AMA plan for improving access to rural general practice

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AMA

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INTRODUCTION

Access to healthcare is a fundamental right for all Australians. Yet people who live in regional, rural, and remote areas (referred to collectively in this report as rural areas) have poorer access to medical and health care and poorer health outcomes than those living in metropolitan areas.[1]

In rural areas, the health of communities is often dependent on the shared role that a general practitioner (GP) has in their practice and the hospital, with the GP moving between providing primary and secondary care in a seamless fashion. Rural generalists (RGs) also provide general practice care and extended medical services to meet the healthcare needs of rural communities.[i] Throughout this document the term rural general practice should be interpreted as including both rural generalists and rural general practitioners who have not undertaken specific rural generalist training.

The AMA plan for improving access to rural general practice provides governments, local communities, and health stakeholders with targeted, sustainable, and economical solutions to improve access to general practice and primary care in rural areas. Without collaboration between all stakeholders on this issue, existing disparities will remain deeply entrenched, eroding Australia's principle of access to universal healthcare. A supported and sustainable rural general practice and primary care workforce is required to improve access to care and health outcomes, with GPs playing a lead role in coordinating access to high quality patient centred care.

The AMA research report *The general practitioner workforce: why the neglect must end* estimates there will be an undersupply of around 10,600 GP FTEs by 2031–32, if GP training places continue to remain unfilled, and the rate of retirement and attrition from the profession escalates.[2]

This shortage will likely be amplified in rural areas given that these areas currently have fewer GPs per capita. There are only 66.2 GPs per 100,000 people in very remote areas compared to 122.7 full-time workload equivalent GPs in major cities.[3] In rural areas chronic medical workforce shortages have forced the closure of medical services, further eroding access to timely health care.[4] Without timely access to primary care from GPs, the burden of disease and pressure within hospitals systems will continue to increase.

These workforce shortages have clear consequences, with people outside of metropolitan areas utilising Medicare up to 40 per cent less than those in major cities.[5] This is not because of low local demand. Rural communities experience excessive wait-times to see a GP, sometimes waiting up to 12 weeks for an appointment.[6] In 2021–22, 28.7 per cent of residents living in rural areas reported waiting longer than they felt acceptable to get an appointment with a GP compared to 21.6 per cent of residents in major cities. In addition, people who live in areas of socioeconomic disadvantage are more likely to report unacceptable wait times compared to those of most advantage, 26.2 per cent compared to 19.2 per cent.

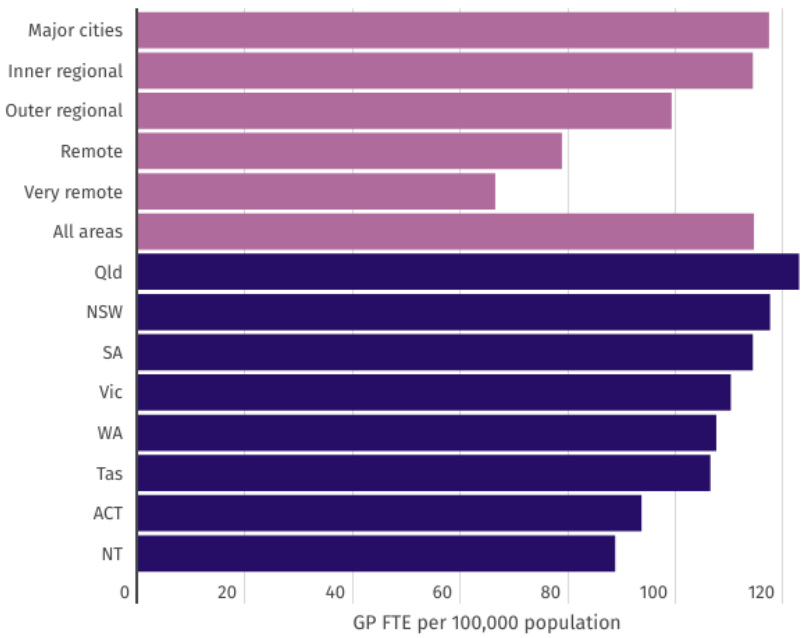
[i] The term 'rural generalist' describes a rural GP who is working to an extended scope of practice with skill sets informed by the needs of the community they serve. The Australian government funded the National Rural Generalist Pathway (NRGP) in 2019 to support GPs and trainees to train as rural generalists to develop skills sets to meet the diverse health needs of regional, rural and remote Australians. The Royal Australian College of General Practitioners (RACGP) and the Australian College of Rural and Remote Medicine (ACRRM) have agreed to develop a national framework for rural generalism and are working on a joint application for the recognition of Rural Generalist Medicine as a specialised field within the speciality of general practice. The application is in progress and has been submitted to the Australian Medical Council (AMC) and the Medical Board of Australia (MBA).

