Rural Workforce Initiatives 2017

1. Background and summary of current problems

About one third of Australia's population, approximately 7 million people, live in regional, rural and remote areas. These Australians often have more difficulty accessing health services than urban Australians, leading them to have a lower life expectancy and worse outcomes on leading indicators of health.

Death rates in regional, rural, and remote areas (referred to as 'rural' in this document unless otherwise specified) are higher than in major cities, and the rates increase in line with degrees of remoteness. People living in rural areas are more likely to defer access to general practitioners (GPs) due to cost. Rural patients often have to travel significant distances for care, or endure a long wait to see a GP close to where they live. They have higher rates of potentially preventable hospitalisations, and are less likely to gain access to aged care.The closure and downgrading of rural hospitals is seriously affecting the future delivery of health care in rural areas. For example, more than 50 per cent of small rural maternity units have been closed in the past two decades in Australia.[1]

Although Australia currently has an adequate supply of doctors nationally, there remains a significant medical workforce shortage in rural areas.[2] Many locally trained doctors are choosing not to work in rural areas and nearly 76% of graduating domestic students reported living in capital cities in the Medical Students Outcome Database Survey (MSOD).[3] Research has shown that although GPs are more likely to practice in rural locations than other specialisations, the growth in the specialist medical workforce has outstripped the growth in GP numbers so that specialists now make up a larger proportion of the overall medical workforce. The rural medical workforce is reliant on internationally trained medical graduates.[4]

Table 1: Full-time equivalent medical practitioners per 100,000 population

Remoteness Area:	Medical Practitioners
Major city	437
Inner regional	292
Outer regional	272
Very remote	264

Table is replicated from Australian Institute of Health and Welfare 2016. Australia's health 2016. Australia's health series no. 15. Cat. No. AUS 199. Canberra: AIHW.

Table 1 is a simple illustration of the current problem with workforce distribution. While it is possible to provide a much more complicated analysis based on other measures, this table provides a useful snapshot of the issue.

The debate is not just about numbers though, it is also about the right skill mix. Rural medical practice requires individuals to possess a broad range of different skills – with primary care practitioners representing the backbone of rural health care. The number of GP proceduralists, or generalists, working across rural and remote Australia has been steadily declining. In 2002, almost a quarter of

the Australian rural and remote general practice workforce consisted of GP proceduralists. By 2014, this figure had fallen to just under 10 per cent.[5]

Rural doctors work longer hours, particularly those in very remote areas.[6] GPs in remote and very remote areas spend shorter periods in their roles than those in regional areas.[7] To encourage participation in the rural medical workforce, greater numbers of doctors will be needed in the future to provide the same level of services. Rural doctors are also getting older. The mean average age of rural GPs in Australia in 2014 was 50 years and 34 per cent were aged over 55.[8] As these doctors approach retirement the workforce shortage will become even more pronounced.

This position statement outlines the factors that influence medical practitioners to work in rural areas and AMA proposed solutions that would relieve current pressures and entice more doctors to work outside metropolitan areas.

2. Addressing the mal-distribution of the workforce

There are a number of fundamental reasons why rural areas are not getting their fair share of the medical workforce. These include:

- inadequate remuneration;
- work intensity including long hours and demanding rosters;
- lifestyle factors;
- professional isolation and lack of critical mass of similar doctors;
- reduced access to professional development;
- reduced access to locum support;
- hospital closures and downgrading or withdrawal of other health services;
- under-representation of students from a rural background;
- poor employment opportunities for other family members, particularly partners;
- limited educational opportunities for other family members; and
- withdrawal of community services, such as banking, from such areas.

In 2016 the AMA conducted a Rural Health Issues Survey, which sought input from rural doctors across Australia to identify key solutions to improving rural health care. The almost 600 doctors who took part in the survey said extra funding and resources to support the recruitment and retention of doctors and other health professionals was their top priority in trying to meet the health care needs of their patients.

Doctors also said that for there to be genuine improvements in access to health care for rural patients, there needed to be:

- funding and resources to support improved staffing levels and workable rosters for rural doctors;
- access to high speed broadband;
- investment in hospital facilities and equipment and practice infrastructure;
- expanded opportunities for medical training and education in rural areas;
- improved support for GP proceduralists; and
- better access to locum relief.

Successive Federal Governments have introduced a range of initiatives in a bid to attract and retain doctors in rural areas. These include:

- an expansion of medical training places;
- improving the rural classification system for the allocation of workforce incentives with the introduction of the Modified Monash Model;
- reform of the GP Rural Incentives Program;
- the establishment of Rural Clinical Schools;
- introducing the Rural Junior Doctor Training Innovation Fund (RJDIF); and
- other initiatives targeting doctors to work in communities with under-serviced health needs.

