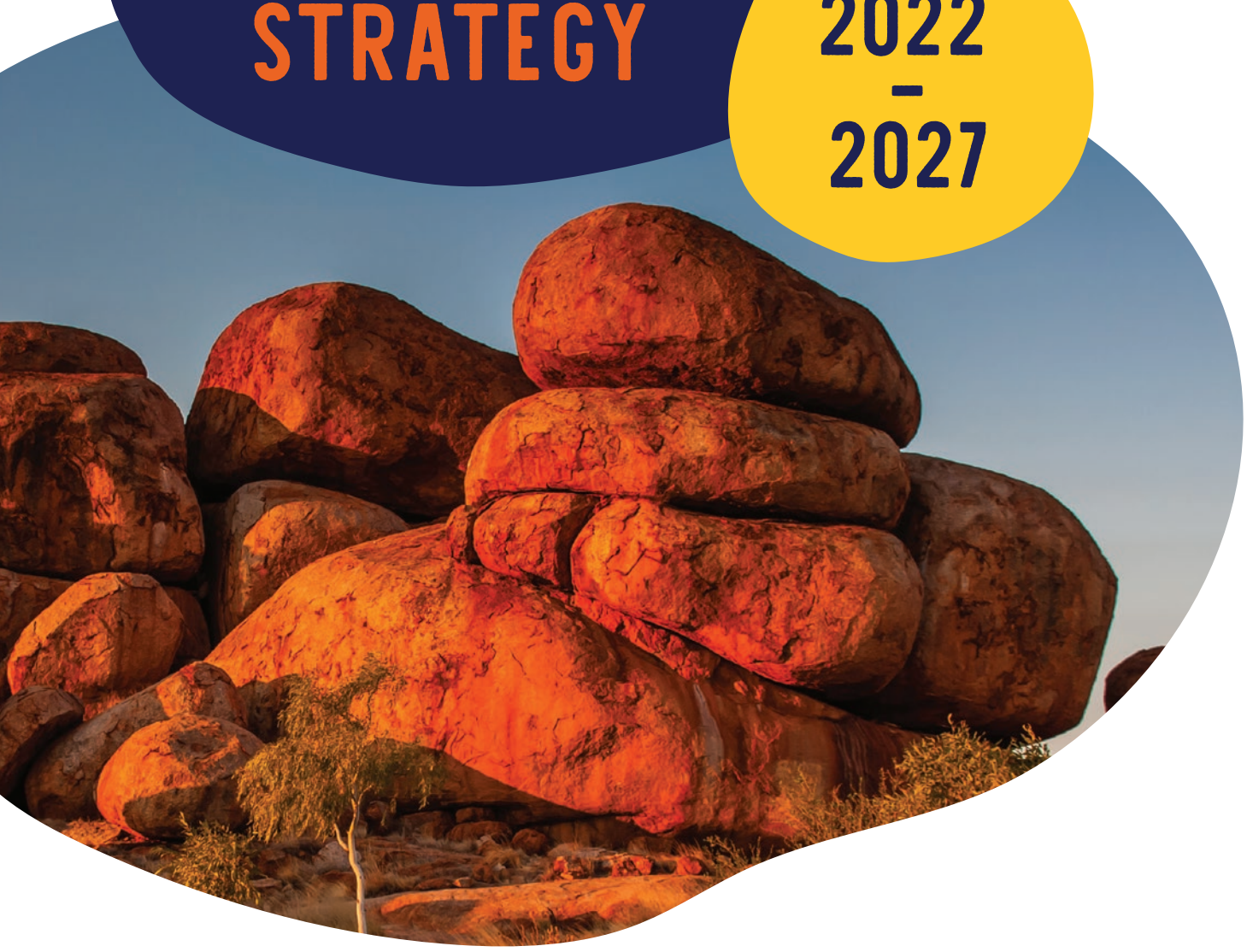
RURAL GENERALIST Pathway Northern Territory

NT HEALTH RURAL GENERALIST STRATEGY

2022 – 2027



An Australian Government Initiative

NORTHERN TERRITORY GOVERNMENT

ACKNOWLEDGEMENT

The Northern Territory Government respectfully acknowledges the First Nations people of this country and recognises their continuing connection to their lands, waters and communities. We pay our respects to Aboriginal and Torres Strait Islander cultures, and to their leaders past, present and emerging. While this strategy uses the term 'Aboriginal', we respectfully acknowledge that Torres Strait Islander peoples are First Nations people living in the Territory. 'Aboriginal Territorians' should be read to include both Aboriginal and Torres Strait Islander Territorians.

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The National Rural Generalist Pathway received grant funding from the Australian Government.

CONTENTS

ABBREVIATIONS

ACCHS	Aboriginal Community Controlled Health Service
ACRRM	Australian College of Rural and Remote Medicine
AGPT	Australian General Practice Training
AIDA	Australian Indigenous Doctors Association
AMSANT	Aboriginal Medical Services Alliance of the NT
ASH	Alice Springs Hospital
AST	Advanced Skills Training
CARHS	Central Australia Regional Health Service
FTE	Full Time Equivalent
FRACGP	Fellow of RACGP
GDH	Gove District Hospital
GP	General Practitioner
ICU	Intensive Care Unit
JMO	Junior Medical Officer
KH	Katherine Hospital
MMM	Modified Monash Model
NGO	Non Government Organisations
NT	Northern Territory
NTAHF	NT Aboriginal Health Forum
NTG	NT Government
PGY	Postgraduate Year
PRH	Palmerston Regional Hospital
RACGP	Royal Australian College of General Practitioners
RDH	Royal Darwin Hospital
RGCU	Rural Generalist Coordination Unit
RMO	Resident Medical Officer
TCH	Tennant Creek Hospital
TERHS	Top End Regional Health Services

MINISTERIAL FOREWORD

The Hon Natasha Fyles MLA

Minister for Health

Chief Minister

For the first time, a formal career pathway has been established in order to help strengthen our medical workforce in remote areas. The Rural Generalist Pathway in the NT is part of a federally funded Australian Government initiative and will support doctors in training, improve access to primary health care and strengthen the Territory's health system.

For many years, the NT has been an informal leader in rural generalism due to the unique challenges of our geography and demographics. The NT carries a high burden of disease and 24%[1] of our population live outside Darwin and Alice Springs, our two main urban centres. Prioritising high quality regional health care is essential to the health and wellbeing of Territorians, and rural generalists are a key part of that investment.

Primary health care has a vital role in the prevention, early detection, and management of illness, as well as preventing hospitalisation. In the NT, this includes both hospital and community-based general practitioners. Specialists who operate across the full scope of practice within their specialty are best placed to provide the clinical oversight and management of the growing number of patients with multiple and complex conditions. The NT medical workforce therefore requires a balance between rural generalists, specialists who practice within a broad, generalist scope of practice and those with expertise within a narrow subspecialist scope of practice.

