



AMA

2016 AMA RURAL HEALTH ISSUES SURVEY REPORT – RURAL DOCTORS HAVE THEIR SAY

Summary

Report on the results of an AMA survey of rural doctors, outlining their views on key solutions to improve rural health care delivery in regional, rural and remote Australia.

1. Introduction

Health care in rural areas depends on a strong GP 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.

Rural Australians often struggle to access health 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.

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, 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.

2. Survey methodology

The AMA's Rural Health Issues survey was conducted during April 2016, with 594 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; CPD; 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.

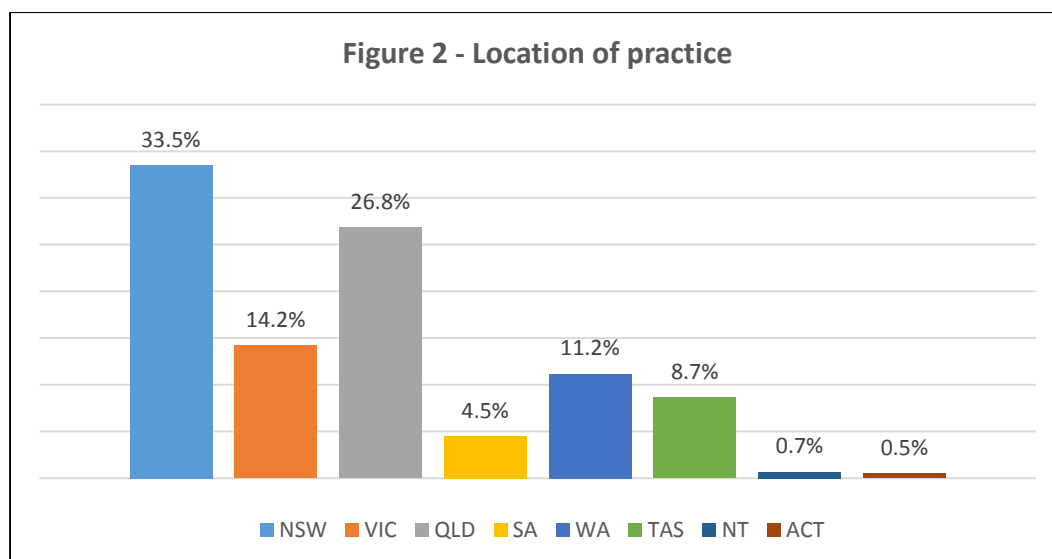
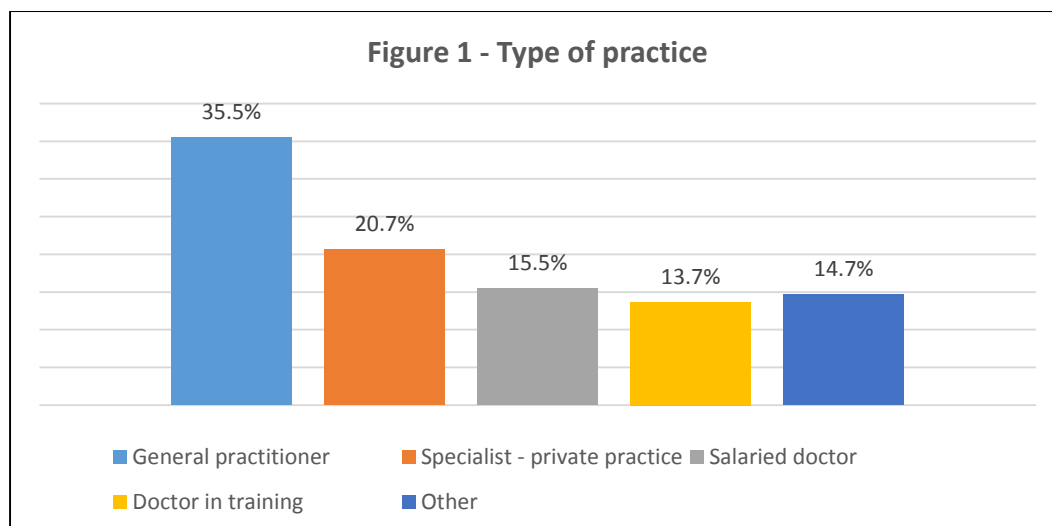
3. Survey results and discussion

3.1 Participation

Rural doctors were given four weeks to complete the survey. The survey, which closed on 29 April 2016, was completed by 594 respondents.