It is unacceptable that research continues to show rural Australians have higher rates of hospitalisations, deaths and injury, and have poorer access to — and use of — primary health care services than people living in major cities.[7] The age standardised rate of the burden of disease increases with increasing remoteness, with very remote areas experiencing 1.4 times the rate of that in major cities.[8] Compared with major cities, the life expectancy in regional areas is one to three years lower, and in remote areas it is up to seven years lower.[9] According to the Australian Institute of Health and Welfare, the burden of disease and life expectancy disparities are even more pronounced for rural, regional and remote Aboriginal and Torres Strait Islander peoples and communities. Governments, local communities, and health stakeholders must take immediate action to support access to primary healthcare for regional, rural and remote communities and to close the health inequality/gap faced by Aboriginal and Torres Strait Islander people.[10]

Key workforce trends

- The 2022 Productivity Commission report on government services found that the rates of GP FTE services increased annually from 105.6 per 100,000 population in 2014 to 117.0 per 100,000 population in 2019, before declining to 114.5 per 100,000 in 2020.[11] In 2020, Queensland had the highest rates of GP FTE services per 100,000 population (122.9 per 100,000 population) and Northern Territory had the lowest rates of GP FTE services per 100,000 population (88.7 per 100,000 population).[12] The availability of GPs varies significantly between each state and territory and decreases with increasing rurality (Figure 1) leaving a smaller number of GPs in rural areas to care for the same number of people spread over a larger geographic area.

Figure 1: GP availability by region, 2020[13]



- International medical graduates (IMGs) make up more than 45 per cent of the medical workforce in rural and remote areas.[14]
- Graduating medical students have consistently shown a preference for practising in capital cities. In a recent survey, 65 per cent of medical students indicated a preference to work in capital cities, while only 17 per cent of students indicated a preference to work in regional and small communities.[15]
- Medicare claims data indicates that rural and remote populations rely more on GPs to provide health care services, because there are fewer local non-GP specialist services (AIHW 2019). People in many rural areas also rely on GPs and RGs to provide hospital maternity, emergency, anaesthetic, and surgical services.

Investing in rural general practice

Countries with a strong primary care system experience better population health and lower rates of unnecessary hospital admissions. General practice is the bedrock of healthcare in rural areas. Ongoing access relies on being able to recruit and retain enough properly distributed doctors in all parts of the country. Investing in initiatives to support a sustainable and thriving general practice workforce in rural areas will ensure those who live and work in rural communities can access healthcare when and where they need it.

As rural Australia continues to deal with natural disasters and the impact of climate change, it is vital rural communities have continuity of access to healthcare. GPs, RGs and nurses are the frontline health care workers providing care in these settings and they also play an essential part in disaster and emergency planning, preparation, response and recovery efforts.[16]

Better access to general practice and primary care will reduce the need for expensive transport and retrieval services and reduce the psychological and financial impact for individuals and families of having to leave their homes to receive care.

We need a plan to provide better access to patient-centred, GP-led, team-based care for people living in rural Australia. Governments must invest in policy and programs to support GPs and healthcare teams to provide ongoing care to their community.

Investing in the rural general practice workforce requires additional and distinct solutions to overcome unique workforce issues such as professional isolation, uncompetitive remuneration compared to state hospital salaries and locum rates and the viability challenges of running a rural general practice. It is critical state and territory governments and the Commonwealth Government work together to resolve GP workforce issues, particularly in areas where GPs are working in hospitals, given that public hospitals are under the jurisdiction of state governments.

