



2019 AMA RURAL HEALTH ISSUES SURVEY

IMPROVING CARE FOR
RURAL AUSTRALIA



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The AMA is grateful to all rural doctors who took the time to complete this survey.

Executive Summary

Australians who live in cities have better health outcomes than Australians who live in rural and remote areas.¹ Rural communities have fewer doctors and are finding it increasingly difficult to attract new ones. Rural patients access Medicare at far lower rates than metropolitan patients and wait longer to see their GP.² Rural doctors are up against it, and it feels like no one is paying attention.

In conducting the 2019 AMA Rural Health Issues Survey, we set out to hear what our rural doctors were saying. We wanted to identify the urgent priorities to begin to improve the health outcomes of our communities. Rural doctors – we asked you to tell us, and you did.

One of the major challenges when conducting a survey of Australia’s rural doctors is that we all work in vastly different areas. Our communities have their own unique issues, we may have state-of-the-art equipment in our hospitals (but lack staff to use it) or we may be the only doctor for hundreds of kilometres around. One doctor may be supporting their community through the complex challenges of a drought while another is battling the waterborne diseases unique to the Wet Season. Regardless of the challenges, rural doctors do their best.

Our challenge now is to produce policy that will support all of our rural (and regional and remote) doctors and improve the health outcomes of their communities. We have started by listening to these doctors. We have listened, and we will base our policies on what we have been told.

In 2019, rural doctors told us that their top 10 priorities are:

1. The need for extra funding and resources to support improved staffing levels at rural hospitals;
2. Encouraging medical colleges to include rural rotations for trainees to rural areas;
3. Ensuring that rural hospitals have modern facilities and equipment;
4. The need for access to high-speed broadband for medical practices, encompassing general practice and specialist practice (reflecting the increasing use of telehealth);
5. Increasing the available infrastructure, resources, and supervision to support the training of junior doctors in rural areas;
6. Establishing regional training networks to enhance opportunities for specialist training in rural areas and support rurally based career paths;
7. Establishing more integrated programs to allow rural doctors to maintain and upgrade their procedural skills in public hospitals;
8. Increasing incentives, such as rural incentive payments, to recruit/retain doctors to work in rural areas;
9. Ensuring general practitioners with recognised procedural skills can access appropriate hospital credentialing and facilities; and
10. Increasing funding for ancillary staff at rural hospitals.

Despite significant investments in rural health since the last Rural Health Issues Survey in 2016, the results have changed minimally. Nine of the top 10 priorities in 2016 are priorities again in 2019. The

¹ AIHW, Australia’s Health: Rural Health Statistics, 2018. (<https://www.aihw.gov.au/reports/australias-health/australias-health-2018/contents/table-of-contents>)

² Department of Health, Annual Medicare Statistics, 2018.

(<http://www.health.gov.au/internet/main/publishing.nsf/Content/Annual-Medicare-Statistics>)

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highest ranked priority is the same. Clearly, rural communities need investment in basic infrastructure, and they need more medical professionals.

While innovative programs like the National Rural Generalist Pathway will lead to improvements in the rural medical workforce and access to care for rural communities, we will not see results from this for years. Likewise, the announcement of a National Medical Workforce Strategy was welcome news, but this strategy will take time, as will the implementation of it. Rural communities need investment now, investment in infrastructure, support for more staff in hospitals to allow workable rosters, support for basic services taken for granted in the cities like high speed internet, and policies to educate and train more doctors in rural communities with support for them to plant roots and stay.

The survey also provides us with a unique paradox: rural doctors work longer hours with patients who have higher incidence of all major diseases with fewer nurses and a smaller allied health workforce to coordinate care with,³ but they love it. Rural doctors told us that cradle-to-grave medicine, challenging caseloads and providing care for entire communities is extremely professionally rewarding. Likewise, living in the community provides the doctors and their families with satisfying lifestyle and opportunities unique to their location.

The point of the survey is two-fold: to call for more funding and more direct policy to improve the health outcomes in rural Australia, and to highlight how rewarding a career in rural medicine can be. We have all the tools we need to ensure all Australians have access to Australia's world class health system. It is time that Governments start listening to rural doctors and acting on their advice.



Dr Tony Bartone
Federal AMA President




Dr Sandra Hirowatari
Chair, AMA Council of Rural Doctors



³ National Rural Health Alliance, Half the services half the workforce.
(<https://www.ruralhealth.org.au/content/half-services-half-workforce>)

Introduction

Around 30 per cent of Australians live outside of regional, rural and remote areas, but they do not have the same access to health care and services that urban Australians would see as a basic right. These inequalities mean that they have lower life expectancy, worse outcomes on leading indicators of health, and poorer access to care compared to people in major cities. Death rates in regional, rural, and remote areas are higher than in major cities, and the rates increase in line with degrees of remoteness.

Health care in rural areas depends on a strong general practice workforce and a viable public hospital system. Without access to quality public hospital facilities, doctors cannot maintain their procedural skills level, and the opportunity to train new doctors in rural areas is greatly diminished, leaving many communities with no doctors or too few doctors.

Since the AMA Rural Health Issues Survey was last conducted in 2016, the Government has announced numerous targeted strategies to improve workforce distribution and address health inequities between urban and rural Australians. The AMA welcomed the Stronger Rural Health Strategy announced as a core component of the 2018/19 Federal Budget, which acknowledged many of the AMA's key platforms. In particular, the National Rural Generalist Pathway has been well received by many rural doctors.

While it is too early to see results from some of these initiatives, the results of this survey indicate that more targeted and deliberate strategies must be presented to address these long standing issues. It is essential that government policy and resources are tailored and targeted to cater to the unique nature of rural health care and the diverse needs of rural and remote communities to ensure they receive timely, comprehensive, and quality health care. This survey highlights the problems and presents a number of potential solutions.

This survey, developed by the AMA Council of Rural Doctors, sought input from rural doctors to identify policy initiatives that they believed would help improve rural health care delivery.

Survey methodology

The AMA's Rural Health Issues survey was conducted during March 2019, with 651 rural doctors responding to the survey invitation.