3.2 Demographics

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



Rural GPs accounted for 33.5 per cent of the responses, followed by specialists in private practice (20.7%), salaried doctors (15.5%), doctors in training (13.7%) and other (14.7%). A number of respondents nominated the “other” category that included: rural generalists, locums, and Visiting Medical Officers (VMOs).

With regard to location of practice, New South Wales accounted for 33.5% of responses, followed by Queensland (26.8%), Victoria (14.2%), Western Australia (11.2%), Tasmania (8.7%), South Australia (4.5%); Northern Territory (0.7%) and Australian Capital Territory (0.5%).

3.2 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 ten 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 occupational groups.

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

Proposed Solutions	Overall Ranking	GPs	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	2	1	2	1	1
<i>Access to high-speed broadband for medical practices, encompassing general practice and specialist practice</i>	2	1	4	1	3	4
<i>Ensure that rural hospitals have modern facilities and equipment</i>	3	4	2	6	6	2
<i>Encourage medical colleges to include rotations for trainees to rural areas - subject to appropriate experience and supervision</i>	4	7	3	3	13	3
<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	6	7	5	7
<i>Ensure general practitioners with recognised procedural skills can access appropriate hospital credentialing and facilities</i>	6	3	14	10	2	12
<i>Establish regional training networks to enhance opportunities for specialist training in rural areas and support rurally based career paths</i>	7	11	9	5	8	6
<i>Establish more integrated programs to allow rural doctors to maintain and upgrade their procedural skills in public hospitals</i>	8	9	11	4	4	9
<i>Further expand funding to ensure locum relief for rural general practitioners and specialists</i>	9	6	5	11	11	14
<i>Increase funding for appropriately trained ancillary staff at rural hospitals</i>	10	14	7	13	12	8

The AMA conducted a similar survey in 2007, which was the first widespread survey of its type conducted in Australia. While some of the policy measures highlighted in the 2007 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. Notably, two new policy priorities have been identified in the 2016 survey being:

- the need for access to high-speed broadband for medical practices, encompassing general practice and specialist practice; and
- establishing regional training networks to enhance opportunities for specialist training in rural areas and support rurally based career paths.

Table 2 Comparison of proposals overall ranking - 2016 vs 2007 survey

Proposed Solutions	Overall Ranking	
	2016	2007
<i>Provide extra funding and resources to support improved staffing levels, including core visiting medical officers, to allow workable rosters</i>	1	1
<i>Access to high-speed broadband for medical practices, encompassing general practice and specialist practice</i>	2	N/A
<i>Ensure that rural hospitals have modern facilities and equipment</i>	3	4
<i>Encourage medical colleges to include rotations for trainees to rural areas - subject to appropriate experience and supervision</i>	4	6
<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>Ensure general practitioners with recognised procedural skills can access appropriate hospital credentialing and facilities</i>	6	7
<i>Establish regional training networks to enhance opportunities for specialist training in rural areas and support rurally based career paths</i>	7	N/A
<i>Establish more integrated programs to allow rural doctors to maintain and upgrade their procedural skills in public hospitals</i>	8	8
<i>Further expand funding to ensure locum relief for rural general practitioners and specialists</i>	9	2
<i>Increase funding for appropriately trained ancillary staff at rural hospitals</i>	10	10
<i>Introduce credible, nationally consistent processes of assessment and support for international medical graduates</i>	NA	2
<i>Encourage medical colleges to offer more generalist training places</i>	12	9

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.

3.3 Top 10 solutions for rural health care

Rural doctors often face similar 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 VMOs, to allow workable rosters. 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.

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

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.¹ There has been an increase in the percentage of people in rural and regional Australia who have access to computers at home and the percentage of country people with access to the Internet has more than doubled since 1998. However, use by country people has yet to reach the level of use in capital cities, and 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 eHealth solutions to some of the challenges faced by people living in rural and remote Australia. Telehealth services such as video-conferencing, for example, when used appropriately, are emerging as effective ways to complement local health services. They 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

¹ Curtin, J (2012) A digital divide in regional and rural Australia.

http://www.aph.gov.au/About_Parliament/Parliamentary_Departments/Parliamentary_Library/Publications_Archive/CIB/cib0102/02CIB01#intro

- Support people with chronic conditions to manage their health.²

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. It permits their patients to receive specialist care online, and is the backbone for the My Health Record.

The following comments provided in the survey give some insight into the thoughts of rural doctors on this issue:

"Internet services by satellite are slow and time consuming. Reliable internet services at reasonable speed and reliability is critical including library facilities."

