Rural Doctors Foundation.

Caring • Committed • Connected

Research report

The health of our rural practitioners 2023

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Editor: Amanda Bailey

Rural Doctors Foundation acknowledges the ongoing dedication of rural doctors, their colleagues, family and community members to provide caring, committed health care in rural Australia. The Foundation supports and encourages their ability to connect with each other to overcome adversity, focusing on better health outcomes for generations of rural Australians.

Our Vision, Purpose and Values

Our vision

Rural doctors for rural communities.

Our purpose

To support better health in rural and remote communities.

Our values

Courage: We will act with conviction and integrity and take informed risks.

Trust: We will be credible, reliable, connected and selfless.

Care: We will be diligent, compassionate, responsive and effective.

We acknowledge and extend our sincere respect and appreciation to the Turrbal People – the traditional Owners of the land on which our office is located. We also acknowledge the Traditional Custodians of the lands where we implement our programs. We acknowledge their connections to land, sea and community. We pay respect to their ancient and continuing cultures, and to their Elders, past, present and emerging.

Image acknowledgments:
Cover – Dr Michael Rice
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Foreword

As a practice GP and Obstetrician at Beaudesert Hospital, I was accustomed to advocating for my patients, and particularly mothers throughout their pregnancies as they welcomed their newborn infants into the world. It wasn't until the pending closure of our maternity unit was announced that I found my voice to bring broader public awareness to issues that affect the health outcomes of people living in rural and remote areas and the challenges of rural practice. That journey led me to the Rural Doctors Foundation, and I am delighted as Chair to support the release of this report. It captures the passionate concerns of fellow medical practitioners for the health of the communities and the GPs that serve them with dedication.

I am proud this research will raise awareness about the health challenges face by rural practitioners and their communities, and of the Foundations unwavering commitment to fulfilling the healthcare needs of those living in rural and remote communities.

Dr Michael Rice
Chair

Throughout my career, I have witnessed the power of research to change hearts and minds and bring awareness to important issues. As the CEO of Rural Doctors Foundation, it is my honour to shine a light on rural and remote communities' needs and amplify the voices of the medical practitioners who know those needs best and whose dedication often leads them to neglect their own health and wellbeing.

This survey is no mere listening exercise, the views shared across these pages are helping to shape a pilot program that addresses the needs expressed by rural practitioners – a program that has the Board's full support. I hope that once you connect with the challenging conditions doctors and communities face, you'll be compelled to support us on this journey. Together, we're creating meaningful change to give people in rural and remote regions better access to lifesaving healthcare.

Fran Avon
Chief Executive Officer

Executive Summary

The survey aims to identify the most pressing challenges experienced by rural and remote General Practitioners (GPs), health practitioners, and the communities they serve.

Around 7 million people – or 28% of the Australian population – live in rural, regional and remote areas. Despite their number, people in these communities experience many disadvantages compared with their urban counterparts. Population health research consistently presents a glaring geographic inequality that threatens to worsen due to critical health workforce shortages and poor access to healthcare.

The survey aims to identify the most pressing challenges experienced by rural and remote General Practitioners (GPs), health practitioners, and the communities they serve.

This report presents evidence and reflects the personal experiences, pressures and challenges facing the dedicated and vital health workforce who are the lifeblood of Australia's rural and remote regions. The results of this survey will be used to assess the potential for introducing a service to meet these needs.

The well-documented issue of rural workforce shortages is being borne by medical practitioners who continue to work long hours to meet their community's healthcare needs. Almost a quarter of respondents (23%) working more than 60 hours per week. Lack of work-life balance will make working in rural and remote regions less attractive to new recruits.

Medical practitioners in rural and remote areas are not only time-poor but are in high demand, with 52% of respondents working multiple roles to meet community needs. As a result, they are more likely to experience pressure from 'work commitments' that overtake self-care health behaviours such as taking leave and seeking healthcare services when needed. This is particularly true of remote and very remote areas (Modified Monash Model 6-7), where 32% of respondents were the only medical practitioner in their town.

Access to healthcare is a challenge for GPs and their patients alike, with 42% of medical practitioners needing to travel out of town and 20% travelling more than 800kms to receive independent and confidential healthcare. For medical professionals working in remote communities (MM 6-7), the vast majority (70%) received no work relief to attend to their health.

