialist care. Training and supporting palliative care specialists for rural areas, to work in rural services, will improve equity.
2. **Improving Quality of Life**
   Palliative care improves the quality of life for patients with serious illnesses and their families. Enhancing access to palliative care in rural areas will make a significant contribution to improving quality of life for rural residents and their families towards the end of life.
3. **Cost-Effectiveness**
   Effective place-based palliative care can reduce hospital bed days, minimise Emergency department presentations, patient retrievals, and avoidable travel and cut fly in fly out service costs.
4. **Building Capacity**
   The RRIPM program builds capacity by training local clinicians and developing local resources. This place-based approach not only improves palliative care but also strengthens the rural healthcare systems overall.
5. **Supporting Rural Communities**
   The program supports rural communities by ensuring that residents can access high-quality palliative care without having to travel long distances. This can reduce the emotional and financial burden on patients and their families.

6. **Supporting Rural Workforce**
   Feeling connected and supported with access to active peer networks is a protective factor for rural employees, contributing to workforce resilience and sustainability.
7. **Fulfilling Ethical and Policy Obligations**
   All individuals, regardless of where they live, have a right to high-quality healthcare. Numerous policies commit to this intent. Funding the RRIPM program helps to fulfill ethical and policy obligations by ensuring that rural residents have access to the palliative care they need, and rural workforce are supported to deliver it in a sustainable manner.

## Value for patients and their rural community

- Care closer to home – less travel, and more understanding of the implications of every test or scan in terms of the burden on a patient and their family
- Choices that are based in the reality of rural life, its geography, its culture, its local community and networks of support, its strengths and relationships
- The ability to support family carers and social networks so they are not overloaded at a time of trauma
- People can die in the place of their choosing with the people who love them
- Care is provided by doctors who understand the rural context




RRIPM can drive significant improvements in care for rural communities.

## Value for participating health services

Specialists working in health services that are participating in the RRIPM pilot already report immediate benefits and expect these will translate into midterm and long-term benefits over time.

### Immediate benefit:

- A collaboration between regional supervisors to support placements and planning
- Access to collaborative colleagues to support supervision as back up if required
- Web-based resources and signposting of opportunities and contacts

### In the mid-term:

- Shared education resource for trainees to access
- Annual networking event
- Coordination through a Medical Lead
- Support for additional sites to accredit and join RRIPM
- Formal relationships with universities for rural research opportunities

### In the longer term:

- Known as the 'rural training network of choice' and supporting a strong workforce pipeline
- Potential to form a Rural Training Review Panel to formally monitor the training progress of rural trainees, as required in the new RACP curriculum for advanced training

## Value for Rural Trainees

Trainees engaged by services linked to the RRIPM network will appreciate significant benefit.

### Immediate benefit:

- Opportunity to access support for decision making about rotations
- Individually tailored approach to planning for training
- Peer support from rural trainees and experienced rural specialists
- New rural training opportunities that provide excellent clinical experience and preparation for a rural career, with exposure to high value clinical issues such as Aboriginal Health

### In the mid-term:

- Guidance and support from RRIPM Medical Lead
- Access to rurally tailored shared education
- Community of practice to ready for transition to consultant role in the rural setting
- Rural complexity is well understood and incorporated into training experience
- Mentoring and tailored support for Aboriginal and Torres Strait Islander trainees

### In the longer term:

- Rural services develop to better meet community need
- Growth in rural employment opportunities
- Annual networking events with other rural alumni
- Links to multi-site rural research opportunities through university relationships
- The opportunity to provide leadership and to make a real difference in ways that are unique to rural health care

## Value for Partner organisations

- Shared sector advocacy to improve a whole range of interlinked health outcomes
- Access to diverse, multi-site rural research opportunities
- Strategic and aligned workforce development
- Creating an aligned training pathway from primary to specialist care
- Enhancing multi-disciplinary rural networks.

This RRIPM roadmap is designed to complement and link in with the training activities of the rural generalist program by providing palliative care expertise that strengthens the palliative care training component of the AST program. A more stable rural specialist workforce also provides a better foundation for rural generalist AST placements in palliative medicine, in turn strengthening primary care. Successful development of a robust training pipeline for rural palliative medicine will necessarily require collaboration and alignment between the generalist and specialist training colleges.