"Without broadband improvement telehealth is very difficult. I provided this service in Victoria and Tasmania and had to use mobiles to assist with sound of the video. There is no point pouring money into a system before the infrastructure to support it has been developed."

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. 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 Council of Australian Government (COAG) discussion about 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 are needed by local communities.

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

Evidence shows that providing doctors with training experiences in rural areas early in their career will make them more likely to stay in rural practice. 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.

² NHRA (2013) eHealth and telehealth in rural and remote Australia.

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

Trainees should be encouraged 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.

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. These include the establishment of a Community Residency Program, an expansion of the Specialist Training Program (STP), and the establishment of the Regional Training Networks (RTNs).

The comment below from one rural doctor sums the situation up neatly:

"I cannot stress enough the importance of rotating specialist/vocational trainees into rural posts. The RACS and RACP have done so for years with great exposure and training of prospective doctors for a rural practice. Other colleges must follow suit especially psychiatry, radiology, pathology, O&G, and emergency medicine, to name a few key deficiencies in rural placement or training."

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

General practice is the backbone of rural health care, providing high quality primary care services for patients, procedural and emergency services at local hospitals, as well as training the next generation of GPs. Rural GPs would like to do more, but face significant infrastructure limitations in areas such as IT, 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 GP, nursing, and allied health. Such funding can also support improved opportunities for teaching in general practice for prevocational and vocational trainee doctors, as well as other health professionals.

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.

6. *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 practice 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.

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 comments below reinforce this message:

“Rural hospitals needs to be resourced in order to care for acutely ill patients and for procedural work to be performed.”

“Rural procedural practice needs to be resourced and supported by all parties – country, health services, country hospitals, Medicare, GP training organisations and specialist colleges. Expanding the range of what can be done in the country is preferred by patients and vastly more cost effective for the tax payer and the patient.”

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

The AMA recommends the establishment of 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 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 development of RTNs would help promote careers in regional and rural centres, and improve patient access to medical care by enabling doctors in training to spend a significant amount of their training in rural and regional areas, only returning to the city to gain specific skills.

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

Procedural practice is for many GPs 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.

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 update their skills on a regular basis. Clearly, these proposals would win significant support among rural doctors.

The comments below reinforce this message:

“Rural patients need access to not only well-trained adequately skilled GPs but also access to specialist services that are affordable not only through a hospital but also in the community.”

“Infrastructure in rural areas is being downgraded especially in small centres. Smaller centres are being made referral centres and triage centres for larger hospitals. Many small hospitals have become nursing homes and a local GP has to send a patient out of town if that patient requires hospital admission. In effect GP has no access to a hospital with discontinuity of care for his patients.”

9. *Further expand funding to ensure locum relief for rural general practitioners and specialists*

Rural doctors often carry a high burden for the delivery of health care in rural and remote Australia, and work long hours. Lack of time off for professional development, family responsibilities, and recreation can be among the most negative aspects of life as a rural doctor.

While Governments have in place a number of programs to provide support for locum relief, the results of this survey suggest that more needs to be done to ensure that rural doctors can achieve a better work-life balance, and opportunities for professional development.

The comment below from one rural doctor sums the situation up neatly:

“It’s very difficult to find locum support to take holidays/attend conferences and as the only specialist in my field in all rural WA, extra support to maintain CPD and be able to go on holidays would be nice.”

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

This priority fits neatly with the number one priority - provision of extra funding and resources to support improved staffing levels, including core visiting medical officers, to allow workable rosters.

Clearly, rural doctors want to get on with the job of being doctors. 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.

3.4 Are these the only solutions?

It must be noted that there was very little difference in the value placed on the top ten solutions compared to those just outside the top ten, particularly issues relating to:

educational support (11); generalist training places (12); and recruitment and retention (13).

Educational support

Regional/rural practice often requires doctors to treat conditions with less professional support than would otherwise exist in a metropolitan region. The development of appropriate continuing professional development (CPD) resources and training programs, along with access to locum support, is essential to maintaining high standards of care.

Training providers need to expand the suite of distance learning tools to assist doctors in these locations to develop their skills on an ongoing basis, and links to Rural Clinical Schools should be encouraged.

Generalist training places

There has been a decline in generalism in public and private medical practice and an increasing trend towards sub-specialisation.³ Generalists play a vital role in the health system, as they are able to manage and treat a wide range of health conditions. The shortage of these professionals is felt acutely in rural and regional areas, and patient access to care in rural areas has decreased in line with the trend towards sub-specialisation.