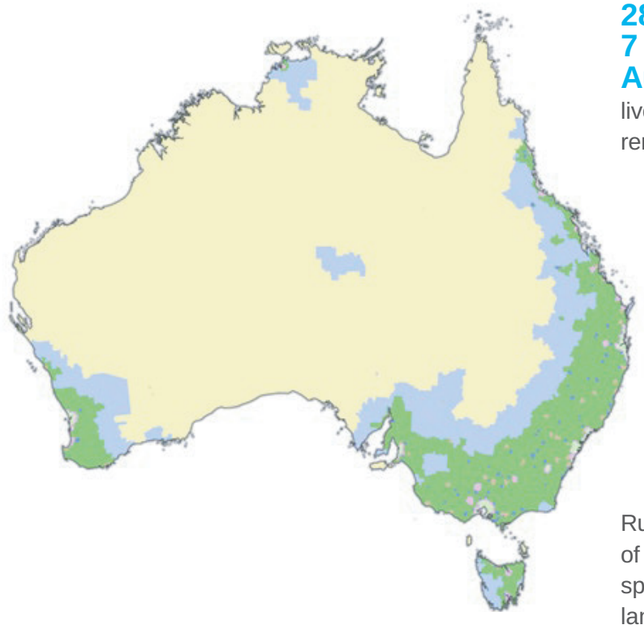
When respondents where asked whether there is a need for a GP service specifically for health practitioners in rural communities, (57%) indicated that a GP service to support the health practitioners is needed. This interest was even higher from respondents living in remote to very remote regions. Any such service would need to reflect medical practitioners' desire for primary care to be delivered face-to-face and as such, would be complementary to existing services.

Supporting our rural and remote medical practitioners is critical to ensuring the health outcomes of people in these communities who are responsible for 90% of the food on Australian tables and the resource boom driving our nation's predicted budget surplus. Rural and remote communities deserve the right access to health services they need, when they need them, no matter where they live. It is time we listen to the needs of our rural medical practitioners who are at the very centre of their communities. It is imperative that support is provided to rural health practitioners if we are to keep them in their community, and we must take action.

State of **rural health in Australia**

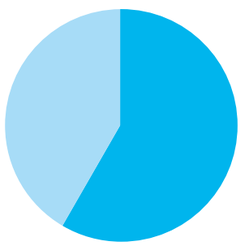
Rural Australia, a snapshot

MM1	Metropolitan
MM2	Regional centres
MM3	Large rural towns
MM4	Medium rural towns
MM5	Small rural towns
MM6	Remote communities
MM7	Very remote communities

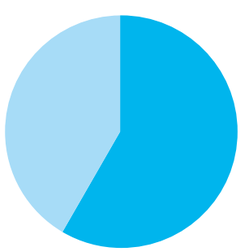


28% or
7 million Australians
live in regional and remote areas[2]

Rural Australia comprises of **12,670** localities and spans **99.3%** of our land mass[12]



Rural Australia contributes approximately **67%** of the value of **Australia's exports** come from regional, rural and remote areas[14]



Rural, regional and remote localities contribute **two-thirds** of Australia's export earnings, including **$400 billion** yearly in resources and agricultural exports[12]

Australians in rural and remote areas face poorer health outcomes

People living in rural and remote areas have higher rates of **hospitalisation, deaths, injury and poorer access** to, and use of primary health care services, than those living in major cities[14]

Australia's total burden of disease and injury increased with increasing remoteness. **Fatal burden rates** were **1.8 times** as high as that of major cities[4]

Rural and remote areas experience a **higher incidence of disease** and **increased health burden**[4]

Life expectancy at birth is **lower** for people living outside of metropolitan areas[4]

Rural, regional and remote areas experience a higher incidence of disease and increased health burden

Coronary **heart disease** was the **leading cause of death** across all remote areas[4]

People living **outside of major cities** had **higher rates** of arthritis, asthma and diabetes[1]

The incidence rate of all cancers combined was **highest in regional areas**[4]

The disease burden due to suicide and self-inflicted injuries in remote areas is **2.2 times that of cities**[13]

Access to healthcare drives poor health outcomes

Australians living in remote areas travel long distances or relocate for healthcare or to receive specialised treatment. **44,930** people in remote and very remote areas had no access to primary healthcare within a **60-minute drive** of their homes[17]

Conversely, Medical **Practitioners make** rural, regional and remote **locations liveable**[16]

General practice is the most accessed sector of the healthcare system. It is foundational to the full range of health services available. Therefore, the health of Australian **general practice** is **essential** to the health of the Australian nation[15]

Australians living in remote and very remote areas experience health **workforce shortages**, despite having a **greater need for medical services** and practitioners with a broader scope of practice[6]

Challenges facing rural medical practitioners

The health and wellbeing of rural doctors is critical to ensuring the health outcomes of the communities they serve.