Improving access to GPs and RGs in rural areas will require the implementation of reforms identified in the AMA 10-Year Framework for Primary Care Reform, the Commonwealth Government's Australia's Primary Health Care 10 Year Plan 2022–2032 and the Strengthening Medicare Taskforce Report.

This plan reflects AMA positions and advocacy related to rural health care and outlines three steps to improve access to GP and RG care in rural communities.

AMA PLAN FOR IMPROVING ACCESS TO RURAL GENERAL PRACTICE

The AMA plan for improving access to rural general practice has three components:

Creating healthy communities

Providing opportunities to train locally

Supporting vibrant general practices

Creating healthy communities

General practice is the backbone of rural primary care. Improving access to general practice care when and where people need it will create healthy communities, improve productivity and liveability in rural areas, and reduce the burden on other parts of the healthcare system.

Rural and remote communities will need bespoke solutions to support the effective delivery of care. Significant investment and support will be required to achieve this goal along with localised and flexible policies and programs to support access to general practice and primary care in rural and remote communities.

AMA solutions:

1. Improving access to care

1.1 Develop a National Rural Health and Workforce Strategy, linked to the National Medical Workforce Strategy, governed by the National Medical Workforce Taskforce, including representative governance across regional, rural and remote public, private and community-controlled health settings. It is essential the strategy acknowledge the importance of localised and flexible solutions to meet the varied healthcare needs of rural communities.[17]

1.2 Implement funding models that support general practices already operating in rural areas and acknowledge the distinct and additional support rural general practice requires to remain viable and to provide access to continuous high-quality care for rural communities. This includes funding models that address the provision of healthcare services to Residential Aged Care Facilities (RACFs) and vulnerable communities in rural areas, which are usually provided by the local GP.

1.3 Provide appropriate funding and resources to rural hospitals to support the provision of adequate facilities, access to pathology/diagnostic imaging services, improved staffing levels, supervision and training opportunities and flexible work arrangements, such as core visiting medical officers, locum relief for GPs and non-GP specialists in consultation with the Commonwealth's locum medical workforce strategy.[18]

1.4 Evaluate and develop fly-in fly-out, drive-in drive-out and bus-in-bus out models of service delivery that meet the needs of rural communities and better support doctors who provide a regular service to communities in that way.

2. Funding for workforce planning

2.1 Fund an independent national health workforce planning agency to provide consistent and evidence-based advice on medical workforce supply and demand, future workforce requirements, skilled immigration requirements, the number and distribution of training places in line with community need, and empower it to ensure accountability for implementation of national medical workforce strategies.

2.2 Classification systems and tools to determine rurality and eligibility for incentives should consider local circumstances and the unique workforce pressures facing rural communities, particularly in areas where the classification has recently shifted.

2.3 The impact of policy decisions on medical workforce supply in rural areas should be evaluated, for example, changes to Distribution Priority Areas (DPA) and action taken to address any unintended consequences to ensure retention and community integration of an IMG workforce in regions of need.[19]

2.4 Develop and implement a governance framework that provides transparency, accountability and reports on the outcomes and impact of rural health policy, planning, funding, and delivery on access to healthcare in rural areas.

3. Improving digital connectivity

3.1 Continue to improve mobile and broadband coverage and performance to support new and innovative models of care that improve access to primary care for rural communities[20] and to enhance the resilience of telecommunications infrastructure in the event of natural disasters.[21]

3. Improving digital connectivity

3.2 Funding is needed to assist rural health settings, including primary care centres, general practices and health services to modernise these digitally-enabled technologies (including hardware and software) to meet the needs of digitally-enabled health care delivery.

3.3 Improving digital capabilities will also facilitate the implementation of quality models of virtual supervision and training. This should be accompanied by strong governance frameworks that allow risk analysis and evaluation to ensure models meet relevant College accreditation standards for specialist training.