The survey canvassed the views of regional, rural, and remote doctors on the most pressing priorities in 11 areas: rural hospitals; procedural skills; specialist services; financial incentives; practice support; education and training; undergraduate medical education; locum relief and family support; continuing professional development; and technology. The survey questions were framed as policy proposals.

Rural doctors were asked to rate the importance of 31 different proposals relating to the above 11 priority areas to improve health care. Respondents were able to rate each policy proposal according to the following categories: critical, large, moderate, small, and none. Each category was assigned a linear rating, which allowed the AMA to calculate the degree of importance of each proposed solution.

Survey participants were also invited to provide additional comments or suggestions.

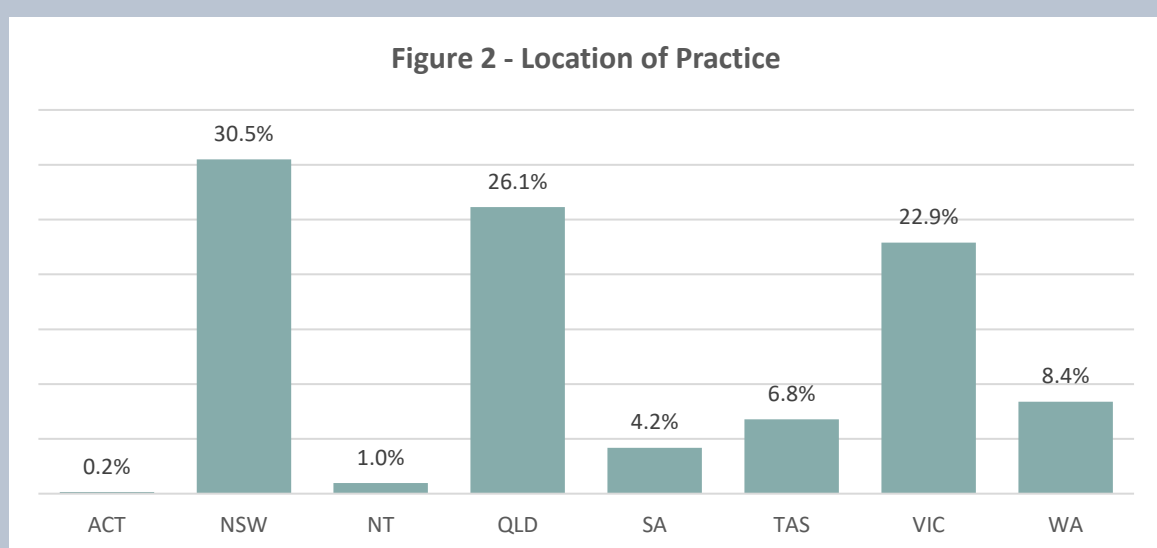
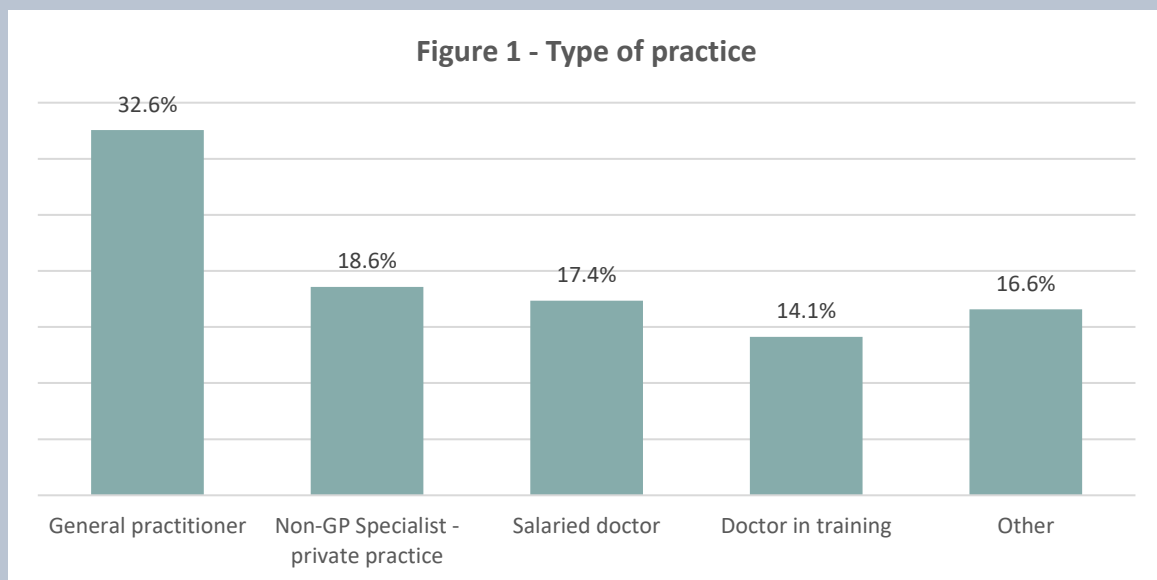
Survey results

Participation

Rural doctors were given two weeks to complete the survey. The survey, which closed on 31 March 2019, was attempted by 651 respondents with 608 completing the survey.

Demographics

Figure 1 and **Figure 2** below show the distribution of responses according to each occupational category and location of practice:



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Rural general practitioners accounted for 32.6% of the responses, followed by non-GP specialists in private practice (18.6%), salaried doctors (17.4%), other doctors (16.6%), and doctors in training (14.1%). Doctors who nominated the “other” category included rural generalists, locums, and Visiting Medical Officers (VMOs).

With regard to location of practice, New South Wales accounted for 30.5% of responses, followed by Queensland (26.1%), Victoria (22.9%), Western Australia (8.4%), Tasmania (6.8%), South Australia (4.2%); Northern Territory (1%) and Australian Capital Territory (0.2%).

Ranking of proposed solutions

The survey results provide a breakdown of what rural doctors see as the key solutions to improving rural health care.