Critical workforce shortages

- There is a marked decline in the rate of full-time equivalent (FTE) medical practitioners per 100,000 population once outside of major cities. The number of employed FTE clinicians decreases with increasing remoteness – with **2.5 doctors per 1,000** people in rural and remote areas vs. 4.1 per 1,000 in urban areas[5]
- GPs working in remote and very remote areas were more likely to **indicate they intend to retire** in the next ten years than GPs working in major cities[15]
- Changes to Distribution Priority Areas saw a more than 50% increase in the **movements of GPs from rural and remote areas** to newly included areas such as regional cities in the second half of 2022.[8]

Mental strain, burnout and longer working hours

- GPs reported substantially **higher rates of psychological distress** and suicidal thoughts than the Australian population and other Australian professionals[9]
- Globally, rates of clinician burnout have been reported ranging from **25-75%**, with Australian levels averaging higher at **65-75%.** Doctors have higher levels of very high psychological distress (3.4%) than the general population (2.6%) and other professionals (0.7%)[7]
- Almost three in four GPs (73%) reported they had experienced feelings of burnout over the past 12 months. **Burnout is the second most cited reason for retiring**, leaving practice, or reducing hours[15]
- **Rural doctors work longer hours supporting patients** with a higher incidence of all major diseases, with fewer nurses and a smaller allied health workforce to coordinate care with.[6]

Impact on medical practitioners health

- GPs often diagnose **burnout in their patients** but may **turn a blind eye to their symptoms** of stress and burnout[15]
- **32%** of Australian doctors experience high levels of emotional exhaustion[11]
- **Isolation is a key risk factor** for poor health amongst all health professionals, particularly those working in rural placements[3]
- Rural GPs experience the **same challenges accessing healthcare as their patients** do, and in remote areas often need to engage locum relief to attend to their health.

Rural GPs need doctors too

"Having a listening ear can be just as important as someone monitoring your physical health."

Dr Sue Masel – Deputy Chair – Rural Doctors Foundation

Dr Sue Masel has lived and worked in Goondiwindi in western Queensland for 25 years. She works as a rural GP and is incredibly connected to the town.

Growing up in Brisbane, her passion for rural medicine was the surprising outcome of an early career placement.

"In my second year out, they sent me to Goondiwindi… it was more difficult than I anticipated and could have been so much better if I had the skills and training to do it properly. So, I returned to Brisbane and did more of the jobs that would give me those skills, including a Diploma of Obstetrics," Sue says.

Sue went on to complete a fellowship in Advanced Rural General Practice Anaesthetics before returning to Goondiwindi for what was to be a six-month period. 25 years later, Goondiwindi is where she and her husband, also a rural GP, have made their home, raised their family and are continuing to serve the community.

"We're two of the five doctors that run Goondiwindi Medical Centre. We're very embedded in the community. You get 10 years into practice and think, 'Oh, I really enjoy this. I'm better understanding what it is I'm here to do," she says.

"Yet, rural practice is not without its challenges – one of those being accessing health care for yourself. I totally respect the skills and experience of the colleagues that I work with. But, when it comes to my own health care, I need some separation between being a doctor and being a patient. So, I choose to travel to Brisbane for my own health care. This is a 700km round trip. Not only does this take me away from my family and my patients, but it is tiring. Additionally, the need to have another doctor trained in anaesthetics in town to cover while I'm away sometimes means my visit to the GP is delayed. And this is what we tell our patients not to do."

Passionate about advocating for the health of our rural GPs, Sue is excited to have be part of the team developing the program for Rural Doctors Foundation to deliver GP services to rural health practitioners.

She understands the challenges that rural doctors face and knows that speaking with a GP is not just about your physical health – it is about chatting with someone who knows exactly what you are going through. Having a listening ear can be just as important as someone monitoring your physical health.

Methodology

The Rural and Remote Medical Practitioners survey was conducted by Rural Doctors Foundation from December 2022 – January 2023. Respondents were randomly selected and participants opted in of their own accord responding to email invitations and social medial promotion. The online survey was open for 6 weeks.

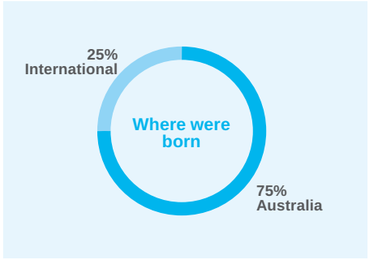
The survey referenced questions previously asked by Health Workforce Queensland with additional items to provide insight into the health needs of rural practitioners and their community.