The reasons for the decline in generalism are many and varied, but include lower remuneration for generalists compared to sub-specialists and training models that disadvantage generalism. The decline in generalism in rural and regional areas has been exacerbated by the closure of rural hospitals and procedural units. The high workload of rural generalists and corresponding poor work-life balance also act as disincentives to generalist practice.

The following broad measures should be considered to help arrest the decline in generalism and attract and retain generalists in the medical workforce:

- elevate the status of generalism;
- facilitate greater exposure to generalist practice during undergraduate medical training;
- develop vocational training models that encourage more generalist careers;
- increase state and federal funding for rural generalist positions;
- increase state and federal funding for rural specialist infrastructure; and
- improve the level of remuneration for generalists to encourage generalist practice, including the removal of anomalies in the MBS that reward sub-specialisation over generalism.

Recruitment and retention

Timely access to a doctor is a key problem for people living in rural areas. The overall distribution of doctors is skewed heavily towards the major cities, which means that regional, rural, and remote areas shoulder a disproportionate workforce shortage burden. The number of medical practitioners, particularly specialists, steadily decreases with increasing rurality. For example, in 2013-14, while the number of full time workload equivalent GPs per 100,000

³ Rural Health Workforce Australia National Minimum Data Set (MDS) Reports 2012, 2013 and 2014. (<http://www.rhwa.org.au/fact-sheets--research---workforce-data>)

population in major cities was 102, there were 91 in outer regional areas, 70 in remote areas, and only 57 in very remote areas⁴.

Rural medical practitioners also work longer hours than those in major cities. For example, in 2012, GPs in major cities worked 38 hours per week on average, while those in inner regional areas worked 41 hours, and those in remote/very remote areas worked 46 hours⁵.

Rural Australia is also heavily reliant on international medical graduates. Though they do an excellent job, Australia cannot continue to rely on them indefinitely to fill workforce gaps. With record numbers of local medical graduates, programs are needed that do more to attract these doctors to rural practice and retain them for the long term.

Importantly, the issue is not just about attracting and retaining an adequate number of doctors to rural areas. It is also about having the right skill mix, including GPs, procedural GPs, other specialists, and medical officers.

The AMA and the Rural Doctors Association of Australia (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.

3.5 Rural practice has its rewards

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. And, from participant feedback, it seems there are many.

The survey received hundreds of comments about the rewards of practising medicine in a rural area. These comments fell under a number of broad headings as follows:

Professional satisfaction

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

- Being part of, and having a closer relation with the community;
- Being genuinely needed;
- Holistic care, cradle to grave medicine and the ability to provide continuity of care;

⁴ Australian Government Productivity Commission, *Report on Government Services 2015*, Table 10A.23 *Availability of GPs by region, 2013-14*.

⁵ National Rural Health Alliance, *The little book of rural health numbers: Health Workforce*, 2012 (<http://ruralhealth.org.au/book/health-workforce-0>)

- High level of autonomy;
- High level of trust;
- Satisfaction of servicing a rural population and being appreciated;
- Collegiate environment with rewarding professional relationship;
- Diversity and greater responsibility;
- Personal interaction with patients and staff;
- Getting to see the positive impact you can make in several generations of a family;
- Real ability to make a difference; and
- The financial reward.

The comments below are typical of the feedback provided:

“Being part of the community and having my patients as my friends. Being my own boss - running my practice with no external interference.”

“The teamwork and variety of conditions that come through the door. The ability to have some continuity of care.”

“Personal contact with patients, whole family medicine. Being a source of information to a community. Being valued as a doctor by patients, peers and specialists alike, due to the level of involvement required to provide optimal care.”

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;
- 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;
- Supporting new/younger rural doctors and innovation e.g. telehealth systems that support regional hub and spoke models;
- Working with Aboriginal and Torres Strait Islander people; and
- Challenges to improve standard, quality and safety of work with limited resources and infrastructure.

The comments below are typical of the feedback provided:

“Range of work and presentations as well as the ability to perform procedural work. Being able to provide cradle to grave care for families.”

“The most rewarding aspect of Rural practice, as a JCCA-Anaesthetist, is the added value I am able to bring to rural hospitals through having had diverse clinical experience in critical care, retrieval medicine as well as anaesthetics and General Practice.”

“The challenges presented by a (comparatively) resource poor context - builds clinical acumen & resourcefulness.”

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 moved to the country last year, having grown up in the city, largely because of good rural terms in that town as a JMO and registrar, better lifestyle, extra financial incentives, a clear need for my services and a willing partner, also a doctor.”

“People are friendly. You live with nature. Fresh air. People treat you well. They make you feel welcome.”