*In summary,* there is strategic value in funding RRIPM as an investment in improving healthcare outcomes, reducing disparities, supporting rural communities and the workforce who serve them. The funding purpose is well aligned with principles of equity, compassion, and the right to healthcare. It sits squarely within the intent of multiple federal and state policy positions. This is not just a financial contribution, but a significant investment in the health and well-being of rural residents.

# RRIPM Roadmap Implementation Plan 2025-2028

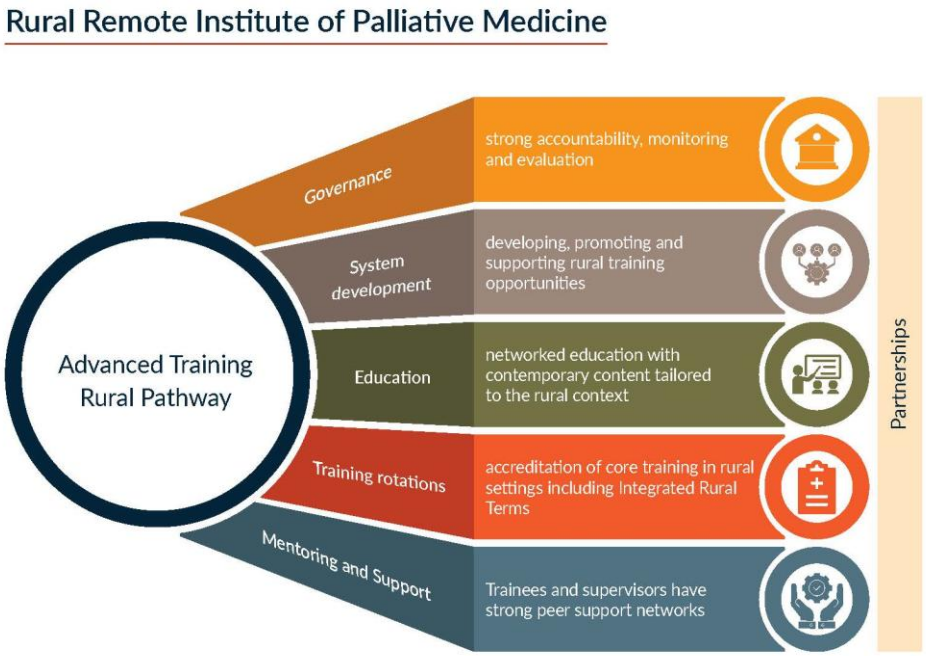
The implementation plan details planned activities to be actioned over the next three years.

## Domains of Activity

Five key domains of activity have been identified and implementation activities within each domain have been projected over a three-year establishment horizon. To note, some actions are currently underway as part of the RRIPM project Year 1 implementation plan. Other actions are dependent on securing ongoing program funding.

The domains considered within this implementation plan include:

- Governance – strong accountability, monitoring and evaluation.
- System development – promoting and supporting rural training opportunities
- Education – networked offerings with contemporary content tailored to rural practice
- Training rotations – accreditation of core training in rural settings including IRT
- Mentoring and support – capability development and strong peer networks



## Domain 1: Governance

To ensure effective oversight and delivery of high-quality training in accredited rural locations the RRIPM program will establish accountable governance arrangements based on the following activities:

| **Activity 1** Description: | Determine RRIPM entity<br>Preferred RRIPM Entity is defined, and governance arrangements are established. |
|---|---|
| Year 1 | • Position RRIPM as an entity; or within an entity to support implementation.<br>• Define governance arrangements as entity; or delegations within an entity |
| Year 2 | • Transition from Project to Program in July 2025. |
| Year 3 | • Maintain regular governance oversight |

| **Activity 2** Description: | Determine measures of accountability for program evaluation and monitoring<br>Establish measures of accountability |
|---|---|
| Year 1 | • Determine evaluation framework for FATES grant acquittal |
| Year 2 | • Define components of RRIPM, to determine Key Performance Indicators [KPIs]<br>• Define measures of accountability for program evaluation |
| Year 3 | • Report against KPIs and monitor performance |

| **Activity 3** Description: | Source recurrent Program Funding<br>Develop proposals seeking funds for RRIPM pilot and ongoing implementation including staffing, information hub, and education programs. |
|---|---|
| Year 1 | • Develop and submit funding proposals. |
| Year 2 | • Interim program funding is secure |
| Year 3 | • Recurrent funding is achieved |