A rural generalist is first and foremost a general practitioner (GP) with additional training and skills in medicine that are tailored to the needs of the community. By providing more care close to home, we can reduce medical retrievals, patient travel, and avoidable hospitalisations.

Doctors in the Territory have always been exposed to diverse and unique medical experiences, allowing them to advance their careers and knowledge faster than anywhere else in Australia.

I want to thank all of our partners, as well as the many individuals and organisations who have contributed their time and expertise to the development of this strategy.

CHIEF EXECUTIVE MESSAGE

Dr Marco Briceno

NT Health

Acting Chief Executive

NT Health is committed to improving the health and wellbeing of Territorians, no matter where they live. The geography of the Territory presents many barriers to accessing primary and specialist health care. People living in remote and regional areas significantly rely on the service and expertise of rural generalists, who have chosen to expand their career beyond the confines of traditional general practice.

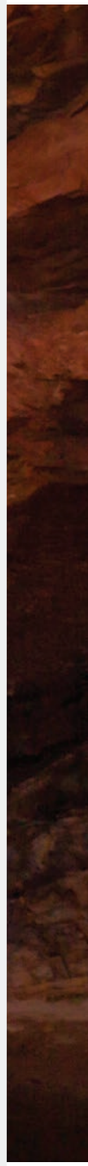
As the acting Chief Executive and former Director of the Rural Generalist Coordination Unit, I am proud to contribute my enthusiasm and expertise in rural generalist medicine to the rural generalist strategy.

Rural generalist training includes extensive advanced skill subspecialisations that are relevant to the needs of rural and remote communities, as well as well-established programs in anaesthesia, emergency medicine, obstetrics, mental health, and Aboriginal health. Rural generalists work in hospitals and primary care clinics, and contribute to the medical workforce in private practices and through Aboriginal Community Controlled Health Services.

More rural generalists working in our communities will increase the delivery of patient-centred care that is evidence-based and tailored to the Territory context. The Rural Generalist Pathway is a critical foundation for developing a culturally responsive, skilled, and sustainable workforce capable of meeting the needs of patients in regional areas.

I have dedicated much of my career to rural generalism, and so I am pleased to see rural generalist pathways emerge as a priority for our health care system, both at a Territory level and Australia-wide. This pathway will not only strengthen NT Health's capability, but also better support our workforce to meet the Territory's rural and remote health needs.

I encourage all NT Health staff and stakeholders to put the strategic focus areas identified in this strategy into action and to continue to build on the collaborative efforts required to meet the pathway objectives.



NT MEDICAL WORKFORCE

As global competition for medical practitioners grows, increasing the domestic pipeline of medical graduates will be required to increase capacity in Australia's medical workforce. Australia's ageing population, increasing life expectancy, and unexpected medical crises like COVID-19 will place additional strain on the health care system.

In Australia, there has been a 15-20% decrease in GP registrars over the last five years due to a decline in interest in GP training[2]. During the same time period, the NT experienced a dramatic 50% decrease in GP registrars[3]. This decline is having a significant impact on medical presence in remote communities, which house 80% of the NT's Aboriginal population and have an 80% higher disease burden per person than the rest of Australia[4].

There is a national trend towards specialisation and an emerging decline in training capacity for the skills required by the community and the skills graduate doctors are seeking vocational training in. On the other hand rural GP training programs have been undersubscribed both nationally and within the NT.

With these factors in mind, an appropriate distribution of the medical workforce will be critical to provide an appropriate level and quality of health services for all communities. Since 2013, the annual rate of increase of employed doctors outside of the cities (MMM2 to MMM7) was 3.9 %[5].

Factors contributing to the challenge of recruitment and retention in rural areas include remuneration and recognition barriers, lifestyle requirements, and limited clinical infrastructure to support clinical practice and other career interests such as research, teaching, and new technology. The geographic dispersion of Australia's medical workforce is a long-standing and complex issue that has been well documented in the National Medical Workforce Strategy[6].

GPs and other generalist non-GP specialists are critical to enabling the delivery of high-quality care on a local level. Specialists with a generalist skill set who can practise across their entire scope of practice are better equipped to manage patients with multiple comorbidities and are more adaptable in the face of changing demand. As a result, the medical workforce requires a balance of rural generalists, specialists, and those who have expertise in a narrow subspecialist scope of practice.

Completion of medical specialist training can take up to 16 years of full-time study. National data can be interpreted to indicate a sufficient supply of doctors in the NT, but in real terms a larger number of doctors is required to serve the dispersed, remote population of the NT and their complex health needs as both of these population characteristics are associated with high costs. A larger number of doctors would also mitigate the transience of a medical workforce who may only be based in the Territory for a short while before returning interstate. More than half of all doctors in the NT are in training, thus requiring teaching, assessment and clinical oversight.

The teaching and supervision requirements of doctors in training and medical students increases the demands on our medical workforce. Reducing turnover and retaining rural practitioners strengthens primary health care by supporting the continuity of care through complementing specialist care from the hospitals, enabling contemporary integrated multidisciplinary care, and offering care closer to home, their families and community. Strong medical leadership is vital and the development of leadership and management competence needs to be an integral part of the investment in developing the future medical workforce and emerging medical leaders[7].

NT TRAINING PIPELINE

NT Health's investment into growing our own doctors has seen the establishment of the NT Medical Program, a four year graduate medical degree, which has now been delivered for over 11 years. The Territory context is at the forefront of this program's curriculum which provides a strong foundation for the practice of rural generalist medicine in the NT. The final two years of the program involves clinical placements in regional rural and remote communities of the NT, providing the graduates with valuable exposure to rural generalism.

The NT Rural Generalist Pathway provides rural and remote primary health care rotation opportunities for prevocational doctors commencing from the initial interest identified in medical school continuing to the first entry point into the pathway at internship, after indicating an interest during their undergraduate years and continues into the second postgraduate year. These formative years provide the foundation skills required to become a rural generalist. These foundational primary care rotations prepare prevocational doctors to begin core generalist training in subsequent years before enrolling in GP vocational training.

The pathway's structure allows for multiple entry points, and has been designed to deliver a robust program that reflects the breadth and depth of rural generalism. The length of the pathway varies depending on the entry point, with the minimum duration being four years of prevocational training (foundation or core generalist training) which is consolidated and supplemented by a minimum of three years of vocational GP training where a relevant advanced skill would be acquired.

The prevocational training component is delivered across regional, rural, and remote NT through health service network integrated teaching and training. These networks are compatible with existing health-care networks as well as a variety of other medical education and training organisations. Ideally, trainees should be able to train in smaller settings that are tailored to community needs and aligned with workforce planning, as well as larger regional centres for relevant curricula.

Rural generalists will be able to work across multi-location networks, providing high-quality, culturally safe community and population-based general practice, as well as emergency and trauma services and inpatient care. They will be trained before or during the vocational training period in an additional advanced skill relevant to the needs of rural and remote communities.

RURAL GENERALISTS

Rural generalists are GPs who provide primary care services and emergency medicine, and have training in additional skills including remote health and Aboriginal health. Rural generalists provide access to a broader range of holistic and specialist medical services that meet the needs of people living in regional, rural and remote communities.