Table 1 shows, in order of priority, the 10 most important solutions to improve the delivery of rural health care according to the views of survey participants. The table also shows the corresponding ranking of each nominated solution among different practice groups.

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Table 1 Comparison of top 10 policy proposals according to occupational groups

| Proposed Solutions | Overall Ranking | GPs | Non-GP Specialists | Salaried Doctors | DIT | Other |
|--|-----------------|-----|--------------------|------------------|-----|-------|
| <i>Provide extra funding and resources to support improved staffing levels, including core visiting medical officers, to allow workable rosters.</i> | 1 | 1 | 1 | 1 | 1 | 1 |
| <i>Encourage medical colleges to include rotations for trainees to rural areas - subject to appropriate experience and supervision.</i> | 2 | 6 | 2 | 2 | 8 | 3 |
| <i>Ensure that rural hospitals have modern facilities and equipment.</i> | 3 | 4 | 3 | 8 | 6 | 2 |
| <i>Access to high-speed broadband for medical practices, encompassing general practice and specialist practice.</i> | 4 | 3 | 9 | 3 | 4 | 8 |
| <i>Increase available infrastructure, resources and supervision to support the training of more doctors in rural areas.</i> | 5 | 8 | 6 | 5 | 2 | 5 |
| <i>Establish regional training networks to enhance opportunities for specialist training in rural areas and to support rurally based career paths.</i> | 6 | 13 | 5 | 6 | 3 | 4 |
| <i>Establish more integrated programs to allow rural doctors to maintain and upgrade their procedural skills in public hospitals.</i> | 7 | 7 | 12 | 4 | 5 | 6 |
| <i>Increase incentives, such as rural incentive payments, to recruit/retain doctors to work in rural areas.</i> | 8 | 5 | 4 | 7 | 14 | 7 |
| <i>Ensure general practitioners with recognised procedural skills can access appropriate hospital credentialing and facilities.</i> | 9 | 2 | 22 | 14 | 7 | 9 |
| <i>Increase funding for appropriately trained ancillary staff at rural hospitals.</i> | 10 | 12 | 7 | 10 | 10 | 12 |

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The AMA first conducted a rural health issues survey in 2007, which was the first widespread survey of its type conducted in Australia. The survey was last conducted in 2016. While some of the policy measures highlighted in the 2016 survey have been taken up to varying extents by governments, **Table 2** shows that many of the policy priorities identified by rural doctors have not changed.

Table 2 Comparison of proposals overall ranking - 2019 vs 2016 survey

| Proposed Solutions | Overall Ranking | |
|--|-----------------|------|
| | 2019 | 2016 |
| <i>Provide extra funding and resources to support improved staffing levels, including core visiting medical officers, to allow workable rosters</i> | 1 | 1 |
| <i>Encourage medical colleges to include rotations for trainees to rural areas - subject to appropriate experience and supervision</i> | 2 | 4 |
| <i>Ensure that rural hospitals have modern facilities and equipment</i> | 3 | 3 |
| <i>Access to high-speed broadband for medical practices, encompassing general practice and specialist practice</i> | 4 | 2 |
| <i>Increase the available support for infrastructure, resources and supervision to support the training of more doctors in training in rural areas</i> | 5 | 5 |
| <i>Establish regional training networks to enhance opportunities for specialist training in rural areas and support rurally based career paths</i> | 6 | 7 |
| <i>Establish more integrated programs to allow rural doctors to maintain and upgrade their procedural skills in public hospitals</i> | 7 | 8 |
| <i>Increase incentives, such as rural incentive payments, to recruit/retain doctors to work in rural areas.</i> | 8 | 13 |
| <i>Ensure general practitioners with recognised procedural skills can access appropriate hospital credentialing and facilities</i> | 9 | 6 |
| <i>Increase funding for appropriately trained ancillary staff at rural hospitals</i> | 10 | 10 |
| <i>Further expand funding to ensure locum relief for rural general practitioners and specialists</i> | 11 | 9 |

While it is concerning that the major issues are so similar, it is unsurprising. Specific programs have been introduced and reform has occurred, all with the intention of improving workforce distribution and improving infrastructure and services, but these have failed to address many of the fundamental barriers to improving the provision of rural health care.

Appendix A provides a full breakdown, in order of priority, of the 31 policy proposals that were surveyed. The score calculated for each policy proposal is also detailed in Appendix A.

Top 10 solutions for rural health care

Rural doctors face a range of challenges in delivering high quality health care. Workforce shortages, the ‘tyranny of distance’, limited facilities and equipment, and heavy workloads are all features of rural practice. It should come as no surprise, therefore, to see that the survey results reveal many common themes among occupational groupings when it comes to identifying key policy solutions and what priority they should be given.

Funding for more staffing in rural hospitals, the need for access to high-speed broadband for medical practices, ensuring that rural hospitals have modern facilities and equipment, encouraging medical colleges to include rotations for trainees to rural areas, and increasing support for training junior doctors, are rated highly among all survey respondents.

1. Provision of extra funding and resources to support improved staffing levels, including core visiting medical officers, to allow workable rosters

At the top of the list is the provision of extra funding and resources to support improved staffing levels, including core visiting medical officers, to allow workable rosters. All groups identified this as their top priority. This reflects rural doctors’ long-held concerns about the lack of staffing in rural hospitals and the high workload and the significant levels of responsibility placed on hospital doctors and VMOs. The high risks of fatigue due to poor roster design and staffing shortages are well known in rural hospitals, and junior doctors often highlight the significant burden of responsibility placed on them when working in rural hospitals.

Clearly, a better working environment in rural hospitals is fundamental to encouraging more doctors to not only spend some time in a rural area, but also give genuine consideration to a long term-career in rural practice. It may also have broader benefits by relieving some of the pressure on an already stretched primary care and specialist workforce by reducing heavy on call commitments.

The notion of “workable rosters” is an increasingly important issue for many doctors, in particular doctors in training who are considering a rural career. Many of the additional comments highlighted how introducing a workable roster would impact their life, such as in this quote:

“More emphasis on part time positions, rather than full time, especially in smaller towns as this decreases fatigue and allows time for someone to actually have some time off...”