“Rural lifestyle. Affordable housing, no traffic, getting involved with community activities and actually being a valuable member of the extended community. Feeling that what I do actually makes a difference.”

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;
- 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:

“Working within a community of people that I know, and being able to see real improvements and differences that I have helped to make.”

“I enjoy the breadth of practice and the sincere appreciation of patients who feel they receive the standard of care for their medical condition in their rural environment without needing to travel out of town to a major metropolitan centre.”

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;
- 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:

“Caring for people in my community gives me great satisfaction.”

“Relationships with patients and staff from our rural hospital. Particularly, long term relationships with many generations of one family and the privilege of being involved in their healthcare.”

“Small towns often appreciate what little I could do for them. Being welcomed by the community. Lifestyle of small town living. Independence of practice, and having to think for myself.”

4. Conclusion

The 2016 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 could be taken and the solutions that could be adopted in order to improve rural health care.

The AMA Rural Health Issues Survey received remarkably consistent responses across all doctor groups and across all states and territories. Rural doctors identified the need for Improved funding for rural hospitals, better access to high-speed broadband, greater exposure to rural practice for junior doctors, expanded rural infrastructure grants to improve patient access to services and support teaching activities, easy access to hospital credentialing, improved training arrangements, support for procedural skills, and time off to prevent burnout.

These solutions can and must be tackled. None of them is an unrealistic proposal, and they would do a great deal to improve the provision of health care to people living in regional, rural and remote Australia. The solutions identified in this survey should form the basis for future work. The AMA believes now is the time for the Federal Government to develop comprehensive plans for health care in regional, rural, and remote Australia, and commit to 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 positives aspects of rural practice. Country practice is a true calling, and a rewarding one.

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
Provide extra funding and resources to support improved staffing levels, including core visiting medical officers, to allow workable rosters	86.6	1
Access to high-speed broadband for medical practices, encompassing general practice and specialist practice	83.8	2
Ensure that rural hospitals have modern facilities and equipment	83.1	3
Encourage medical colleges to include rotations for trainees to rural areas - subject to appropriate experience and supervision	81.6	4
Increase the available support for infrastructure, resources and supervision to support the training of more doctors in training in rural areas	80.5	5
Ensure general practitioners with recognised procedural skills can access appropriate hospital credentialing and facilities	80.3	6
Establish regional training networks to enhance opportunities for specialist training in rural areas and support rurally based career paths	79.3	7
Establish more integrated programs to allow rural doctors to maintain and upgrade their procedural skills in public hospitals	79.3	8
Further expand funding to ensure locum relief for rural general practitioners and specialists	79.0	9
Increase funding for appropriately trained ancillary staff at rural hospitals	77.7	10
Improve access to educational support for rural doctors including CPD and mentoring	77.5	11
Encourage medical colleges to offer more generalist training places for trainees	77.3	12
Increase incentives, such as rural incentive payments, to recruit/retain doctors to work in rural areas	77.1	13
Develop specific initiatives to improve access to specialist services	76.7	14
Increase funding for specialist outreach services, appropriately integrated with local services	76.2	15
Implement a funding program to support prevocational doctors to undertake rotations in rural general practice settings	75.2	16
Increase funding for patient assisted travel schemes for patients (including their carers) who must travel long distances for hospital treatment	72.0	17
Improved funding for rural maternity services	71.7	18
Introduce a public interest test to apply before a rural hospital can be closed or downgraded	71.7	19
Provide general practice infrastructure grants to support enhanced medical and/or allied health services or improved training facilities	71.3	20

Improve access to employment opportunities for rural doctors' partners and/or family members	71.2	21
Increase the number of medical students who undertake at least a one year rural clinical placement (s)	70.8	22
Expand Medicare rebates to cover GP video consultations with a usual GP for rural patients who live some distance from a GP	70.8	23
Improve access to education for rural doctors' family members through better infrastructure or financial support	70.4	24
Provide funding to small rural general practices to assist with the costs of undertaking and maintaining practice accreditation	69.4	25
Encourage all State Government hospital outpatient clinics to offer telemedicine consults to rural patients and increase the number of urban specialists providing telehealth consults	68.1	26
Establish tied funding for rural hospitals, including requirements for state/territories to meet agreed performance benchmarks	68.0	27
Strengthen scholarship based programs to support medical students from a rural background	67.8	28
Expand the eligibility criteria so more specialists are able to qualify for rural workforce incentive payments	65.0	29
Increase the intake to medical schools of students with a rural background	64.7	30
Develop targeted incentives to encourage rural doctors who are 55 and over to delay retirement	63.9	31