4. Implementing local solutions and support

4.1 Develop, implement, and evaluate models of care to support access to general practice and primary care in areas where there is a chronic shortage, or total absence, of local GPs and/or RGs. The AMA proposes the Easy Entry/Gracious Exit model, whereby a third party (government or other) would provide practice infrastructure, allowing rural GPs and rural generalists to work as clinicians without having to become small business owners and managers.[22]

4.2 Enable general practice to coordinate better access to GP led multidisciplinary care in rural areas with funding from Primary Health Networks (PHN). This will help improve continuity, coordination, and connection between all primary care providers.[23]

5. Supporting International medical graduates (IMGs)

5.1 Streamline migration and assessment pathways and processes for suitably qualified IMGs while maintaining standards and providing adequate support to allow them to achieve general or specialist registration in line with broader medical workforce strategy.[24]

5.2 Identify and address the barriers to registration and employment for IMGs who are currently in Australia but are not able to practice.[25] This includes providing financial, social, and professional supports such relocation support, access to leave and subsidies for training, as well as programs that support IMGs to effectively train and work within the Australian health care system (such as understanding Medicare and cultural safety training).

5.3 Increase financial support for supervising practices to allow them to appropriately support IMGs in rural areas.

Providing opportunities to train locally

A range of programs have been designed to improve the recruitment of doctors in rural Australia, including in relation to medical school enrolment targets, prevocational, and specialist and rural generalist training. Despite this, rural workforce shortages persist.

We know doctors who come from a rural background or spend time training in a rural area are more likely to take up long-term practice in a rural location. Programs that support medical students, doctors in training and fellows to train, live and work in rural and regional areas across all career stages are essential to address geographic distribution.

The National Medical Workforce Strategy outlines steps to address supply and distribution, reform training pathways and build the generalist capability of the medical workforce to improve access to medical care for rural communities. The policy proposals below complement this and other workforce strategies to improve access to general practice and primary care for rural communities, and provide support for GPs to train and be recognised for the advanced skills they might acquire as an RG to meet the healthcare needs of rural communities.

AMA solutions:

1. Embedding rural primary care in medical school

1.1 Increase the intake of medical students from a rural background to one third of all new enrolments.[26]

1.2 Increase the number of medical students undertaking clinical placements in rural areas from 25 per cent to one third.

1.3 Expand academic positions for rural GPs and RGs to teach in medical schools.

1.4 Increase exposure of medical students to rural educators in education sessions.[27]

1.5 Increase accountability for universities to develop models of training delivery that produce a generalist and rural workforce,[28] and support equitable distribution of the medical workforce through the allocation and distribution of Commonwealth Supported Places (CSPs) and full fee-paying places.

1.6 Grow well supported opportunities for medical students to experience extended placements in rural areas, particularly in general practice.[29]

2. Support for doctors to train in rural areas

2.1 The Australian Medical Council National Framework for Prevocational (PGY1 and PGY2) Medical Training should be revised to include community terms as a requirement, noting this will require funding and organisational support from a range of stakeholders.

2.2 Until then, continuing and expanding programs such as the John Flynn Prevocational Doctor Program (JFPDP) which provide doctors in training with prevocational general practice placements in rural areas.[30] These placements support efforts to deliver more training and care in the community and rural areas, promote 'generalist' careers and give doctors in training valuable insight into life as a rural GP, encouraging a long-term career in rural general practice.

2.3 State and territory governments should provide more support for increased exposure to general practice as part of prevocational training, leveraging off the experience of medical school training.

2.4 Implement an employment model that delivers equitable working conditions for general practice registrars to ensure trainees have access to equitable remuneration and parental, study and other leave entitlements as they complete their training across multiple workplaces. The AMA supports the introduction of a single employer model (SEM) for GPs in training in all states and territories to ensure equity of employment conditions with non-GP specialist trainees, and to encourage a career in general practice.[31]

2.5 Provide financial incentives to attract and retain both prevocational doctors and specialist trainees to live and work rurally, and to choose general practice and/or rural generalism as a career. Incentives could come in the form of:

- direct payments such as salary, bridging payments, or allowances
- training and examination fee discounts for trainees in MMM3-7 locations
- decentralised examinations for rural trainees (reduces travel costs)
- support for upskilling, with reliable locum cover at no cost to the practice[32]
- addressing housing, spousal employment, and childcare barriers for trainees
- ensuring rural health services are resourced to meet industrial requirements including accommodation and security, adequate staffing capacity and safe rostering practices and teaching and training requirements.