Additional funding would also help resolve discrepancies between rural and metropolitan hospitals, as outlined in the following quote:

“I also find the discrepancy of salary between local registrars and city registrars or locum registrars does not make sense, especially when local registrars are for example told unrostered overtime cannot be paid due to budget issues.”

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2. *Encourage medical colleges to include rotations for trainees to rural areas - subject to appropriate experience and supervision*

Evidence shows that if a medical student is from a rural background or undertakes training in a rural area they are four times more likely to choose a rural career.⁴ Doctors who complete their vocational training in rural areas are also more likely to remain in those communities.⁵ There is little doubt that rural areas have the potential to offer young doctors a very good learning experience with a wide variety of clinical experience available. There are plenty of opportunities to be part of the whole patient journey and to take on greater responsibility.

Trainees should be supported to undertake rotations to regional/rural areas as part of their training program. The rotation should be included in the postgraduate medical education/Medical College accreditation processes. Providing training in regions where doctors live and care for their communities allows these doctors to plant roots in these communities. This is highlighted in the following quote:

“I have set up with my husband and children in the community, bought a house and become part of the rural community... I have to uproot and move to [the city] to complete my training at some point... Often those training years are when partners are found, weddings, children come on the scene. If this happens in the city, it is likely that the doctor will stay in the city. We have to make it possible for more of the training to be done out of [the city] so that doctors and their families can become entangled within the rural communities and stay there.”

In this context, and recognising that doctors who come from a rural background and/or spend time training in a rural area are more likely to take up long-term practice in a rural location, the AMA has developed a number of policy proposals that have the potential to make a real difference for rural patients. For example, the [2018 AMA Medical Workforce and Training Summit Report](#) recommended that Colleges set targets for training in rural areas. Other policies include expanding the Specialist Training Program to 1,400 places by 2021. There must also be employment opportunities available to these trainees post-training.

It is also important to highlight that training outside metropolitan areas is of very high quality, as outlined in the following comment:

“Training in rural settings is excellent - often better than in large metropolitan centres - because the exposure is much broader. This is not acknowledged.”

⁴ Srinivas Kondalsamy-Chennakesavan et al. Determinants of rural practice: positive interaction between rural background and rural undergraduate training, *Medical Journal of Australia*, 2015; 202 (1): 41-45 (<https://www.mja.com.au/journal/2015/202/1/determinantsrural-practice-positive-interaction-between-rural-background-and>).

⁵ McGrail, Matthew R., Russell, Deborah J., and Campbell, David G., Vocational training of general practitioners in rural locations is critical for the Australian rural medical workforce, *Medical Journal of Australia*, 2016; 205 (5), 216-222 (<https://www.mja.com.au/journal/2016/205/5/vocational-training-general-practitioners-rural-locations-critical-australian>).

3. *Ensure that rural hospitals have modern facilities and equipment*

Public hospitals are critical to rural health for reasons that go well beyond the services they provide to patients. They provide essential training opportunities. Unfortunately, as the [2019 AMA Public Hospital Report Card](#) shows, Australia's public hospitals are under pressure. Many rural doctors who work in private practice also work at their local hospital on a salaried basis or as Visiting Medical Officers. Without access to decent public hospital facilities, these doctors cannot maintain their procedural skill levels, and the opportunity to train new doctors in rural areas is greatly diminished.

If rural patients are to receive the same standards of care as other Australians, modern facilities and equipment are essential. Without the latest technology, rural patients cannot benefit from improved surgical techniques or improved methods of care. They may face longer recovery periods, or may not have the same quality of outcomes as they would have if they lived in the city.

[The AMA's Rural Workforce Initiatives 2017](#) calls on the Commonwealth and State/Territory Governments to work together to ensure that rural hospitals are adequately funded to meet the needs of their local communities. Rural hospitals must be funded to deliver quality patient care, strong and relevant training experience for doctors in training, support for the development and maintenance of procedural skills, opportunities for professional development, and safe working hours

The AMA has proposed the establishment of an innovation budget for development of local infrastructure solutions to facilitate this.

4. *Access to high-speed broadband for medical practices, encompassing general practice and specialist practice*

Access to high-speed broadband remains a core issue for our rural and remote doctors despite significant investment in the National Broadband Network. Living in rural or regional areas of Australia does not in itself determine internet access, but there remains a regional dimension to the digital divide, which is not reducing with time.⁶ In many country areas the internet connection is still very poor.

Rural communities need access to reliable and affordable high-speed broadband to support advances in information technology, which can act as a catalyst for the development of a range of potential e-health solutions to some of the challenges faced by people living in rural and remote Australia. While telehealth services are not the solution to the health disparities experienced by rural Australians, when used appropriately they can provide effective ways to complement existing health services and improve access. Telehealth can:

- Deliver health services into remote communities, reducing the need to travel;
- Provide timely access to services and specialists, improving the ability to identify developing conditions;
- Help educate, train and support remote healthcare workers on location; and

⁶ ABS (2018) Household Use of Information Technology, Australia, 2016-17.
<http://www.abs.gov.au/ausstats/abs@.nsf/mf/8146.0?OpenDocument>

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- Support people with chronic conditions to manage their health.⁷

This would also require appropriate MBS items to allow patients to claim for the consults, and to encourage doctors and practices to make the significant investment in the infrastructure required.

The internet also plays a big part in the lives of doctors and their families, assisting with education and social cohesion. It enables rural doctors to learn from the most current resources, explore treatment options, watch demonstrations of procedures, and attend live discussions with experts. Many of the respondents stated that improved access online Continuing Professional Development (CPD) modules would facilitate their continued learning while improving their quality of life. Internet access is also essential for a properly functioning My Health Record.

The internet is now also one of the main sources of entertainment for Australians, with the advent of streaming television services. Many communities in remote Australia have never been able to watch the same television programs as the rest of the country, but with appropriate internet speeds that can be overcome. Simple factors which are often taken for granted by Australians living in metropolitan centres, such as being able to watch television shows or films, are challenges to recruiting doctors for many remote Australian areas.