A rural generalist may have additional specialist skills in areas like:

- Obstetrics
- Anaesthetics
- Mental Health and Alcohol and Other Drugs
- Advanced Emergency Medicine
- Surgery
- Adult Internal Medicine
- Paediatrics
- Public Health

NT Health employs rural generalists to work in regional hospitals and primary health care clinics. Employment opportunities also exist in ACCHS and private practices outside of Darwin and Alice Springs. ACCHS are an essential part of the hybrid model of care presented in the Rural Generalist Pathway.

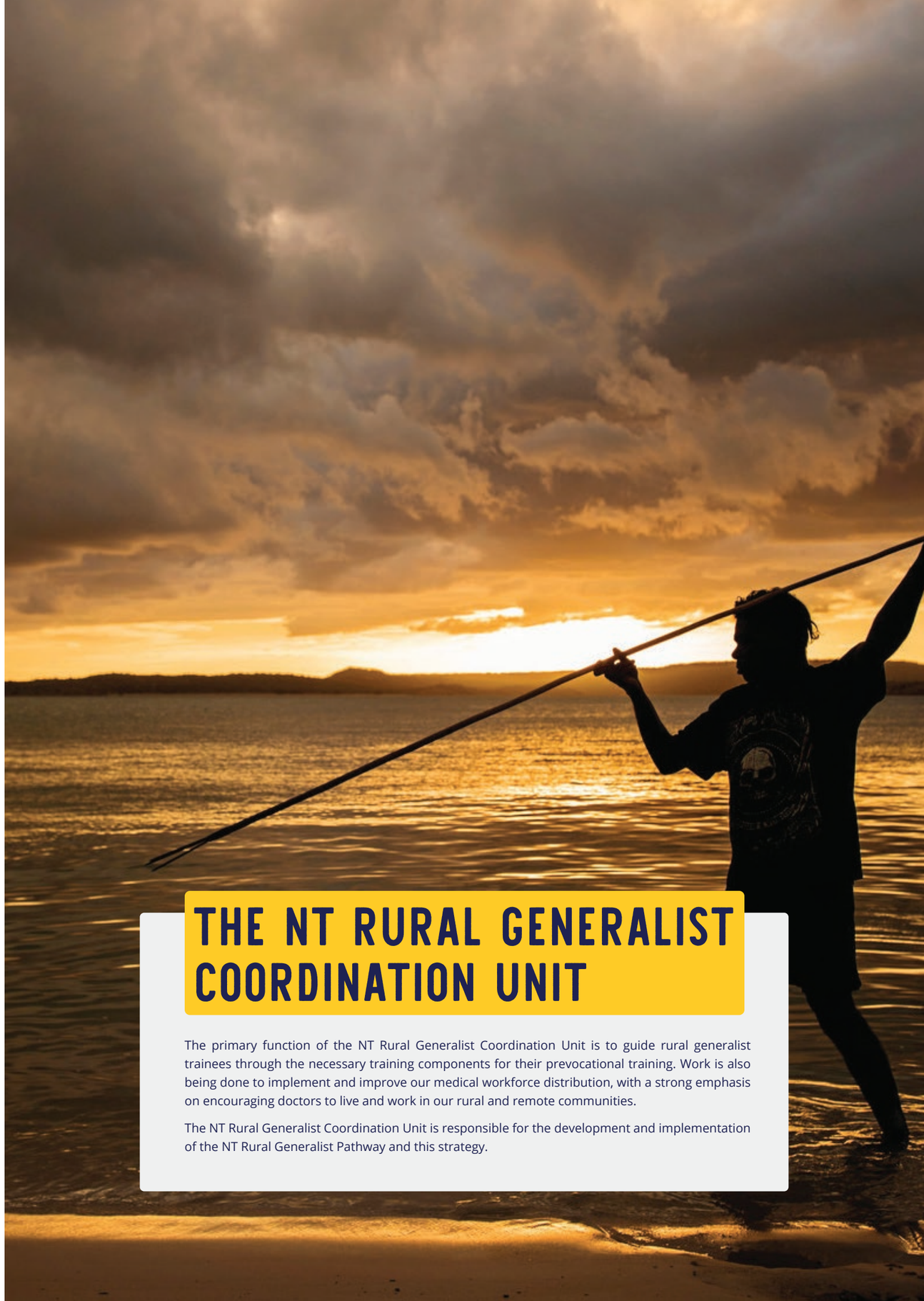
THE NATIONAL RURAL GENERALIST PATHWAY

In 2019-20, the Australian Government committed $62.2 million in 2019-20 to establish a National Rural Generalist Pathway to attract, retain, and support rural generalist doctors working in rural and remote Australia. This commitment has led to the establishment of Rural Generalist Coordination Units across Australia, including in the NT.

The Collingrove agreement presented a definition of rural generalism and formalised the importance of the commitment to rural generalism at a federal level.

A rural generalist is described as:

> *A medical practitioner who is trained to meet the specific current and future health care needs of Australian rural and remote communities, in a sustainable and cost-effective way by providing both comprehensive general practice and emergency care and required components of other medical specialist care in hospital and community settings as part of a rural health care team*
>
> COLLINGROVE AGREEMENT, 2018



THE NT RURAL GENERALIST COORDINATION UNIT

The primary function of the NT Rural Generalist Coordination Unit is to guide rural generalist trainees through the necessary training components for their prevocational training. Work is also being done to implement and improve our medical workforce distribution, with a strong emphasis on encouraging doctors to live and work in our rural and remote communities.

The NT Rural Generalist Coordination Unit is responsible for the development and implementation of the NT Rural Generalist Pathway and this strategy.

VISION

Our vision is that all Territorians have access to medical services and doctors who are equipped to meet rural and remote community needs. An increased number of rural generalists in the NT will enable the provision of decentralised, patient-centred and culturally safe care across multiple health services, resulting in fewer inefficiencies and, ultimately, better patient outcomes by reducing hospital admissions, reducing the use of locum services, and limiting the need for patient travel.

MISSION

To incorporate rural generalist medicine into the NT health system and its employment models through optimising the rural generalist scope of practice, embedding patient-centred models of care that better accommodate the rural generalist model and ensuring appropriate governance structures are in place to support and promote the medical generalist workforce model in the NT.

This strategy provides a coordinated training pipeline, increasing opportunities for advanced skills training and post-fellowship training for rural generalists. Under this strategy, NT Health will expand the rural generalist workforce into primary care settings where new models of care incorporate rural generalist medicine principles. The rural generalist strategy aims to ensure that approximately 40% of the NT population has access to medical services and doctors who are equipped to meet rural and community needs.

PRINCIPLES

1. **EQUITY AND ACCESS**
   All Territorians have access to a high standard of medical services without distinction of race, religion, political belief, economic or social condition, or physical location[8].

2. **RECOGNITION**
   Rural generalists are recognised, valued, and given opportunities to maintain and develop skills in order to meet the needs of our remote communities in the long term.