2.6 Increase flexibility in GP training pathways and expand capacity for remote learning and supervision in rural sites.[33] This includes better recognition of prior learning and/or weighting in specialist GP/RG entry applications to recognise accredited competencies to incentivise a career in general practice and rural generalism.

2.7 Evaluate existing rural medical workforce policy and programs to determine if they are meeting workforce objectives including their impact and evidence base.[34]

3. Encouraging rural careers

3.1 Champion and promote the benefits of a rural medical career and lifestyle including clinical variety, greater levels of autonomy and a sense of being part of a community.

3.2 Provide access to career advice counselling from the beginning of medical school through to fellowship and later practice utilising the capacity found in Rural Workforce Agencies (RWAs) and PHNs.

3.3 Ensure collaborative partnerships exist between general practice, education providers, the profession, health sector, governments, and the community to support and resource general practice training in rural areas.

3.4 Encourage end-to-end rural medical training models that provide positive rural exposure.

4. Leveraging the National Rural Generalist Program

4.1 Complete the rollout of National Rural Generalist Program with a commitment to ongoing funding.[35]

4.2 Improve remuneration and support for generalist medical practitioners in both public and private practice and allow RGs to access all MBS items.[36]

4.3 Provide advanced skills training and credentialling for RG practitioners.[37]

5. Support for reskilling and upskilling

5.1 Implement a credentialing framework for rural GPs and RGs that is consistent, fair, non-burdensome and equitable to ensure patient safety. Credentialling should not be unfairly restrictive to a rural GP or RG's scope of practice, but a process that assures competency and safe practice in a rural setting consistent with the capability of the facility.

5.2 Provide access to innovative methods and flexible training models to ensure maintenance of clinical skills for credentialed GPs and RGs. This may comprise (but is not limited to) the use of "in reach" upskilling, as well as innovative technologies and educational models to maintain additional skills appropriate to the practitioner's rural or remote context. This should be proactively supported by local hospital or health services.

Supporting vibrant general practices

A wide range of health stakeholders play a role in attracting and retaining a vibrant multidisciplinary healthcare workforce in rural areas.

Health professional decisions to stay or leave rural practice are multifaceted involving personal, organisational, and social aspects. Professional isolation can also be a major issue for rural doctors, with a lack of networking opportunities, and few daily interactions with colleagues negatively impacting doctor wellbeing and career progression.

Rural GPs and RGs tell us that job satisfaction, practice viability and an environment that is attractive to their families are among the key priorities that influence their decisions to work in rural areas. These must be addressed to ensure rural communities have access to a thriving and vibrant general practice.

Rural communities, local government, and health services working collaboratively together to support doctors to live, train, and work in rural areas will contribute to the productivity, sustainability and liveability of a region. This will in turn create and improve access to vibrant patient-centred rural general practice primary care services, including promoting the rewarding aspects of rural practice, overcoming professional isolation, and supporting long term place-based patient care.

AMA solutions:

1. Promoting the benefits of rural practice

1.1 Ensure rural health professionals and communities are involved in policy making decisions at all levels.

1.2 Promote the positive aspects of rural practice and lifestyle to doctors and medical students including highlighting the variety of what a career in rural general practice and as a rural generalist can offer.[25]

1.3 Identify and endorse local champions of rural practice.

2. Providing support for shared networking

2.1 Fund the establishment of practice networks between small, geographically close practices and/or rural and urban general practices, for example through shared administration and provision of locum relief.[38] This could also include providing access to professional development and improving access to self-care support, wellbeing and mental health related services and information.