Despite the progressive implementation of the National Broadband Network, the percentage of homes with internet access is still 12.8 per cent lower in remote areas than it is in major cities, and this has not narrowed. People in remote areas are also using the internet for education and entertainment at far lower rates than people in the city, due in part to poor quality connections and limited bandwidth.⁸

The AMA developed the Position Statement [Better Access to High Speed Broadband for Rural and Remote Health Care – 2016](#) in response to the results of the 2016 Rural Health Issues Survey, which calls on the government to implement a number of specific actions to rectify this issue.

5. Increase the available support for infrastructure, resources and supervision to support the training of more doctors in training in rural areas

One of the major programs to emerge from the Stronger Rural Health Strategy was the More Doctors for Rural Australia Program (MDRAP). The MDRAP, along with allowing doctors on a pathway to general practice Fellowship to claim Medicare at 100 per cent, are initiatives which seek to directly address the issue of training and retaining more GPs in rural Australia. While significant funding has been allocated to this, there has been no funding specified to support the supervision of the doctors in these programs. Without funding and support for GPs to train the next generation of rural doctors, the whole program is at risk of failure.

Rural GPs already work longer hours than GPs in major cities,⁹ and many report they are unable to take the holidays they need and deserve as they do not want to leave their communities without a doctor. Asking them to take on another task, which will require intense supervision at the beginning

⁷ NHRA (2013) eHealth and telehealth in rural and remote Australia.

(<http://ruralhealth.org.au/sites/default/files/publications/nrha-factsheet-ehealth.pdf>)

⁸ ABS (2018) Household Use of Information Technology, Australia, 2016-17.

(<http://www.abs.gov.au/ausstats/abs@.nsf/mf/8146.0?OpenDocument>)

⁹ Rural Health Workforce Australia (2016) Fact Sheet, GP Workforce Trends,

(http://www.rhwa.org.au/client_images/1770749.pdf)

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and incur costs to the practice, is unrealistic and unfair. Many practices also face significant infrastructure limitations such as information technology, equipment, and physical space.

If rural general practices are properly funded to improve their available infrastructure, they can expand the services that they provide to patients, including general practice, nursing, and allied health. Such funding can also support improved opportunities for teaching prevocational and vocational trainee doctors, as well as other health professionals.

One solution is funding rural GP infrastructure grants. Previous rounds of infrastructure grant funding have delivered real results for rural communities, with local practices taking realistic steps to improve patient access to services and support teaching activities. The Australian National Audit Office reports that infrastructure funding grants are effective and a good value-for-money investment.¹⁰

It is not just general practice which requires support. As noted earlier, many doctors in training who are completing specialist training have no option other than to leave their rural community to complete their training in metropolitan centres. While there has been significant effort to develop rural training pathways for general practice and progress has been made on the implementation of a National Rural Generalist Pathway, only minimal effort has been made to establish meaningful rural specialist training pathways, and they are undermined by the need to return to cities for training. A solution is outlined in the quote below:

“Governments should do everything to make training in rural centres attractive... Where College policies obstruct training in rural settings or make it very hard for rural institutions to comply with training accreditation criteria that were designed for tertiary settings in metropolitan settings, the government needs to intervene. The disadvantages that larger hospitals in rural settings have in regards to training young doctors need to be minimised. Training in rural settings is excellent - often better than in large metropolitan centres - because the exposure is much broader. This is not

The Specialist Training Program must be expanded to 1,400 places by 2021, with higher priority being given to training places in regional and rural areas, generalist training, and specialties that are under-supplied. The National Medical Training Advisory Network must be included in decision making in regards to specialties in under-supply, and in identifying and encouraging training in rural settings. Fully functioning regional training networks (RTNs) as outlined in the AMA's [Position Statement on Regional Training Networks](#) would enable this, as discussed below.

6. Establish regional training networks to enhance opportunities for specialist training in rural areas and support rurally based career paths

The AMA has been advocating for the establishment of regional training networks for many years in the form of vertically integrated regional networks of health services and prevocational and specialist training hubs. The networks would build on existing infrastructure and enable doctors in training to receive much of their training in rural and regional areas.

¹⁰ ANAO Audit Report No.44 2011-12, 'Administration of the Primary Care Infrastructure Grants Program', Commonwealth of Australia 2012, (<https://www.anao.gov.au/sites/g/files/net3416/f/201112%20Audit%20Report%20No%2044.pdf>)

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The AMA welcomed the announcement by the Government in 2017 of the introduction of 26 Regional Training Hubs. However, they have as yet had no significant impact beyond facilitating rural placements for medical schools.

These hubs must be leveraged to bolster rural training opportunities, and to provide a valuable and meaningful career pathway for doctors in training who want to work in regional and rural Australia. Many medical students have positive training experiences in rural areas, but prevocational and specialist medical training often requires a return to metropolitan centres.

The [AMA Position Statement on Regional Training Networks](#) calls for:

- Federal and State Governments, their agencies, health services and networks, and employers to fund additional training places and improve industrial arrangements for trainees based in regional areas rotating into metropolitan areas;
- the Learned Colleges, Postgraduate Medical Councils and training providers to participate in the governance of RTNs, provide support to trainees and remove barriers for accreditation of prevocational and vocational training posts in regional areas;
- constructive engagement with medical schools, building from the experiences of Rural Clinical Schools.

7. Establish more integrated programs to allow rural doctors to maintain and upgrade their procedural skills in public hospitals

Many doctors who responded to the survey supplied insightful open-ended responses detailing what they find most rewarding about rural medical practice. One of the most frequent responses was the variety of work, including procedural practice. This is despite the significant reduction in rural GPs working as proceduralists.

“I enjoy the generalist nature of our work, I enjoy being part of the community and our ability to connect/receive advice from larger tertiary centres.”

“Being able to be a true generalist and manage a wide range of conditions. Also, having the opportunity to develop and practice procedural skills.”