While some gains have been made,[9] the geographical mal-distribution of doctors persists and the sustainability of some rural health services remain under threat.

Evidence to date points to a number of elements that can positively affect the recruitment and retention of doctors in rural areas:

- the early and continuing exposure of medical school students to rural medicine and measures to encourage students from rural areas to enrol in medical schools are the most likely of all initiatives to increase the workforce in these areas;
- proper medical infrastructure, a strong training experience, and access to community and professional resources, and continuing medical education are essential to the provision of a rewarding professional and personal experience;
- the opportunity to maintain and update skills is as important for rural specialists and GP proceduralists as for their city counterparts.
- consideration must be given to not only the needs of the medical practitioner, but also their family - particularly with respect to access to employment opportunities, health and education, and social amenities;
- a critical mass of doctors within a region is important in improving the viability of a practice, as well as enhancing professional development; and
- appropriate remuneration and incentives.

3. AMA Proposed Solutions

Going forward, the AMA has identified five key priority areas for the Government to implement that would help attract medical practitioners and students to rural areas. These are:

1. encourage students from rural areas to enroll 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.

These five key priority areas are addressed in detail below:

3.1. Education and Training

Evidence suggests that students from rural backgrounds and/or those who train in a rural area (12 months) are more likely to practise in a rural area.[10] Rural Clinical Schools, enrolment targets for students with a rural background, and requirements for students to spend extended periods in rural clinical settings are effective policy measures that should be built on.

The AMA has developed a number of policy proposals regarding education and training that have the potential to improve the sustainability and distribution of the medical workforce. These include:

- lifting the targeted intake of medical students from a rural background from 25 per cent of all new enrolments to one-third of all new enrolments;
- lifting 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;
- moving beyond the more limited RJDTIF and establishing a Community Residency Program to provide doctors in training with prevocational general practice placements in rural areas. These placements would support efforts to deliver more training and care in the community, supplement the traditional hospital-based approach to medical training, and promote 'generalist' careers. They give doctors in training a valuable insight into life as a rural GP, and encourage a long-term career in rural general practice;
- expanding the Specialist Training Program to 1,400 places per annum (from 1,000 in 2018), with a strong emphasis on rural placements;
- establishing regional training networks (RTNs) to bolster rural training opportunities, and to provide a valuable and meaningful career pathway for doctors in training who want to work in rural Australia. It would also improve patient access to medical care. The AMA has advocated for this policy and in April 2017, the Federal Government announced 26 regional training hubs would be built into the Rural Health Multidisciplinary Training (RHMT) program at existing RHMT program training sites. Many medical students have positive training experiences in rural areas but prevocational and specialist medical training often requires a return to metropolitan centres – this is progress towards more training in rural areas, with city training required only for specific skills;
- a culture shift needs to occur so that a rural term is considered favourably for doctors in training and given prestige when applying for a specialty training program;
- providing adequate accommodation and access to services, including the internet, for doctors undertaking training in rural and remote locations;
- rural specialists and GP proceduralists must have fully funded access to centres of excellence to regularly enhance and broaden their skill base.

Further reading:

AMA Vision Statement for General Practice Training 2016

National Code of Practice - Flexible Work and Training Practices

3.2 Rural Generalism

In rural and remote areas GPs are often required to provide a wider scope of practice than in metropolitan areas. Although generalist numbers have been declining, a number of jurisdictions have established strong rural generalist training pathways, particularly Queensland, which are helping to boost the number of doctors with the range of skills needed to meet the health needs of country Australians.

The AMA supports the expansion of the rural generalist model. The AMA formed part of the technical working group organised by the Rural Doctors Association of Australia (RDAA) which developed a policy document listing a set of agreed core principles that could be used as a basis for a national rollout of an advanced training program for GPs. The principles agreed upon include:

- Meeting the workforce and clinical needs of rural and remote Australia;
- Early entry and ongoing support;
- Curricula training and assessment;
- Qualifications;
- Management and organisational oversight;
- Impact on established programs;
- Availability of advanced training positions; and
- Recognition.

For details of the principles:

Meeting the health needs of rural and remote Australia through an integrated strategic framework – an Advanced Rural Training Program

Further reading:

AMA Position Statement - Fostering Generalism in the Medical Workforce 2012

Employment of generalist medical practitioners 2017

3.3. Work Environment

Infrastructure and Facilities

The Commonwealth and State/Territory Governments must work together to ensure that rural hospitals are adequately funded to meet the needs of their local communities. They need modern facilities, and must be able to attract a sustainable health workforce. Our rural hospitals must provide an environment that is conducive to delivering:

- quality patient care;
- a 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.