3. Providing incentives for rural and regional practices[39]

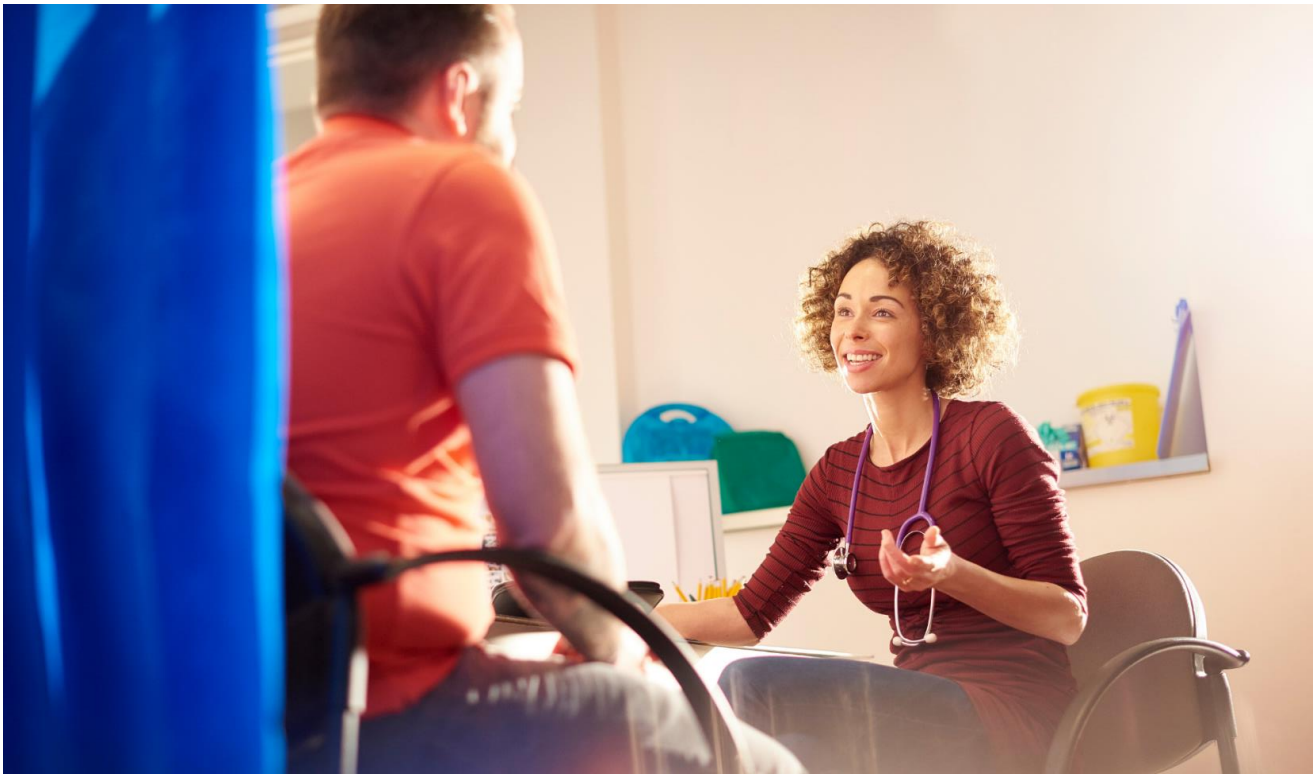
3.1 Provide rural, emergency/on call and advanced skills loadings and incentives that encourage doctors to work in rural areas and reward long service.[40] Tax offsets and/or exemptions for rural practices and incentive payments for GPs and RGs who move to rural areas should also be considered.

3.2 Provide tax free infrastructure grants to rural practices to support teaching and training and investment in new technologies such as telehealth and home monitoring.[41]

3.3 Introduce practice manager incentive payments to encourage recruitment and retention of skilled staff.[42]

3.4 Local health networks should consider how they could provide support to practices to recruit additional staff and assist in the coordination of out-of-hospital care.

3.5 Local governments and councils should consider how to provide family support for doctors to practice in rural areas including spousal employment, educational opportunities for children, childcare, subsidy for housing and relocation cost and/or tax relief. Investing in housing infrastructure for rural GPs and RGs should also be considered to support recruitment and retention.



CONCLUSION

The AMA believes that access to health care must be improved for people who live in rural Australia. These communities are served by highly skilled doctors who often work long hours and who are dedicated to the needs of their community. The work is both challenging and rewarding. Finding solutions that will work for each community requires a firm understanding of local priorities, challenges, resources, and values. This will require all level of governments and stakeholders to work collaboratively to develop workforce planning at local and regional levels, underpinned by patient centred care principles.

The AMA plan for improving access to rural general practice creates a platform for discussion. We look forward to discussing the solutions outlined in this plan with all stakeholders to identify areas for implementation and collaboration to improve access to rural general practice for rural communities.

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