For many GPs, it is one of the highlights of rural practice. It means variety and provides a stimulating and challenging work environment. However, in many areas the utilisation of procedural skills is becoming increasingly difficult. This problem is in large part driven by the closure or downgrading of rural hospitals.

Unless procedural GPs can be assured of a suitable caseload, deskilling becomes a significant problem. In addition, it becomes more difficult to keep up with the latest techniques. Governments must develop a more rigorous decision-making framework to govern hospital closures, along with innovative programs to allow rural practitioners to keep up with the latest procedural techniques.

One area of particular concern is in maternity care, with the closure of rural maternity services across much of Australia and the exclusion of doctors from models of maternity care. In addition to the risks and challenges this presents to rural women, GPs also risk losing obstetrics skills, undermining the health workforce and risking patient safety. The AMA has been advocating for increased funding for rural maternity services and models of care that provide for continued

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involvement of medical professionals at all stages pregnancy, while ensuring patient choice is respected.

The AMA welcomed the announcement of the NRGP which will encourage GPs to practice at an extended scope and provide procedural skills. Already in Queensland we have seen a successful rural generalist program introduced. However, the introduction of the NRGP will not resolve the fundamental issue of the closure or downgrading of rural hospitals and the closure of maternity services.

The AMA has previously proposed a public interest test to apply to hospital closures that takes into account the impact on the local skills base, and has also pushed for the establishment of dedicated training posts in tertiary hospitals for rural doctors to allow them to develop and maintain their skills on a regular basis. Clearly, these proposals would win significant support among rural doctors and rural communities.

8. Increase incentives, such as rural incentive payments, to recruit/retain doctors to work in rural areas.

Incentives are important not just for attracting doctors, but also for retaining them, as explained by this quote:

"I was on the verge of leaving the remote practice I am in 15 years ago but was able to stay because the area health service increased my on-call allowance by \$10k/year to cover boarding school costs of our child who was starting year 7 in Sydney. Funding matters."

The AMA and the Rural Doctors Association of Australia (RDAA) released a package of measures that recognises both the isolation of rural and remote practice and the need for the right skill mix in these areas. [Building a sustainable future for rural practice: the rural rescue package](#), proposes two tiers of incentives:

- a rural isolation payment available to all rural doctors including GPs, locums, other specialists, salaried doctors and registrars, with the level of support provided increasing with rurality; and
- a rural procedural and emergency/on-call loading, aimed at boosting the number of doctors in rural areas with essential advanced skills in a range of areas such as obstetrics, surgical, anaesthetic, acute mental health, or emergency skills.

All doctors should receive incentives in recognition of the services they provide and the challenges that accompany rural and remote practice.

The General Practice Rural Incentive Program (GPRIP) and the Practice Nurse Incentive Program (PNIP) have been successful and are appreciated by doctors, practices, and communities. The expansion of these Programs into the Workforce Incentive Program in 2020 to include allied health professionals will also improve access to communities.

However, payments under the current incentives are not indexed. This means the incentive payments do not keep pace with inflation and thus become less effective as an incentive over time. Capping the funding that a practice is eligible for inhibits the capacity of practices to evolve and expand the range of health care services they can provide to meet their patients' healthcare needs.

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Other financial incentives could be provided simply by guaranteeing employment contracts for doctors in training. This would involve financial support for returning to metropolitan centres for necessary training. Providing employment support for partners and spouses would also alleviate a significant barrier for many doctors considering relocating.

9. *Ensure general practitioners with recognised procedural skills can access appropriate hospital credentialing and facilities*

Before any doctors in private practice can utilise hospital facilities, they must go through a credentialing process. This is an important check in the system to ensure patient safety.

However, some procedural GPs have become disenchanted by delays and barriers in the credentialing system. Procedural GPs go to significant effort to acquire new procedural skills as part of accredited training programs, only to find on some occasions they cannot utilise these skills in their local hospital.

In more challenging clinical environments, a strong procedural skills base is essential to ensuring that a practitioner has the confidence to deal with a wide range of clinical situations. If procedural GPs are not given opportunities to practise these skills, this is a wasted opportunity. This leads to rapid deskilling and, for many, will remove one of the more rewarding aspects of rural practice.

Many of these GPs will ultimately decide to look at other practice options. They may cut back on the range of conditions that they will treat, or move to larger towns or metropolitan areas.

Another challenge is that in Australia, States/Territories and hospitals have separate policies (though all are similar in many ways) and individual hospitals are responsible for administering the process of credentialing.

Requiring a police check every time a doctor needs to be credentialed accumulates to a high cost over time. This can be particularly challenging for international medical graduates who still constitute a significant proportion of the rural medical workforce. From a rural perspective it is particularly challenging as there are no standards for recognising a GP's skills in practising in a rural sense, no defined minimum case numbers, and no definition for current skills.

The system is burdensome and a constant challenge for many locums in particular, as noted by this comment below:

"Please advocate for a national credentialing system in Australian hospitals to allow freer movement of locums, workforce support and training."

Hospitals must ensure that credentialing processes are transparent, rigorous, and fair, and that they do not prevent procedural GPs from having reasonable access to hospital facilities. The AMA Council of Rural Doctors is currently exploring options for improving the credentialing system.

10. *Increase funding for appropriately trained ancillary staff at rural hospitals*

The final proposal fits with many of the others. The fundamental issue is funding. The provision of extra funding and resources will support improved staffing levels, including core visiting medical officers, to allow workable rosters.

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Increased funding in rural hospitals will allow the hiring of more staff to allow doctors to provide the services they should be providing. Too much time is tied up with administrative duties that rob the community of valuable hands-on clinical work. With an already overstretched rural medical workforce, more funding must be given to provide doctors with support to ensure that they can get on with what they do best, treating patients.

This also aligns with the frustration many rural doctors feel with the credentialing requirements, and the lack of allied health staff available to allow for genuine multi-disciplinary care.

Clearly, rural doctors want to get on with the job of being doctors and providing care to rural communities.

Are these the only solutions?

It must be noted that there was very little difference in the value placed on the top 10 solutions compared to those just outside the top 10, particularly issues relating to: funding for locum relief (11); educational support (12); and improving access to specialist services (13).