3. **LEADERSHIP AND CULTURE**
   Clinical leadership is recognised, enhanced, and supported, and education and professional peer support are valued and available.

4. **PARTNERSHIPS CENTRED APPROACH**
   Work with partners to support workforce planning in order to develop and expand the NT rural generalist workforce through communication and mutual respect.

5. **CONTINUOUS LEARNING**
   Experienced personnel will offer career advice and current information on skill development opportunities, as well as application advice and support.

PRIORITIES

- Build the rural generalist capability of the NT medical workforce.
- Support medical professionals who pursue rural generalism with the opportunity to train and work in both hospitals and primary health care settings.
- Incorporate rural generalist medicine into the NT Health system and promote integrated employment models through optimising the rural generalist scope of practice and embedding patient-centred models of care.
- Ensure appropriate governance structures are in place to support and promote the rural generalist workforce.
- Develop and support rural generalist medicine models of care and service models that meet the community's needs.
- Identify sustainable and ongoing funding models for rural generalist medicine.
- Target medical students and advocate for the rural generalist profession.
- Provide excellent case management, career navigation, mentoring and support.
- Collaborate with key stakeholders to address workforce maldistribution.
- Improve working conditions in rural areas to attract and retain rural generalists.
- Provide safe and supportive supervision in hospital and primary care settings.
- Ensure adequate infrastructure is available to support the rural generalist program.

POLICY AND PLANNING CONTEXT

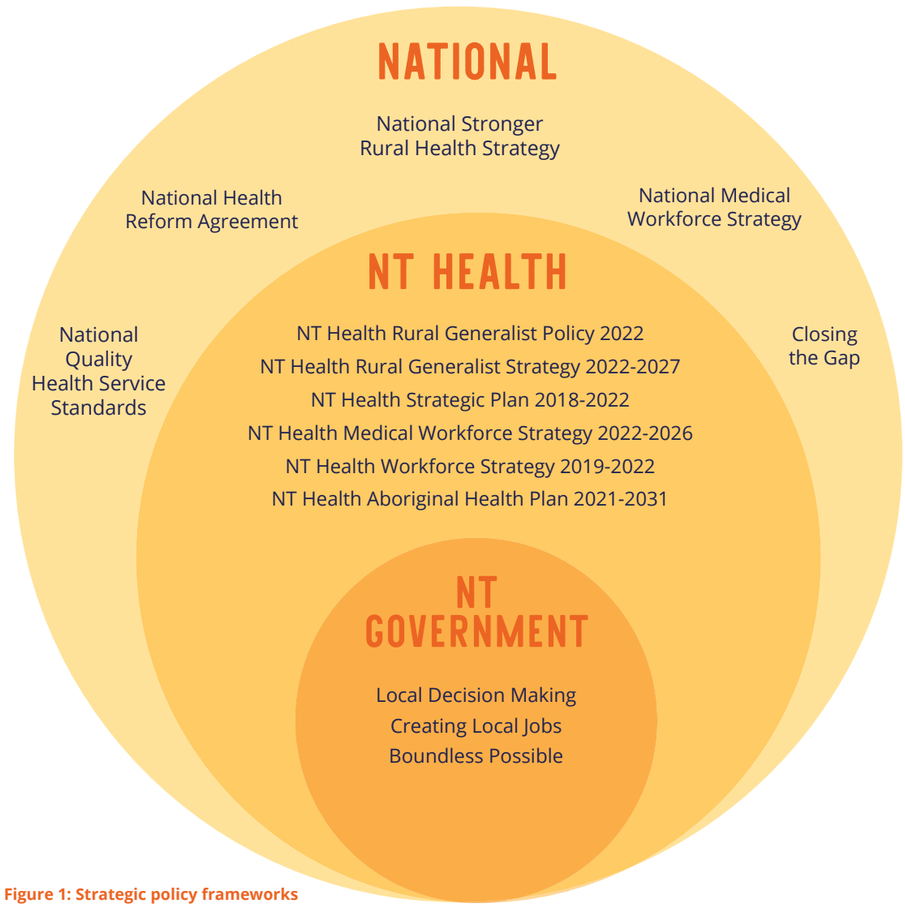


Figure 1: Strategic policy frameworks

STRATEGIC DIRECTION 1:

SERVICE DELIVERY AND MODELS OF CARE

OBJECTIVES		MEASURES
1.1	Attract and recruit prevocational doctors and other interested medical practitioners onto the NT Rural Generalist Pathway	Stakeholders use the rural generalist coordination unit as the central point of contact for the Rural Generalist Pathway
1.2	Support prevocational doctors on the Rural Generalist Pathway and facilitate opportunities for a rural and remote primary health experience at all entry points	Best practice benchmarks to expand and maintain quality primary care rotations and additional skills training posts are met, and rotations and posts are regularly evaluated
1.3	Engage with health employers, specialist training colleges, primary health care providers and communities to facilitate a coordinated end to end rural generalist training program	Documented stakeholder engagement across local and national networks to attract and retain doctors in general practice in rural and remote locations in the Territory
1.4	Facilitate a variety of primary health care rotations (models of care) for the rural generalist program	Personalised career navigation, mentoring, support and case management for prevocational doctors and rural generalist trainees
1.5	Participate in expanding rural generalist placement opportunities across the breadth of service delivery in the NT	Industrial negotiations for rural generalist roles established and monitored with mixed employer models explored to better fill NT areas of need
1.6	Engage with health service providers to develop additional skills opportunities relevant to NT communities	Improved support systems, community-based approaches to services and program delivery available closer to home to address key health issues
1.7	Maintain a strong focus on promoting and increasing the number of Aboriginal doctors within the medical workforce, this includes NT residents	Work closely with AIDA to ensure there are culturally safe and respectful local selection processes that support the increasing the number Aboriginal trainees entering, and successfully completing, GP training programs

STRATEGIC DIRECTION 2:

PARTNERSHIPS, COLLABORATION AND INNOVATION

OBJECTIVES		MEASURES
2.1	Promote the status of the role of rural generalists locally and nationally	Monitor outcomes of collaborative and individual marketing and promotional events and career expos attended and involved in the territory and nationally Increased number of rural generalists locally and nationally tracked
2.2	Support national advocacy for recognition of the rural generalist as a registered specialist	Medical board of Australia awards specialist recognition for rural generalists
2.3	Work with local and national stakeholders to develop strong links across the NT health system working to provide holistic patient centred care	Documentation of progress of models of care and mixed employer models that focus on holistic patient centred care
2.4	Support the local undergraduate pipeline, the NT medical program and its objectives	Strengthen governance to leverage capacity and deliver streamlined fit for purpose services across the continuum of the pathway
2.5	Target collaborative training opportunities from existing medical rural generalists, rural generalist posts and prevocational doctor training programs	Rural generalist networks harnessed to provide education and training opportunities locally and nationally
2.6	Collaborate with NT Health, health services and NGOs to fund and support additional skills posts to ensure opportunities meet rural and remote service demand	NT Rural Generalist Unit engaged with relevant stakeholders involved in recruitment, allocation and education and training of rural generalists for all entry points
2.7	Work with Aboriginal communities and the ACCHS sector to support communities to understand rural generalism, build community capacity to engage rural generalists in community-controlled service delivery models	Partnership established with the NTAHF to strengthen partnerships with the ACCHS sector