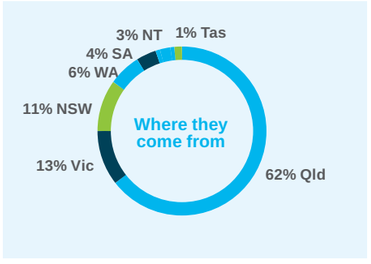
The survey was attempted by 268 respondents across Australia. Results from 126 respondents who completed the survey 80% and above were used to compile the final report.

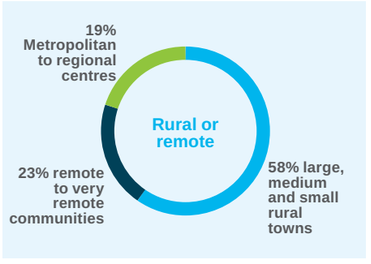
Results were analysed looking at the responses of all participants as well as a more refined analysis based on the participants' location. This was done using the Modified Monash Model (MM).[10] This measures remoteness and population size on a category scale of Modified Monash (MM 1 to MM 7). MM 1 being a major city and MM 7 very remote communities.

Survey respondents covered a wide range of demographics and reflect the rural and remote GP and healthcare community across Australia with a majority of respondents based in Queensland.

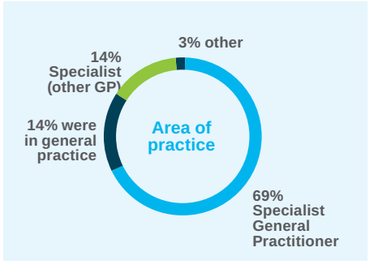
Demographics

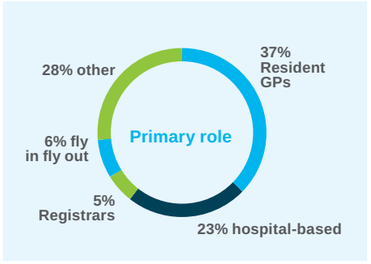






Qualifications and experience





See Appendix 1 for further details.

Results part 1 – **Work-life balance: working hours and taking leave**

The first section of the survey explored typical working hours and respondents ability to take leave and whether they received suitable relief when taking leave. This provides important insight into the work-life balance of rural medical practitioners and provides quantitative evidence of how the challenges of rural and remote medicine translate to increased hours and reduced ability to take leave for rest and recovery.

Unsurprisingly, working and on-call hours increased with increasing remoteness, and work commitments were more frequently cited by respondents working in remote and very remote areas (MM 6-7) as the main reason for not taking leave.

Working hours

26% of respondents were working part-time hours – this is reflective of the trend observed by the Royal Australian College of General Practitioners (RACGP),[15] with the number of GPs opting to work part time hours increasing on average since 2015. In their most recent Health of the Nation report, burnout was the second most cited reason for reducing hours, retiring or leaving practice.

Of those working full-time, 87% of respondents were working more than the prescribed workload of 40 hours per week for medical practitioners. Participants were asked to estimate their working hours over a typical four-week period, including all work relating to the profession, such as clinical practice, medical administration, research, program design, teaching and supervision, but not including on-call hours.

30% of respondents were working up to 50 hours, 34% were working up to 60 hours, and 23% were working more than 60 hours per week. This finding is consistent with surveys of rural doctors conducted by the Australian Medical Association in 2019 for their Rural Health Issues report.[6] This noted that rural doctors work longer hours with patients who have a higher incidence of all major diseases with fewer nurses and a smaller allied health workforce to coordinate care with.

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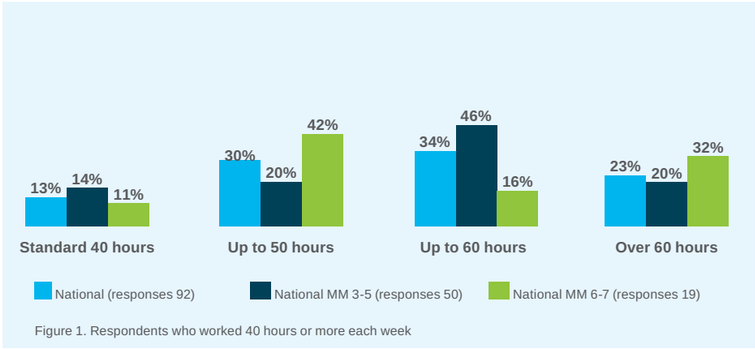

Figure 1. Respondents who worked 40 hours or more each week

Hours worked increased with remoteness – 66% of respondents in rural communities (MM 3-5) were working more than 50 hours per week. Of significance, 32% of respondents in remote and very remote areas (MM 6-7) were working more than 60 hours each week.