| **Activity 4** Description: | Appoint and manage RRIPM Program Team<br>Appoint and manage a part time RRIPM Medical Lead and administrative support to coordinate the RRIPM network |
|---|---|
| Year 1 | • Transition project team at opportune time before June 2025<br>• Appoint program team<br>• Embed cultural safety considerations in all program decision making |
| Year 2 | • Assess program resource requirements |

| **Activity 5** Description: | Initiate Partnerships for RRIPM establishment<br>Establish partnerships with national, state, and territory governments, health services, universities, and other stakeholders to develop the RRIPM community. |
|---|---|
| Year 1 | • Convene reference group workshops<br>• Commence relationship building for tri-partite working committee |
| Year 2 | • Consult and build partnerships.<br>• Explore collaboration opportunities. |
| Year 3 | • Establish shared rural research partnerships |

| **Activity 6** Description: | Refine RRIPM Strategic Plan<br>Refine strategic plan outlining goals, key activities, timeframes, and responsibilities. |
|---|---|
| Year 1 | • Draft Roadmap 2025-2028 to inform strategic plan |
| Year 2 | • Refine strategic workforce plan |
| Year 3 | • Implement strategic workforce plan |

## Domain 2: System Development

The RRIPM team will coordinate system development to support effective collaboration between rural training sites, promoting and supporting rural training opportunities. Activities will include:

| **Activity 7** Description: | Develop RRIPM Information Hub<br>Develop an online information hub providing current information about training sites and job opportunities, support available to trainees, and network profiles. |
|---|---|
| Year 1 | • Develop website |
| Year 2 | • Maintain information hub content |
| Year 3 | • Expand and refine information hub content based on sector need |

| **Activity 8** Description: | Develop RRIPM Communications and Awareness Strategy<br>Collaborate with regional training hubs and rural health sector to develop a pipeline strategy to increase awareness and raise the profile of the RRIPM training opportunities. |
|---|---|
| Year 1 | • Map stakeholders |
| Year 2 | • Co-design implementation strategy<br>• Explore rural competency relating to Indigenous knowledge |
| Year 3 | • Promote and support pipeline activities |

## Domain 3: Education

The following activities are about developing a networked rural education offering

| **Activity 9** Description: | Promote shared education opportunities through online calendar of events<br>Develop online calendar of events networking sites to share educational opportunities for rural trainees. |
|---|---|
| Year 1 | • Online portal operational |
| Year 2 | • Education coordinator maintains calendar |
| Year 3 | • Rurally specific education offerings sourced<br>• Ensure cultural safety concepts are embedded throughout training topics |

| **Activity 10** Description: | Develop education modules for rural specific competencies<br>Rural education modules that can be delivered within existing curriculum, meet RACP curriculum requirements, and provide rurally appropriate content will be curated |
|---|---|
| Year 1 | • Gain consensus view and sector collaboration |
| Year 2 | • Map rural education competencies against curriculum |
| Year 3 | • Promote access to multi-disciplinary team-based learning |

| **Activity 11** Description: | Improve Access to Research and Quality Improvement projects<br>Establish RRIPM-specific research partnerships with universities, rural clinical schools, and academic research organizations to support rural trainees in completing their research requirements |
|---|---|
| Year 1 | • |
| Year 2 | • Explore university partnership opportunities |
| Year 3 | • Establish research partnerships.<br>• Support rural trainees and services in research projects. |

## Domain 4: Training rotations

A focus on developing supported rural training rotations including the evaluation of a specific integrated rural core term

| **Activity 12** Description: | Design and advocate for the introduction of accredited integrated rural terms<br>To be offered as part of a core advance training requirement within a rural pathway, aligned with the new competency-based curriculum |
|---|---|
| Year 1 | • Co-design new terms in collaboration with RACP – through TCPM and CEC |
| Year 2 | • Support uptake and site accreditation of integrated rural term<br>• Expand rural training collaborative to include newly accredited sites |
| Year 3 | • Explore expansion of training rotations to include nurse practitioner models |