STRATEGIC DIRECTION 3:

A RESPONSIVE AND INTEGRATED SYSTEM

OBJECTIVES		MEASURES
3.1	Enhance capability, understanding and responsiveness to the rural generalist program objectives	Established systems to support prevocational doctor employers, primary health care placement sites and posts, rural generalists and other key stakeholders to implement the programs pathway
3.2	Reduce duplication, maximise the use of technology and digital options, and harness the power of collaborative partnerships	Monitor, evaluate and report on progress of the rural generalist program using existing governance structures and frameworks
3.3	Embed within rural generalist pathway policy accountability and responsibility to drive implementation activities whilst ensuring oversight of the collation of quantitative and qualitative data	Engagement with NT Reference Committee membership to provide advice and oversight to program. Contribute to the national data sharing process and evaluate and analyse the national and local outcomes
3.4	Provide leadership in modelling rural generalism and driving systemic change across the health sector	Monitor capacity building measures in place to increase the NT rural generalist workforce and impacts on NT health outcomes
3.5	Share NT Health rural generalist career opportunities across the rural generalist pipeline	Communications plan in place and implemented to share rural generalist career opportunities
3.6	Collaborate with NT Health, health services and NGOs to fund and support additional skills posts to ensure opportunities meet rural and remote service demand	NT Rural Generalist Unit engaged with relevant stakeholders involved in recruitment, allocation and education and training of rural generalists for all entry points
3.7	Explore partnerships with other jurisdictions for rotations and additional skills posts	Partnerships (trainee exchange) established with other jurisdictions for rotations and additional skills posts

THE RURAL GENERALIST PATHWAY

STUDENT TRAINING | **PRE-VOCATIONAL TRAINING** | **VOCATIONAL TRAINING** | **FELLOWSHIP**

Student Training
MEDICAL SCHOOL

Australian Community Based Placements

- Intern application preference indicated for Rural Generalist Program

Prevocational Years 1-2
RURAL GENERALIST FOUNDATION YEARS

Internship/Resident Medical Officer
Primary health care/Regional hospital

- 2 year NT government employment contract offered
- Minimum of two primary health care rotations in first three years on the Rural Generalist Pathway

- General Surgery
- General Medicine
- Emergency Medical Care
- Paediatrics
- Obstetrics & Gynaecology
- Mental Health
- Primary Health Care Rural & Remote
- Anaesthetics/ICU or ProStart

Prevocational Years 3-4
RURAL GENERALIST CORE TRAINING

Senior Resident Medical Officer
Primary health care/Regional hospital

- NT government employment contract offered all regions
- Core training is individual and based on experience
- May have enrolled in vocational training by end of PGY3
- Option to complete 6 months extended skills training in PGY4

- Primary Health Care Rural & Remote
- Regional Hospital
- Mental Health
- Paediatrics
- Obstetrics & Gynaecology

Vocational Years
RURAL GENERALIST TRAINEE

Registrar
Regional hospital, Aboriginal Community Controlled Health Service or private practice

- Can be undertaken at either or both GP Specialist College of choice
- Vocational trainees enter pathway at the point appropriate to their training readiness and/or eligibility for Specialist College recognition of prior learning (RPL)

Royal Australian College of General Practice (RACGP) **AND/ OR** Australian College of Rural and Remote Medicine (ACRRM)

Vocational Years
ADVANCED/ADDITIONAL SKILLS

Rural generalist trainee - Registrar
Minimum 12 months

- Can be undertaken any time after enrolled with GP specialist college of choice
- Vocational trainees enter pathway at the point appropriate to their training readiness and/or eligibility for Specialist College recognition of prior learning (RPL)

- Anaesthetics
- Surgery
- Adult Internal Medicine
- Population Health (ACRRM)
- Paediatrics
- Obstetrics & Gynaecology
- Palliative Care
- Remote Medicine (ACRRM)
- Aboriginal Health
- Mental Health
- Emergency Medicine

Vocational Years
RURAL GENERALIST LEVEL 1 – FELLOW

Senior Registrar

- Completion of all assessment requirements of GP Specialist College of choice

Fellowship of ACRRM **AND/ OR** Fellowship of RACGP - RG

- Core Terms
- Elective Terms
- Advanced Skills

*** Flexible entry and lateral entry also available at each level of the pathway**

NT PROFILE

POPULATION

The NT has one of Australia's most geographically dispersed populations and an extremely low population density with approximately 0.17 people per square kilometre[9]. The population of the NT is approximately 250,000 people, accounting for about 1% of the Australian population, with the majority residing in the greater Darwin region and the remainder dispersed across remote and very remote areas[10]. Up to 80,000 Territorians live in remote and extremely remote areas, with limited access to medical practitioners and the services they can provide[11]. Many remote Territorians are Aboriginal people who live in one of 600 communities or remote outstations.

The population of the NT has the lowest health outcomes in Australia, high levels of social disadvantage, and many people live with the burden of chronic disease with the majority of these challenges faced by Aboriginal people[12]. The health needs of Territorians are numerous, complex, and diverse, and in many cases remoteness presents additional barriers to accessing the required treatment or care.

NT CONTEXT

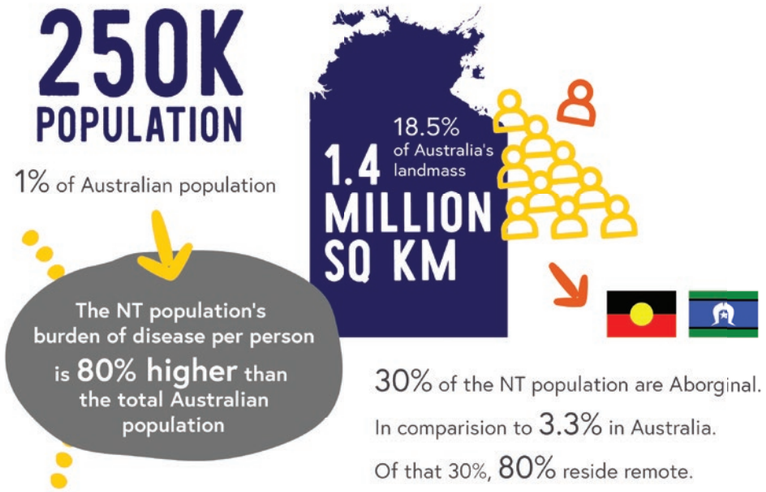


Figure 2: Population and landmass

25%

UNEMPLOYMENT

One-quarter of Aboriginal Territorians are unemployed. In comparison, only 2.3% of non-Aboriginal Territorians are unemployed[13].