Many of these issues proposals were also rated highly in 2016. The AMA incorporated them into [the Rural Workforce Initiatives 2017](#), which calls on the government to act on improving medical workforce distribution through a series of targeted measures in five key areas:

1. Encourage students from rural areas to enrol in medical school, and provide medical students with opportunities for positive and continuing exposure to regional/rural medical training;
2. Provide a dedicated and quality training pathway with the right skill mix to ensure doctors are adequately trained to work in rural areas;
3. Provide a rewarding and sustainable work environment with adequate facilities, professional support and education, personal comfort, and flexible work arrangements, including locum relief;
4. Provide family support that includes spousal opportunities/employment, educational opportunities for children's education, subsidy for housing/relocation and/or tax relief; and
5. Provide financial incentives including rural loadings to ensure competitive remuneration.

The fundamental issue behind all of this is funding. Mandating service will never secure a permanent workforce, but incentives can. Identifying those incentives and leveraging them will help achieve this.

Rural Medicine is a rewarding career

While the AMA Rural Health Issues Survey sought to identify a list of priority policy areas for stakeholders to pursue in order to improve the delivery of health care in rural communities, it also attempted to identify the positive aspects of rural practice. As noted earlier in the report, participant feedback on the positives was substantial.

The survey received hundreds of comments about the rewards of practising medicine in a rural area. While the challenges of practising medicine rurally have changed little since the 2016, so too have the positives. The main positives associated with 'going rural' are outlined below:

Professional satisfaction

Rural and remote practice has the potential to offer enormous professional satisfaction. Examples of what respondents found rewarding are:

- The variety of professional skills used;
- Being part of, and having a closer relation with the community;
- Whole person care for the entire family,
- cradle to grave medicine and the ability to provide continuity of care;
- High level of autonomy and trust;
- Satisfaction of servicing a rural population and being appreciated;
- Collegiate environment with rewarding professional relationship;
- Diversity and greater responsibility;
- Getting to see the positive impact you can make in several generations of a family;
- Personal interaction with patients and staff; and
- Real ability to make a difference.

The comments below are typical of the feedback provided:

“Ability to make a difference in people's lives and have a personal connection.”

“Providing a service where it is needed, not where there is already an abundance of doctors and tertiary hospitals, which improves job satisfaction through grateful and supportive patients and community, and wider scope of practice.”

Challenge and variety of work

There is no doubt that rural practice offers a challenging work environment with a variety of clinical experiences. Rural doctors said they valued:

- Variety of presentation;
- Being an important stakeholder in decision-making;
- Using procedural skills in a supportive, non-threatening environment;
- Working with Aboriginal and Torres Strait Islander people;
- Maintaining a broad knowledge base;
- Procedural work such as surgery, anaesthesia, obstetrics and pathology;
- The necessity to retain multiple skills across a specialty to cope with a broad range of diagnostic techniques; and

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- Challenges to improve standard, quality and safety of work with limited resources and infrastructure.

The comments below are typical of the feedback provided:

“professionally being able to be a true generalist and manage a wide range of conditions. Also, having the opportunity to develop and practice procedural skills..”

“The challenge of acting semi autonomously as a junior doctor, long hours on call and the variety of patient issues seen in rural general practice.”

“The professional challenge of independence and isolation enables greater professional rewards, even if not financial.”

Lifestyle

Life is different in a rural community and rural doctors enjoy the difference. Lifestyle is a big factor in choosing rural practice with respondents nominating a number of positive areas including:

- Good quality of life;
- Ease of access to work and little time commuting;
- Country life in general;
- Work-life balance;
- The healthy environment;
- Able to spend more time with family;
- The best environment to raise children;
- Affordable housing; and
- Lifestyle choices not possible in the cities.

Perhaps these benefits are best summed up by the following statements:

“I live in an attractive place which enables me to undertake my hobbies.”

“It’s not about my work it’s about my family and the lifestyle.”

“Work life balance and being a critical part of local community. My family lives on 100 acres 10 minutes from their school and my admitting hospitals.”

Doctor-patient relationship

Rural doctors play a key role in the delivery of health care at the local level, and in smaller communities this role becomes even more important. Feedback indicated that rural doctors value the following:

- Continuity of care;

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- Getting to know patients and their family well;
- Appreciative patients;
- A whole of person approach;
- Being genuinely needed;
- Developing knowledge of Indigenous health issues;
- Developing long-term relationships with many generations from one family; and
- Collaborative, comprehensive patient care with patient-centred focus.

Again, typical comments on this aspect of rural practice included:

“I know my patients well, see them in the grocery store and feel like I make a personal difference in their lives. The air is also cleaner.”

“The personal touch due to continuity of care ensures you have lasting impressions in the community. The ensuing trust and gratitude are very fulfilling.”

Community involvement

Finally, rural doctors clearly enjoy the central role they have in the community and the degree of community involvement that flows from this. They like:

- Managing people's health care in the context of their community;
- Serving the community;
- Being part of a local community;
- Having enough time to volunteer;
- Providing a quality essential service to country people;
- Treating people where they live; and
- Being a valued member of the community.

The comments below are typical of survey responses:

“From both personal and professional perspectives remote practice is a unique opportunity to be a part of and contribute in a meaningful way to improve the lives of those around you.”

“It has been a privilege to be part of a regional community: the mixture of the personal and the professional.”

“You really get a chance to become part of community and you as an overseas doctor originally in a way I think it was easier to integrate myself in smaller town and hospital than in a big city.”

Conclusion

The 2019 Rural Health Issues survey reflects the grassroots input of rural doctors who have first-hand experience of working in Australia's health care system and in knowing, and providing for, the needs of their patients. The Survey did not simply focus on identifying what is wrong with rural health care, but instead sought to identify and prioritise the broad policy directions that should be taken and the solutions to improve rural health care.

Despite the many programs and initiatives announced since the 2016 AMA Rural Health Issues survey, many of the priorities identified by rural doctors remain the same. While it is unrealistic to expect any initiatives to simply and quickly resolve issues of maldistribution of the medical workforce or the structural inequalities, the results from the survey are clear: we need action.