| **Activity 13** Description: | Facilitate implementation of new RACP competency-based curriculum<br>Support implementation of competency-based Fellowship regulations when released to support newly configured rural training terms |
|---|---|
| Year 1 | • Map rural competencies to new curriculum |
| Year 2 | • Further define rural competencies and support uptake of new curriculum |
| Year 3 | • Nominate to be the RACP Rural Training Review Panel |

| | |
|---|---|
| **Activity 14**<br>Description: | Collaboration between specialist and generalist colleges to ensure a functioning training pipeline for rural palliative medicine<br>Collaborate and develop a shared approach to generalist and specialist training for rural palliative medicine. It is essential to articulate the connections between the Clinical Foundation in Palliative Medicine (RACP), Advanced Skills Training for GP /rural generalists (RACGP/ACCRM), and palliative medicine advanced training pathways (RACP). |
| Year 1 | • Initiate discussions<br>• Reference group input through workshops |
| Year 2 | • Establish working group<br>• Explore approaches to STP funding alignment |
| Year 3 | • Develop aligned accreditation standards<br>• Develop aligned supervision requirements<br>• Establish RPL agreements |

| | |
|---|---|
| **Activity 15**<br>Description: | Develop Networked Arrangements to Expand Rural Training Opportunities<br>Collaborate with TCPM and training ready sites to establish networked arrangements with public and/or private health services in other rural regions. |
| Year 1 | • Increase number of accredited rural training sites |
| Year 2 | • Collaborate with TCMP / RACP and accredited sites to explore network readiness |
| Year 3 | • Facilitate transition to rural network arrangements |

## Domain 5: Mentoring and Support

The following activities are about developing effective mentoring and support networks for trainees and supervisors

| **Activity 16** Description: | Establish a rural trainee peer support network<br>Develop peer support channels such as online forums, journal clubs, and study groups for/with rural trainees. |
|---|---|
| Year 1 | • Map existing peer support channels |
| Year 2 | • Consult with sector to enhance peer support channels |
| Year 3 | • Establish online and face to face forums and events |

| **Activity 17** Description: | Establish a Rural Supervisor Learning Network<br>Facilitate professional development opportunities for rural supervisors |
|---|---|
| Year 1 | • Map rural supervisor distribution |
| Year 2 | • Facilitate professional development opportunities. |
| Year 3 | • Facilitate annual / bi-annual supervisor meetings / workshops |

| **Activity 18** Description: | Advocate for flexibility and modernization of supervision requirements<br>The metro-centric approach to supervision that is embedded in the training program at present clearly prevents the accreditation of many rural services and need to include flexibility for a mix of face to face and remote supervision |
|---|---|
| Year 1 | • Review current supervision regulations.<br>• Consider changes needed to adapt regulations for remote supervision.<br>• Seek TCPM approval |
| Year 2 | • Models of supervision suitable for quality rural training are defined and evidenced |
| Year 3 | • Ongoing evaluation of supervisory models relevant to rural practice |

| **Activity 19** Description: | Facilitate Buddy and Mentor Arrangements for New Rural Trainees<br>Explore options to pair new rural trainees with experienced buddies and mentors for support and guidance. |
|---|---|
| Year 1 | • |
| Year 2 | • Explore buddy and mentor arrangement options.<br>• Focus on Aboriginal and Torres Strait Islander trainee support on country |
| Year 3 | • Facilitate rural trainee / registrar meetings (see also activity 16) |

## Partnerships

While RRIPM is dedicated to building capability and enhancing access to palliative medicine training in rural areas this also involves advocating in partnership with ANZSPM for policies and initiatives that improve access to palliative care workforce and rural services more broadly. A sector wide RRIPM reference group has been established.

## Reference Group

RRIPM continues to work collaboratively with key stakeholders in the sector, inviting participation and partnership from consumer advocates, healthcare providers, research institutions, ACRRM and RACGP, peak bodies and jurisdictional entities to ensure RRIPM activities are well aligned and contributing to the broader health eco-system. In this way, the aim is to create synergy of effort to maximise opportunities for rural communities. The reference group meet twice a year and consider strategic opportunities.