EDUCATIONAL ATTAINMENT

14.2% of Aboriginal Territorians have completed Year 12 in comparison to 58.7% of non-Aboriginal Territorians have completed Year 12[14].

WEEKLY HOUSEHOLD INCOME

Aboriginal Territorians have a median weekly income of $430. Non-Aboriginal Territorians have a median weekly income of $1,247[15].

15%

LANGUAGE & COMMUNICATION

Over 15% of the NT population speak an Aboriginal language at home, and there are up to 104 Aboriginal languages or dialects spoken[16].

HOUSING

Homelessness, inadequate housing and overcrowding disproportionately affect Aboriginal people and these factors are directly increased contact with the health system.

MIGRATION

Net overseas migration in the Territory contributed 741 people in the year to December 2021, an increase from the previous year's net gain of 61 people[17].

REMOTENESS

Many Territorians live hundreds of kilometres away from the nearest hospital or specialist medical services. The NT has a small population dispersed over a massive area (1.4 million square kilometres).

DISABILITY

In 2014–15, 40% of Aboriginal Territorians aged 15 years and over reported having a disability or a restrictive long-term health condition[18].

COST-PROHIBITIVE TRAVEL

People on low incomes experience challenges in ability to travel for medical reasons.

RACIAL INEQUALITY

Structural or systemic racism is a key social determinant of health for Aboriginal people[19].

HEALTH WORKFORCE

Between 2015 and 2020 NT had the highest number of registered health professionals relative to its population (2,898 FTE per 100,000 people in 2020)[20].

TRANSIENT POPULATION

The largest cohort moving in and out of the NT in a given year are people in their twenties and early thirties[21].

HOMELESSNESS

Aboriginal people make up 88% of the homeless population. Non-Aboriginal people make up 9%[22].

SUBSTANCE USE

Across Australia, Aboriginal people are less likely to drink alcohol than non-Aboriginal people, but those who do consume alcohol are more likely to drink at harmful levels[23].

MENTAL HEALTH

In 2017 the NT recorded the highest suicide death rate at 20.3 suicide deaths per 100,000 persons[24] in Australia.

ACCESS

Services are delivered through health centres and primary health care sites based in a number of regional and remote areas of the NT.

CHRONIC DISEASE

The higher burden of chronic conditions are estimated to contribute to 77% of the life expectancy gap between Aboriginal and non-Aboriginal populations[25].

REGIONS OF THE NT

NT Health is administered by five regions, each of which includes at least one public hospital and multiple primary health clinics. The regions of the NT Regional Health Services correspond to the regional boundaries set by the NT Government and allow for locally responsive decision making. Each region is accountable and responsible for the administration of health services within its defined geographic region.

Top End Region

The Top End region is located in the far north of the NT covering the areas of Darwin, Palmerston, as well as the Tiwi Islands, and 14 major Aboriginal communities on the mainland. The Top End region has two hospitals, Royal Darwin Hospital and Palmerston Regional Hospital.

Big Rivers Region

The Big Rivers region is centred on Katherine and covers an area between the Western Australia and Queensland borders to the west and east, extending south to Dunmarra and north to Pine Creek. It includes the Victoria River area and the Roper Gulf region to Borroloola. The Big Rivers region incorporates the regional health services of the Katherine Hospital as well community health and primary health care services to remote communities.

Central Australia Region

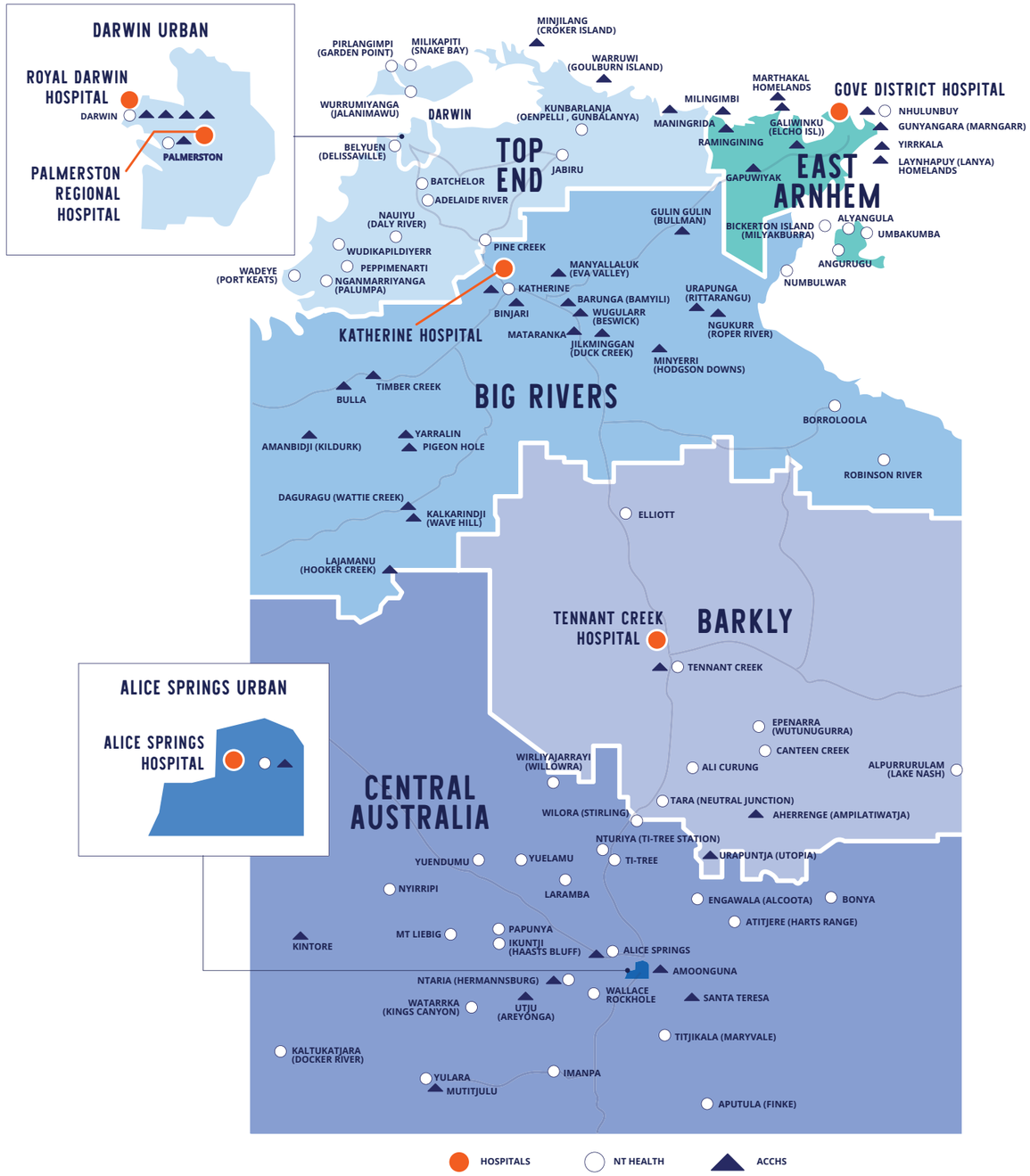
The Central Australia region is located in the centre of Australia and is the largest region by area. Central Australia's main hub, Alice Springs, is surrounded by the major remote centres of Ntaria, Yuendumu and Papunya and communities and outstations including Wallace Rockhole, Haast's Bluff, Yuelemu, Mt Liebig and Titjikala. The Central Australia region incorporates the regional health services of the Alice Springs Hospital as well as primary health care services in remote communities.