Rural doctors from all groups identified the need for: 1) Improved funding for rural hospitals, 2) better access to high-speed broadband, 3) greater exposure to rural practice for junior doctors, 4) expanded rural infrastructure grants to improve patient access to services, and 5) support teaching activities, easy access to hospital credentialing, improved training arrangements, support for procedural skills, and time off to prevent burnout.

All of the proposals in the survey are realistic and would do a great deal to improve the provision of health care to people living in regional, rural and remote Australia. These results complement existing AMA work, such as the [Rural Workforce Initiatives 2017](#) and [the AMA and RDAAs' Rural Rescue Package](#). The results of the survey also contributed to the policy requests in the AMA's [Key Health Issues for the 2019 Federal Election](#). The AMA is calling for:

- More resources to increase staffing levels to allow workable rosters for rural doctors, and investment in hospital facilities, equipment, and practice infrastructure;
- expanding the successful Specialist Training Program to 1,400 places by 2021, with higher priority being given to training places in regional and rural areas;
- funding for a further 425 rural GP infrastructure grants of up to \$500,000 each;
- additional funding for individual GP supervisors and practices to support non-vocationally registered doctors to attain fellowship; and
- increasing the targeted intake of medical students from a rural background from 25 per cent to one-third of all new enrolments, and increase the proportion of medical students required to undertake at least one year of clinical training in a rural area from 25 per cent to one-third.

It is the intention of this report that immediate and genuine commitment to improving rural health outcomes becomes a real priority. However, this will require significant funding increases to bridge the gap between city and country.

Importantly, despite the problems in rural health care, it is heartening to see just how many doctors in the survey highlighted the positive aspects of rural practice. While we must highlight the challenges of rural medical practice, it is just as important to highlight the benefits of rural medicine. Country practice is a true calling, and a rewarding one. Go rural.

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Appendix A

The table below details the full list of solutions that survey participants were asked to rate, along with the overall score calculated for each proposed solution. Each score is out of possible 100.

| Proposed solution | Score | Ranking |
|--|--------------|----------------|
| <i>Provide extra funding and resources to support improved staffing levels, including core visiting medical officers, to allow workable rosters.</i> | 89.8 | 1 |
| <i>Encourage medical colleges to include rotations for trainees to rural areas - subject to appropriate experience and supervision.</i> | 84.1 | 2 |
| <i>Ensure that rural hospitals have modern facilities and equipment.</i> | 83.5 | 3 |
| <i>Access to high-speed broadband for medical practices, encompassing general practice and specialist practice.</i> | 83.0 | 4 |
| <i>Increase available infrastructure, resources and supervision to support the training of more doctors in rural areas.</i> | 81.9 | 5 |
| <i>Establish regional training networks to enhance opportunities for specialist training in rural areas and to support rurally based career paths.</i> | 81.7 | 6 |
| <i>Establish more integrated programs to allow rural doctors to maintain and upgrade their procedural skills in public hospitals.</i> | 81.2 | 7 |
| <i>Increase incentives, such as rural incentive payments, to recruit/retain doctors to work in rural areas.</i> | 81.1 | 8 |
| <i>Ensure general practitioners with recognised procedural skills can access appropriate hospital credentialing and facilities.</i> | 80.6 | 9 |
| <i>Increase funding for appropriately trained ancillary staff at rural hospitals.</i> | 79.1 | 10 |
| <i>Further expand funding to ensure locum relief for rural general practitioners and specialists.</i> | 77.9 | 11 |
| <i>Improve access to educational support for rural doctors including CPD and mentoring.</i> | 77.8 | 12 |
| <i>Develop specific initiatives to improve access to specialist services.</i> | 77.8 | 13 |
| <i>Encourage medical colleges to offer more generalist training places for trainees.</i> | 77.1 | 14 |
| <i>Additional funding for specialist outreach services, appropriately integrated with local services.</i> | 75.7 | 15 |
| <i>Implement a funding program to support prevocational doctors to undertake rotations in rural general practice settings.</i> | 74.8 | 16 |
| <i>Improve access to employment opportunities for rural doctors' partners and/or family members.</i> | 73.7 | 17 |
| <i>Improve funding for rural maternity services.</i> | 73.6 | 18 |
| <i>Increase funding for patient assisted travel schemes for patients (including their carers) who must travel long distances for hospital treatment.</i> | 73.2 | 19 |
| <i>Improve access to education for rural doctors' family members through better infrastructure or financial support.</i> | 72.9 | 20 |
| <i>Expand Medicare rebates to cover GP video consultations with a usual GP for rural patients who live some distance from a GP.</i> | 72.4 | 21 |
| <i>Introduce a public interest test to apply before a rural hospital can be closed or downgraded.</i> | 72.2 | 22 |
| <i>Increase the number of medical students who undertake at least a one year rural clinical placement(s).</i> | 71.4 | 23 |

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| | | |
|--|------|----|
| <i>Provide funding to small rural general practices to assist with the costs of undertaking and maintaining practice accreditation.</i> | 70.2 | 24 |
| <i>Encourage all State Government hospital outpatient clinics to offer telemedicine consults to rural patients and increase the number of urban specialists providing telehealth consults.</i> | 69.7 | 25 |
| <i>Provide general practice infrastructure grants to support enhanced medical and/or allied health services or improved training facilities.</i> | 69.6 | 26 |
| <i>Establish tied funding for rural hospitals, including requirements for state/territories to meet agreed performance benchmarks.</i> | 68.2 | 27 |
| <i>Strengthen scholarship based programs to support medical students from a rural background.</i> | 68.2 | 28 |
| <i>Expand the eligibility criteria so more specialists are able to qualify for rural workforce incentive payments.</i> | 67.4 | 29 |
| <i>Increase the intake to medical schools of students with a rural background.</i> | 66.4 | 30 |
| <i>Develop targeted incentives to encourage rural doctors who are 55 and over to delay retirement.</i> | 61.7 | 31 |



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