Further reading:

AMA Position Statement: Workplace Facilities and Accommodation for Hospital Doctors - 2006

AMA Position Statement: Safe work environments - 2015

The AMA believes that Council of Australian Government (COAG) discussions about the reform of health care must consider a dedicated funding stream for rural hospitals, backed by a national benchmark and performance framework, to ensure that State/Territory Governments maintain the level of services that is promised to local communities.

The AMA recommends that the Government continue to fund rural GP infrastructure grants. Previous rounds of infrastructure grant funding have delivered results for rural communities,[11] 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. For more see the AMA Plan for better health care for regional rural and remote Australia 2016.

The role of the internet and telehealth

The development of medical and communication technology has the potential to deliver significant benefits to rural medicine. The health sector needs telecommunications connectivity for health service delivery and management, including high resolution image transfer, doing business with Government and complying with Government requirements, continuing professional development and videoconferencing, online education, clinical decisions and other support. Doctors living in rural locations rely on access to the internet for private use to maintain support networks, complete personal administration and more.

To effectively leverage telecommunications technology to deliver better health outcomes at lower cost in rural areas and to implement new models of health care, both mobile and broadband technology must be ubiquitous, reliable, affordable, and supply adequate capacity.

However, the use of telehealth and telemedicine in rural Australia remains patchy and is not used to full potential because of no, or inadequate, internet access. As mainstream healthcare provision becomes increasingly technology based and requires more and faster broadband services to operate, there is a real risk that rural areas will be left further and further behind in their ability to provide quality health services.

The Government needs to ensure that high-speed broadband is available to the same standard and at the same cost to all communities, businesses and services across the whole of Australia. Improved Internet services will not eliminate the need for more doctors in rural areas and proper funding and staffing for rural hospitals.

Further reading: AMA Position Statement - Better Access to High Speed Broadband for Rural and Remote Health Care 2016

3.4. Support for Doctors

Personal circumstances

For doctors in rural locations, particularly those that have relocated, arrangements need to ensure that they can access quality accommodation, understand the availability of local services and how to access them, and there is support for their general wellbeing.

Isolation can also be a problem for rural doctors. The toll on an individual's mental health can be acute, not only for social networks but also for feeling connected professionally. When doctor's relocate to a rural location they can find it more difficult to maintain a robust and supportive network of colleagues. There needs to be support from organisations, particularly Colleges where rural doctors train, to ensure networks are built and maintained.

Community and Practice Support

The Commonwealth Government should continue to provide funding grants to allow local governments in rural areas to purchase facilities to support medical practitioners such as housing/practices/equipment, so that practitioners can operate a practice on a walk-in walk-out basis. The costs of establishing a practice have been nominated as one of the major disincentives to doctors who might otherwise relocate to an area of workforce shortage.

Further reading: AMA Position Statement - Easy Entry, Gracious Exit Model for Provision of Medical Services in Small Rural and Remote Towns 2014

Indigenous Health Professionals

There is a strong link between the health of Indigenous people in rural communities and their access to culturally appropriate health services. The AMA believes that:

- greater effort should be made to encourage Indigenous people to undertake medical or health professional training, and incentives provided to encourage Indigenous and non-Indigenous doctors and medical trainees to work in rural and remote Indigenous communities;
- Aboriginal Medical Services should be resourced to offer mentoring and training opportunities in rural Indigenous communities to Indigenous and non-Indigenous medical students and vocational trainees; and
- training modules, resource material and ongoing advice should be developed for, and delivered to, all medical schools and rural and remote medical practices on Indigenous health issues, Indigenous-specific health initiatives and culturally appropriate service delivery.

Locum Services

Locum services are a key element to addressing the problems of high workload for rural practice. Lack of time off for professional development, family responsibilities and recreation can be among the most negative aspects of life as a rural doctor. The Commonwealth Government should continue to support local programs, including those coordinated by the rural workforce agencies and medical

colleges, and where appropriate provide increased support based on the needs of particular communities.

Family Support

The decision for a doctor to relocate or practise on a medium to long-term basis in rural areas also has a significant impact on their family. Where a partner works or children are at school there may be considerable direct or opportunity cost and loss of amenity from a decision to move to rural practice. Simply paying a medical practitioner more, while helpful, does not address the full dimensions of the problem and ignores significant factors in any individual's decision-making process when considering rural practice.

There should be adequate compensation, support and access to re-training if required, so that a partner or spouse can remain employed in an acceptable occupation if their partner moves to a remote area. Job seeking assistance should also be offered if required. If the family requires assistance to maintain a child in school in a larger town or city centre, there needs to be school fee assistance, given the possible requirement for boarding and other increased services or tuition.