East Arnhem Region

The East Arnhem region is located in the far north-east of the NT. It encompasses the towns of Nhulunbuy on the Gove Peninsula, Alyangula on Groote Eylandt, the islands of Elcho, Milingimbi, Milyakburra and the major Aboriginal communities on the mainland. The East Arnhem region is comprised of the regional health services of the Gove District Hospital as well as community and primary care services.

Barkly Region

The Barkly is a large, remote region centred on the township of Tennant Creek, 500km north of Alice Springs. Tennant Creek is surrounded by the major communities and outstations of Ampilatwatja, Urapuntja, Alpurrurulam, Ali Curung, Canteen Creek and Wutunugurra (Epenarra). The Barkly region incorporates the regional health services of the Tennant Creek Hospital as well as primary health care services in remote communities.



NT Health Regions

- Top End Region
- Big Rivers Region
- East Arnhem Region
- Barkly Region
- Central Australia Region

PRIMARY HEALTH CARE IN THE NT

NT Health provides primary health care in remote locations and visiting allied health professionals, public health nurses, diabetes and chronic disease educators, child health nurses, and wound specialists.

GPs, nurses, and midwives play an important role in improving health outcomes in urban and remote communities, as well as at Darwin and Alice Springs Correctional Centres and police watch houses. These frontline roles provide direct care such as clinical assessment and management, case management, care coordination, primary health care programs (child health, women's health, and chronic disease), community visits in urban and remote areas, and after-hours emergency care response.

A full list of NT Health primary health care centres are listed in Appendix B.

ACCHS

Aboriginal Community Controlled Health Services (ACCHS) are an essential component of the broader health care system in the NT. The provision of high quality and culturally safe services is a key focus of ACCHS who have a significant role to play in the physical, social and emotional wellbeing of Aboriginal people in urban, regional, and remote areas of the NT. The Rural Generalist Pathway includes opportunities to work within the ACCHS sector.

The peak body for ACCHS is AMSANT, which has 12 full members and 14 associate members. Appendix C contains a complete list of ACCHS members.

REMOTENESS

The Modified Monash Model (MMM) scale is used across Australia to determine remoteness against a national classification system (whether a location is considered a city, rural, remote, or very remote). MMM1 is a major city (like Sydney or Melbourne), whereas MMM7 is extremely remote (NT examples include Groote Eylandt and Yulara). With the exception of Darwin, which is classified as MMM2, the remaining health clinics in the NT are classified as MMM 6-7 which demonstrates the isolation of communities and health clinics throughout the NT[26].

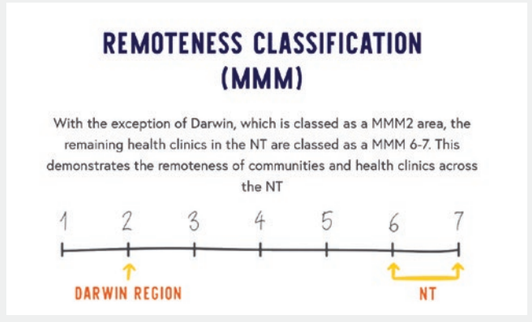


Figure 3: Remoteness classification scale

People living in these areas may find it more difficult to obtain medical assistance and travelling to see a doctor can take longer and cost more money, which may be prohibitive for some people.

Many Aboriginal people have limited access to specialist services within their local communities, making it critical to provide effective primary health care services, outreach or visiting services, community workers, and appropriate support for Aboriginal people as they transition to and from their community to access the required specialist or hospital-based care.

SUBSIDISED PATIENT TRAVEL

The Patient Assistance Travel Scheme (PATS) assists NT residents in accessing these services[27]. The program provides a financial subsidy to cover some of the out-of-pocket expenses incurred when residents must travel long distances to access specialist services. Patient travel alone costs NT Health approximately $66 million per year[28] and the number of PATS applications increases year after year.

INCREASED RELIANCE ON REMOTE AND REGIONAL SERVICES DURING COVID-19 PANDEMIC

The COVID-19 pandemic has disrupted health service delivery across primary and acute care settings since 2020 and its impact is still being managed by NT Health. The pandemic (and associated lockdowns and travel restrictions) significantly increased the reliance on rural generalists and regional health services to coordinate patient care. Throughout the pandemic, managing capacity and meeting elective surgery demand has been delivered through increased focus on community and virtual care. Health services are now focused on preparing for future waves of infection and resuming services to a post-pandemic 'new normal.'

GOVERNANCE

Rural Generalist Coordination Unit

The core function of the Rural Generalist Coordination Unit is to assist Rural Generalist trainees in navigating the various educational and training components for their prevocational training. It serves as a central point of contact for medical students and practitioners interested in or already on the rural generalist training pathway.

The RGCU actively collaborates with local and national stakeholders to establish and strengthen strong links between hospitals, primary care networks, ACCHS, and training providers, all with the goal of recruiting more doctors to rural and remote areas.

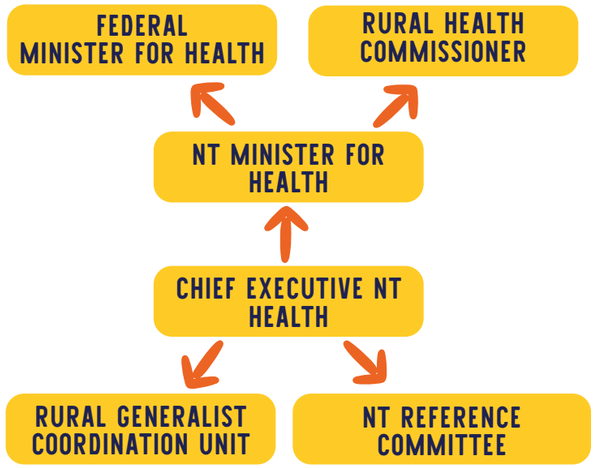


Figure 4: Governance structure

NT REFERENCE COMMITTEE

As part of the development of this strategy, more than 350 people and eight external organisations attended consultation activities hosted by NT Health. The Rural Generalist Strategy was developed with input from a dedicated reference group, the NT Reference Committee. The committee's membership reflects the stakeholders who are invested in the development of the Rural Generalist Pathway. The committee oversees the strategy's implementation and drives its progress towards meeting the pathway objectives.