## The RRIPM Roadmap has been endorsed by key rural sector stakeholders:

- Australian College of Rural and Remote Medicine [ACRRM]
- Australian Indigenous Doctor's Association [AIDA]
- Cancer Australia
- National Rural Health Alliance [NRHA]
- Palliative Care Australia [PCA]
- Research Centre for Palliative Care, Death and Dying, [RePaDD] Flinders University
- Royal Australian College of General Practitioners [RACGP]
- Royal Australasian College of Physicians [RACP]

## Strategic Commitments

The timeframe for the success of this roadmap will rely on appropriate investment by all parties. As described, the RACP has responsibility for the standards, coordination and delivery of the RACP Fellowship Program; while trainee positions, employment conditions, supervision and support are reliant on government-funded health services. Coordination between collaborating services is the responsibility of RRIPM as a program within ANZSPM.

Successful implementation of this roadmap requires a commitment to partnerships and collaboration with national, state and territory governments, peak bodies, workforce planning bodies, health services, universities and regional training hubs. With full endorsement of the sector, RRIPM is well placed to achieve its aims.

## ANZSPM

**ANZSPM** is the legal entity within which the RRIPM program operates**.** Operating within an agreed program framework ANZSPM Council will oversee the following governance actions:

- Establish governance and program management arrangements within the ANZSPM structure.
- Ensure rural representation to key stakeholders where relevant.
- Appoint RRIPM Medical Lead and staff
- Foster partnerships required to develop RRIPM, including with national, state and territory governments, health services, health regions, workforce planning bodies, universities, regional training hubs and other colleges.
- Support the development of funding and sponsorship proposals to deliver RRIPM including seeking government funding for components of the RRIPM program
- Oversee development of a Monitoring, Evaluation and Learning framework for RRIPM.

## Australian Department of Health and Aged Care (DOHAC)

It is proposed that **DOHAC**

- provide recurrent program funding under the national palliative care program from 2027
- enhance current Specialist Training Program (STP)/Integrated Rural Training Pipeline (IRTP) funding agreements to enable the creation of dedicated training positions for RRIPM trainees
- support rural components of formal education programs, including subsidies for rural trainees to attend workshops and events
- support data collection and reporting capability activities that may also align with National Medical Workforce Strategy and data requirements
- consider funding additional trainee positions tailored for Aboriginal and Torres Strait Islander health service trainees

## State and Territory governments

It is proposed that **state and territory governments:**

- contribute dedicated funding to share the support of RRIPM into the future
- provide dedicated funding for additional palliative medicine trainee positions in rural areas, Funding should include:
  - paid supervision time, travel and associated rural supervision costs, and incentives to attract supervisors to targeted locations
  - supports for rural specialists including continuing professional development (CPD), networking and research support
  - increased incentives for rural specialists through competitive salary packages (and relocation costs), access to locum services and travel support for CPD.

- build service capacity to expand rural training to more rural locations (in collaboration with the RRIPM and RACP)
- ensure infrastructure (facilities and IT) is available to enable effective access to education, supervision and peer support for rural trainees
- contribute funding to a pooled education fund to coordinate shared education access for trainees
- consider the introduction of multi-year trainee contracts, transferable across all states and territories that includes dedicated time for education and support activities.

## Health services

It is proposed that **health services**:

- provide dedicated regional and rural specialist training positions and ensure positions are adequately funded
- ensure that all new rural trainees receive training in cultural safety
- assist in finding housing for trainees and their families, and consider how to support employment for a trainee's partner to enable couples to be recruited and retained in regional, rural and remote locations
- ensure access to and uptake of peer networking opportunities
- ensure access to locums to cover specialist leave, including leave for professional development and networking
- provide protected time for trainees to attend conferences and networking events
- engage in networked arrangements to expand training opportunities.
- contribute financially to a shared education pool

## Universities and Regional Training Hubs

It is proposed that **Universities and Regional Training Hubs** (RTH):

- work in partnership with RRIPM to promote RRIPM to prospective trainees
- link medical students and junior doctors interested in palliative medicine with RRIPM Medical Lead and rural services
- improve access to research opportunities and support.

## Sector Opportunity

It is proposed that philanthropic and benevolent institutions and including private organizations and providers will have opportunity to donate services and funds to the RRIPM program via the ANZSPM entity, operating as a registered not for profit charity with deductible gift recipient status.

## Key Performance Indicators

Refining Key Performance Indicators (KPI) for the RRIPM program will be an important development activity during the implementation and establishment phases of RRIPM. In the short term, proposed KPI's may include:

1. **Number of Specialists Trained:** This KPI measures the number of medical professionals who have completed the RRIPM advanced trainee program. This could additionally be expressed as a percentage of available placements.