International Medical Graduates

The AMA recognises the substantial contribution that International Medical Graduates (IMGs) make to the medical workforce and the delivery of health care in Australia, particularly in providing patients with access to care in rural and remote communities. Australia has a strong reliance on IMGs, which make up over 40 per cent of the medical workforce in rural and remote areas.[12]

It is in the interests of the profession and the public that appropriate, clearly defined and transparent standards are in place to govern the assessment, recruitment and training of IMGs, and that every effort should be made to support IMGs to enhance their long-term contribution to the medical workforce. Though they do an excellent job, Australia cannot continue to rely on them indefinitely to fill workforce gaps.

Further reading: AMA Position Statement - International Medical Graduates 2015

Nurses and multidisciplinary team care

Multidisciplinary team care involves professionals from a range of disciplines, such as dieticians, physiotherapists and non-dispensing pharmacists in general practice, working as a GP led team to deliver comprehensive care that addresses as many of the patient's needs as possible. General practice nurses and other members of a multidisciplinary health care team make a valuable contribution to the delivery of primary health care services in rural areas.

The AMA believes funding arrangements must reflect and support the full range of work undertaken by practice nurses for and on behalf of GPs in rural areas. Specific loadings for the cost of employing practice nurses in rural areas should continue.

While the AMA does not support a role for independent nurse practitioners, this does not preclude the capacity for highly skilled nurses, working as part of a collaborative primary care team led by one

or more GPs to be supported in the delivery of services to remote areas where access to health care is often very difficult. These nurses should:

- have appropriate clinical experience and training; and
- be supported through the provision of appropriate communication technologies to ensure that treatment can be properly co-ordinated with the supervising GP(s).

3.5. Financial Incentives

The AMA and the RDAA have developed 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. Other areas of skills need may be added as required, for example palliative care, paediatrics, or Indigenous health, to ensure that community needs are met.

Further reading: Building a sustainable future for rural practice: the AMA/RDAA Rural Rescue Package 2016

Funding for Outreach Programs

Outreach programs to provide funding assistance for specialists visiting rural and remote areas are a valuable means to enhance the delivery of services in these areas. These programs should be adequately funded and based upon the following principles:

- services must be directed to communities where an unmet need is established by the local medical practitioners;
- services must be designed to fit in with local healthcare services, and wherever possible they should include up-skilling and other measures to enhance the sustainability of local medical services;
- funding must be available to existing outreach services; and
- there should be strong medical college involvement in outreach programs in order to encourage greater participation and services should not be withdrawn without consultation with local practitioners and the local community.

[1] Hoang H, Le Q, and Kilpatrick S., 'Small rural maternity units without caesarean delivery capabilities: is it safe and sustainable in the eyes of health professionals in Tasmania?', *Rural and Remote Health,* 12: 1941. (Online) 2012. (http://www.rrh.org.au/articles/showarticlenew.asp?ArticleID=1941)

[2] According to *Australia's Health 2016* (pg47), the number of full-time equivalent medical practitioners per 100,000 people in 2014 in major cities was 437, compared to 292 in inner regional areas, 272 in outer regional areas, and 264 in both remote and very remote areas.

[3] Medical Schools Outcomes Database National Data Report 2015, http://www.medicaldeans.org.au/wp-content/uploads/Medical-Students-Workforce-Survey-Report-FINAL-14102015.pdf.

[4] McGrail, Matthew R., and Russell, Deborah J., 'Australia's rural medical workforce: Supply from its medical schools against career stage, gender and rural-origin', *Australian Journal of Rural Health*, 5:1, November 2016.

[5] Rural Health Workforce Australia National Minimum Data Set (MDS), Reports 2012, 2013 and 2014, http://www.rhwa.org.au/fact-sheets--research---workforce-data.

[6] Ibid. On average, regional, rural and remote GPs worked a total of 40.9 hours per week in 2014, compared with a mean average of 37.6 hours per week for GPs in major cities. GPs working in very remote Australia work (on average) an extra 9.1 hours per week compared with those working in major cities.

[7] Ibid.

[8] Rural Health Workforce Australia Fact Sheet, GP Workforce Trends, January 2016, http://www.rhwa.org.au/client_images/1770753.pdf.

[9] There were 9,158 GPs recorded as working in rural and remote Australian in 2016, a 5.8% increase compared to the previous reporting period. For more see Rural Health Workforce Australia (2017), 'Medical practice in rural and remote Australia: Combined Rural Workforce Agencies National Minimum Data Set report as at 30 November 2016', Melbourne: RHWA, https://www.rwav.com.au/wp-content/uploads/2016-National-MDS-Report-30-November-2016.pdf

[10] 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', *The Medical Journal of Australia*, 205 (5), 216-222, https://www.mja.com.au/journal/2016/205/5/vocational-training-general-practitioners-rural-locations-critical-australian.

[11] 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

[12] AMA International Medical Graduates 2015 Position Statement.