The committee, guided by its terms of reference, ensures that an annual report card is provided to the Chief Executive of NT Health and the NT Minister for Health.

A full list of stakeholders consulted can be found in Appendix A. A full list of NT Reference Committee members can be found in Appendix D.

NT Health also maintains representation on a Jurisdictional Implementation Forum to enable continuous reporting to the Australian Government Department of Health, Federal Minister for Health, and National Rural Health Commissioner.

MEASURING OUR PERFORMANCE

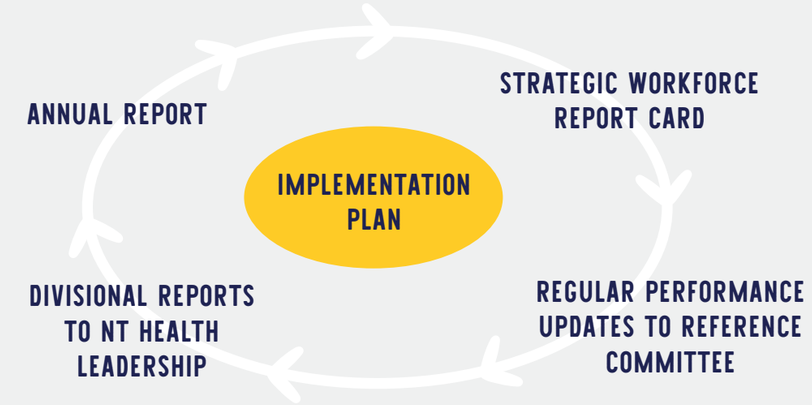


Figure 5: Monitoring progress

EVALUATION

NT Health will conduct an internal mid-term evaluation in 2025, followed by a formal evaluation before the strategy's expiration in 2027. The current plan focuses on the next five years due to the rapidly changing landscape of the pandemic environment. The benefit is a more targeted roadmap for system implementation and adaptation. Over the course of the project, meaningful data will be gathered to assess the pathway's outcomes and impact. The evaluation results will be used to inform and adjust the pathway's long-term planning.

Figure 6: Evaluation timeline

APPENDIX A: STAKEHOLDERS INVOLVED IN CONSULTATIONS

KEY STAKEHOLDERS
NT Health Leadership Committee
NT Health Media and Communications
Career Navigators
Policy Guideline Centre
Aboriginal Health Policy
Medical/Dental Executive Leadership Committee/s (TERHS and CARHS)
TERHS / CARHS Medical Education Units
Strategic Workforce Committee (NT Health) includes Quality and Safety
National Jurisdictional Implementation Forum
NT Aboriginal Community Controlled Health Services (ACCHS)
NT Junior Medical Officers Forum
NT Health employees (Clinical and Non-Clinical)
Danila Dilba Health Service
East Arnhem region
Big Rivers region
Central Australia region
East Arnhem region
Barkly region
Top End region
Prison Health , Mental Health, Darwin PHC (FIFO)

APPENDIX B: REMOTE PRIMARY HEALTH CENTRES

1. Alyangula
2. Angurugu
3. Ali Curung
4. Alcoota
5. Adelaide River
6. Aputula
7. Batchelor
8. Belyuen
9. Bonya
10. Borroloola
11. Canteen Creek
12. Daly River
13. Docker River
14. Elliot
15. Epenarra
16. Haasts Bluff
17. Harts Range
18. Hermannburg
19. Julanimawu
20. King's Canyon
21. Mt Liebig
22. Milikapiti
23. Laramba
24. Lake Nash
25. Numbulwar
26. Nyirripi
27. Palumpa
28. Peppimenarti
29. Papunya
30. Pine Creek
31. Pirlangimpi
32. Robinson River
33. Tara
34. Wilora
35. Ti Tree
36. Titjikala
37. Umbakumba
38. Wadeye
39. Wallace Rockhole
40. Willowra
41. Yuelemu
42. Yuendumu

COMMUNITY HEALTH CENTRES

43. Casuarina
44. Alice Springs
45. Katherine
46. Palmerston
47. Tennant Creek

PRISON PRIMARY HEALTH CENTRES

48. Alice Springs Correctional Centre Health Centre
49. Darwin Correctional Centre Health Centre

TRANSFERRING TO ABORIGINAL COMMUNITY CONTROL

Docker River : 1 July 2023

Gunbalanya : 1 July 2024

Imanpa : 1 March 2023

Jabiru : 1 July 2023

Yulara : 1 March 2023

APPENDIX C: MEMBERS OF AMSANT

Full members of AMSANT include the ACCHS that are incorporated with a Board and have a sole focus on primary health care service delivery. Associate members include ACCHS that operate a primary health care service in conjunction with the NT Health or through auspicing by a full member; ACCHS that operate a primary health care service but also provide non-primary health care functions or services; or Aboriginal organisations that provide health related services.

FULL MEMBERS	ASSOCIATE MEMBERS
Ampilatwatja Health Centre Aboriginal Corporation	Amoonguna Health Clinic Aboriginal Corporation
Anyinginyi Health Aboriginal Corporation	Balunu Foundation
Central Australian Aboriginal Congress	Central Australian Aboriginal Alcohol Program Unit
Danila Dilba Health Service Aboriginal Corporation	Council for Aboriginal Alcohol Program Services Aboriginal Corporation
Katherine West Health Board Aboriginal Corporation	Foundation of Rehabilitation with Aboriginal Alcohol Related Difficulties
Miwatj Health Aboriginal Corporation	Laynhapuy Homelands Aboriginal Corporation
Peppimenarti Health Association	Mpwelarre Health Service (Santa Teresa)
Pintupi Homelands Health Service	Mala'la Health Service Aboriginal Corporation
Red Lily Health Board Aboriginal Corporation	Marthakal Homelands Health Service
Sunrise Health Service Aboriginal Corporation	Mutitjulu Health Service
Urapuntja Health Service Aboriginal Corporation	Ngaanyatjarra Pitjantjatjara Yankunytjatjara Women's Council
Wurli Wurlinjang Health Service Aboriginal Corporation	Utju Health Aboriginal Corporation
	Western Aranda Health Aboriginal Corporation
	Western Desert Nganampa Walytja Palyantjaku Tjutaka Aboriginal Corporation (Purple House)

APPENDIX D: NT RURAL GENERALIST REFERENCE COMMITTEE MEMBERSHIP

NT Health, Chief Executive Officer
Top End Regional Health Service
NT Health Medical Workforce Advisor
Australian College of Rural and Remote Medicine
Royal Australian College of General Practitioners
NT Primary Health Network
Rural Doctors Association Australia
Australian Medical Association
Flinders University (NT Medical Program / Regional Training Hub)
Aboriginal Medical Service Alliance of the NT
NT Health Trainee Representative
Prevocational Medical Assurance Services
Remote Vocational Training Scheme
Indigenous General Practice Registrars Network
NT Rural Generalist Coordination Unit (Secretariat)

FOOTNOTES

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RURAL GENERALIST Pathway Northern Territory

An Australian Government Initiative

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