2. **Number of GP, Rural Generalists and other trainees supported:** This KPI measures the number of trainees supported to undertake training in rural locations.

3. **Number of new accredited rural sites:** This KPI shows growth in the size of the RRIPM network with new services achieving site accreditation and participating in the rural collaboration.

4. **Number of rural training vacancies:** This KPI shows uptake of available rural training positions

5. **Patient Access:** This KPI measures the number of rural residents who have accessed palliative care services within the RRIPM network.

6. **Patient Experience:** This KPI measures the reported (deidentified) patient experience using validated quality assessment tools and qualitative research methods.

7. **Cost Efficiency:** This KPI measures the cost-effectiveness of the RRIPM program. This could be assessed by comparing the cost of training and retaining specialists in rural areas with the savings realised by reduced use of locums, retrievals and hospital bed days. (need advice about relevant measures)

## Recognising Risk

The RRIPM Roadmap Implementation Plan 2025-2028 carries inherent risk. Key risks and risk mitigation strategies have been considered and are summarised below.

**Governance:** Setting up effective funding and governance arrangements including measures of accountability for program monitoring and evaluation requires careful planning and execution amongst multiple stakeholders. **Analysis of Risk level:** MEDIUM

| Risk | Mitigation |
|---|---|
| Poorly defined governance arrangements | • Clear governance structures and processes<br>• Program management group operates under agreed terms of reference<br>• Program is overseen by ANZSPM Council |
| Governance is not sufficiently inclusive to represent diverse and underrepresented stakeholder perspectives | • Management group membership is national with rural specialists from each jurisdiction<br>• Conjoint membership with representation from ANZSPM council as the legal entity, and RACP AChPM as the regulatory body.<br>• [paid] representation for AIDA membership<br>• Advanced Trainees working in rural rotations<br>• Sector wide reference group contribute every six months, to ensure the program alignment |
| Lack of long-term program funding | • develop funding proposals.<br>• actively seek recurrent program funding and grants, and<br>• demonstrate the value and impact of the program<br>• contingency planning for funding interruption |
| Burnout of participants if inadequately resourced | • Administrative support for governance functions<br>• Adequate program resourcing |

**System development:** Coordination to support rural access and information relies on accurate timely systems of communication. **Analysis of Risk level:** LOW

| Risk | Mitigation |
|---|---|
| Communication methods fail to convey information effectively | • Communication management is informed by industry experts who design effective modes and methods of communication, well-tailored and informed by the needs of the target audience. |
| Communication modalities are not achieving desired reach and target audience | • Clear communication strategy using best practice principles is regularly monitored and adjusted as required to respond to changing market conditions. |

**System change:** Progressing system change carries inherent risk, and requires careful planning, collaboration and coordination. **Analysis of Risk level:** MEDIUM

| Risk | Mitigation |
|---|---|
| RACP reject need for change to accreditation standards | • National scoping review to evidence the need for system change<br>• Extensive consultation to capture diverse perspectives<br>• Co-design and collaboration with RACP to create acceptable solutions<br>• Continue the project with a reduced scope |
| Rate of change is slow | • Establish realistic expectations and timeframes<br>• Follow established decision-making mechanisms |

**Partnerships:** Establishing partnerships with national, state, and territory governments, health services, universities, and other stakeholders is a key enabler of the plan. However, building these partnerships can be complex and time-consuming. **Analysis of Risk level:** MEDIUM

| Risk | Mitigation |
|---|---|
| Key entities do not engage in partnership | • Build relationships with potential partners, demonstrate the mutual benefits of partnership, and maintain open and regular communication.<br>• Involve partners in planning system change and through reference group engagement. |

## In summary

People living in rural locations have a right to receive quality palliative medicine close to home, and existing services are vulnerable in the absence of a sustainable well-resourced workforce plan. Mapping has demonstrated a palliative medicine workforce shortage and a significant maldistribution of specialist workforce between metropolitan and rural communities. National policy identifies the need to address this issue and the RRIPM project aims are well aligned.

There is opportunity to make positive change in the distribution of available training placements and ultimately in the available rural specialist workforce. RRIPM has potential to double the number of rural palliative medicine fellows by 2035 which is a tremendous return on investment.

The RRIPM function of streamlining and coordinating activities in support of rural palliative medicine training will be essential to drive needed change across the national landscape and the activities outlined in the RRIPM 2025-2028 implementation plan clearly show the actions required for success.

Most critical to the success of this important undertaking is securing program funding for implementation of the RRIPM Roadmap 2025-2028 beyond the grant funding period.

## Appendix 1: Budget (Proposed)

The following budget summary includes all salary, governance and operational costs.

Detailed costings are available upon request

| | 2025-2026 | 2026-2027 | 2027-2028 |
|---|---|---|---|
| Budget per annum | 539,190.47 | 652,167.44 | 709,670.96 |
| TOTAL COST | | | $1,901,028.87 |

## Appendix 2: Acronyms

| | |
|---|---|
| **AChPM** | Australasian Chapter of Palliative Medicine |
| **ACRRM** | Australian College of Rural and Remote Medicine |
| **AIDA** | Australian Indigenous Doctors' Association |
| **AIHW** | Australian Institute of Health and Welfare |
| **ANZSPM** | Australia New Zealand Society for Palliative Medicine |
| **APHRA** | Australian Health Practitioner Regulation Agency |
| **ASGS** | Australian Statistical Geography Standard |
| **AST** | Advanced Specialised Training |
| **AT** | Advanced Trainee |
| **CEC** | College Education Committee |
| **DOHAC** | Department of Health and Aged Care |
| **FAChPM** | Fellowship of the Australasian Chapter of Palliative Medicine |
| **FATES** | Flexible Approach to Training in Expanded Settings |
| **FTE** | Full-time equivalent |
| **GP** | General practitioner |
| **IRTP** | Integrated Rural Training Pipeline |
| **JMO** | Junior Medical Officer |
| **KPI** | Key Performance Indicator |
| **MMM** | Modified Monash Model |
| **RACGP** | The Royal Australian College of General Practitioners |
| **RACP** | The Royal Australasian College of Physicians |
| **RPL** | Recognition of Prior Learning |
| **RRIPM** | Rural and Remote Institute of Palliative Medicine |
| **RG** | Rural Generalist |
| **RMO** | Resident Medical Officer |
| **RTH** | Regional Training Hub |
| **STP** | Specialist Training Program |
| **TCPM** | Training Committee Palliative Medicine |

# Appendix 3: Definitions

## Rural

In this paper we use the term 'rural' to refer to regional, rural and remote locations in Australia.

Several systems of classification exist to describe geography in the Australian context.
The Australian Statistical Geography Standard – Remoteness Areas (ASGS-RA) (2016) is a measure of relative access to services with the following structure:

**ASGS-RA 1** – Major Cities of Australia
**ASGS-RA 2** – Inner Regional Australia
**ASGS-RA 3** – Outer Regional Australia
**ASGS-RA 4** – Remote Australia
**ASGS-RA 5** – Very Remote Australia

The Modified Monash Model classifies metropolitan, regional, rural and remote areas according to geographical remoteness, as defined by the Australian Bureau of Statistics (ABS). The MMM is used to determine eligibility for a range of health workforce programs, such as rural Bulk Billing Incentives, Workforce Incentive Program, Bonded Medical Program. MMM classifications are based on the Australian Statistical Geography Standard-Remoteness area (2016)

This scoping project uses the Modified Monash Model when describing rurality.

| Modified Monash category (MM2019) | Description [including the Australian Statistical Geography Standard-Remoteness area (2016) |
|---|---|
| MM1 | **Metropolitan Areas:** Major Cities accounting for 70% of Australia's population ASGS-RA1 |
| MM2 | **Regional Centres:** inner and Outer Regional areas that are in, or within a 20km drive of a town with over 50,000 residents.<br>ASGS-RA2 and ASGS-RA3 |
| MM3 | **Large Rural Towns:** Inner [ASGS-RA2] and Outer regional areas [ASGS-RA3] that are not MM2 and are in, or within a 15km drive of a town between 15,000 to 50,000 residents.<br>For example- Dubbo, Lismore, Yeppoon, Busselton<br>ASGS-RA2 and ASGS-RA3 |
| MM 4 | **Medium Rural Towns:** Inner [ASGS-RA2] and outer regional areas [ASGS-RA3] that are not MM2 or MM3, and are in, or within 10km drive of a town with between 5,000 to 15,000 residents. For example, Port Augusta, Charters Towers, Moree. |
| MM5 | **Small Rural Towns:** All remaining inner [ASGS-RA2] and Outer regional areas. [ASGS-RA3]. For example: Mount Buller, Moruya, Renmark, Condamine. |

| Modified Monash category (MM2019) | Description [including the Australian Statistical Geography Standard-Remoteness area (2016) |
|---|---|
| MM6 | **Remote Communities:** Remote Mainland areas [ASGS-RA4] AND islands less than 5km offshore. For example: Cape Tribulation, Lightning Ridge, Alice Springs, Mallacoota, Port Hedland. Additionally, islands that have an MM5 classification with a population of less than 1,000 without bridges to the mainland will now be classified as MM6 for example: Bruny Island. |
| MM7 | **Very Remote Communities:** Very Remote Areas [ASGS-RA5]. For example: Longreach, Coober Pedy, Thursday Island, and all remote island areas more than 5 km offshore. |

Table 1: Source: health.gov.au. modified /modified-monash-model-factsheet.

Note: For the purposes of this report, rural training sites, or potential sites, have been identified only in MM3 – 7 regions. However, it is acknowledged that the MM2 (Inner Regional) classification is extremely diverse, including at one end of the spectrum two capital cities (Hobart and Darwin), as well as the outer suburban sprawl of the other capital cities, whilst at the other end of the spectrum it captures numerous rapidly growing centres that are distant from the major metropolitan centres and serve extremely rural communities, such as Albury-Wodonga. Furthermore, regional growth patterns mean that in the near future it is likely that some services currently in communities classified as MM3 will be reclassified to MM2 because of population shifts. Therefore, whilst the RRIPM focus is MM3 – 7 regions, in future RRIPM will adopt a pragmatic approach to defining rural services.

# References


[i] Analysis of AIHW, 2021. Cancer in Australia 2021. Supplementary tables for Chapter 10: Key population groups.
[ii] Analysis of ABS, 2022. Deaths Table 6.1.Cat 33020DO006_2022
[iii] Humphrey, G.B., Inacio, M.C., Lang, C., Churches, O.F., Sluggett, J.K., Williams, H., Morgan, D.D., To, T.H., Kellie, A., Wesselingh, S. and Caughey, G.E., 2024. Estimating potential palliative care needs for residential aged care: A population-based retrospective cohort study. *Australasian Journal on Ageing*.
[iv] AIHW, 2024. Palliative care services in Australia
[v] RRIPM 2024, Beyond the 'Burbs: Specialist Palliative Medicine Training in Rural Australia – A scoping review.
[vi] Analysis of AIHW, 2024. Palliative care services in Australia – Palliative care workforce.
[vii] ibid
[viii] https://pursuit.unimelb.edu.au/articles/it-s-more-than-the-money-getting-gps-to-go-to-rural-areas
[ix] RRIPM 2024, Beyond the 'Burbs: Specialist Palliative Medicine Training in Rural Australia – A scoping review.
[x] https://pursuit.unimelb.edu.au/articles/it-s-more-than-the-money-getting-gps-to-go-to-rural-areas
[xi] Le, B., Eastman, P., Vij, S., McCormack, F., Duong, C. and Philip, J., 2017. Palliative care in general practice: GP integration in caring for patients with advanced cancer. Australian family physician, 46(1/2), pp.51-55.
[xii] Bajwah, S., Oluyase, A.O., Yi, D., Gao, W., Evans, C.J., Grande, G., Todd, C., Costantini, M., Murtagh, F.E. and Higginson, I.J., 2020. The effectiveness and cost-effectiveness of hospital-based specialist palliative care for adults with advanced illness and their caregivers. *Cochrane database of systematic reviews*, (9).
[xiii] Spilsbury, K., Rosenwax, L., Arendts, G. and Semmens, J.B., 2017. The impact of community-based palliative care on acute hospital use in the last year of life is modified by time to death, age and underlying cause of death. A population-based retrospective cohort study. *PloS one*, *12*(9), p.e0185275.
[xiv] Youens, D. and Moorin, R., 2017. The impact of community-based palliative care on utilization and cost of acute care hospital services in the last year of life. *Journal of Palliative Medicine*, *20*(7), pp.736-744.