Results part 1 – **Work-life balance: working hours and taking leave**

On-call hours

61% of all respondents were on a regular on-call roster, increasing to 74% of those in remote and very remote areas (MM 6-7).

Respondents who were on-call were working a median of five on-call hours per week. Again, this nearly doubles to nine hours for those in remote and very remote areas (MM 6-7).

Taking leave

Encouragingly, 69% of all respondents reported taking four or more weeks of leave in the last twelve months. However, 4% had taken no leave at all, and 19% only took two weeks of leave or less.

Interestingly, 23% of respondents took over six weeks' leave. Further research is needed to explore whether this is a typical result or is due to extended periods without leave since 2020 due to the impacts of the COVID-19 pandemic. It may even be the result of need to take extended leave due to personal health issues or burnout.

Respondents were asked how many weeks of leave they would have preferred to have taken, with 63% indicating they would have preferred to have taken more weeks' leave in the last 12 months. On average, respondents would have preferred to take an additional 3 weeks' leave.

The main reason (53%) cited by all respondents for not taking leave was work commitments. This response increased by remoteness, with 71% of respondents in remote and very remote (MM 6-7) naming work commitments as their main reason.

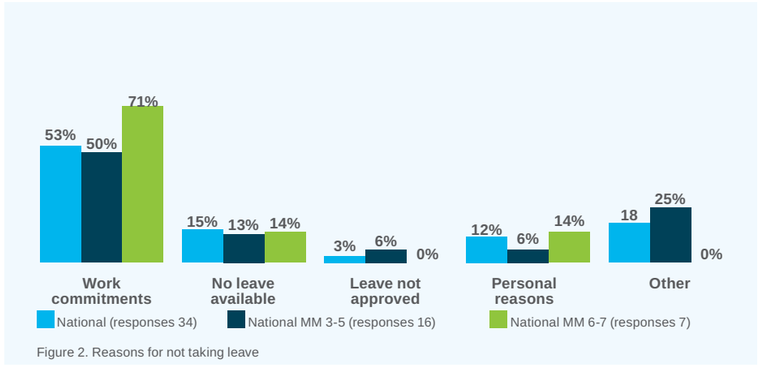

Figure 2. Reasons for not taking leave

Probing deeper, the survey asked whether suitable work relief was available for taking leave. 63% of respondents did not receive or only partially received suitable work relief for these periods. 68% of respondents in rural areas (MM 3-5) did not receive or only partially received suitable relief. Fewer respondents (54%) in remote and very remote areas (MM 6-7) report insufficient relief to take leave.

Results part 2 – **Personal health status, healthcare and wellbeing**

Nationally, respondents on average scored their health at 3.91, giving an overall health rating of just below 'good.' This decreased to 3.87 or 'average to good' for those in rural areas (MM 3-5).

The second section of the survey explores personal health status and access to personal healthcare. It looks at the factors affecting receiving healthcare, including preferences for accessing healthcare and barriers to receiving it.

Respondents were asked to rate the quality of care that both they and their staff receive and to state the impact of not being able to access care. The responses show there is a concerning and persistent inequity of healthcare available in rural and remote areas. This also points to potentially dire effects on the personal health and life of medical practitioners, their families and communities.

Personal health status

Respondents were asked to rate their health on a five-point scale, with one being 'very poor' and five being 'very good'. Nationally, the average score was 3.91, giving an overall health rating of just below 'good'. Health scores were highest for respondents who offer rural health services but live in urban areas (MM 1-2) at 4.05. This decreased to 3.87 or 'average to good' for those in rural areas (MM 3-5) and rebounded slightly to 3.91 in remote areas (MM 6-7). Remote to very remote respondents in QLD (MM 6-7) scored their personal health the lowest at just 3.70.

Personal healthcare

Participants were asked to respond to a series of questions about their personal healthcare, with 84% indicating they had sought healthcare services in the past 12 months. This result was consistent across all location classifications, with 83% of rural (MM 3-5) and 82% of remote respondents (MM 6-7) seeking personal healthcare.

Regarding where the healthcare services were available, 42% said they travelled out of town to receive services, 37% received healthcare from a doctor at another practice, 16% from a doctor within their practice and 5% from a visiting locum.

Respondents in remote and very remote areas (MM 6-7) indicated that circumstances required them to travel out of town (53%) compared to their rural counterparts (45% in MM 3-5). They also more commonly received healthcare from a doctor within their practice (23%) than their rural counterparts (13%). This is indicative of reduced healthcare services available in remote areas, and for these people, the issue of privacy may present a concern.

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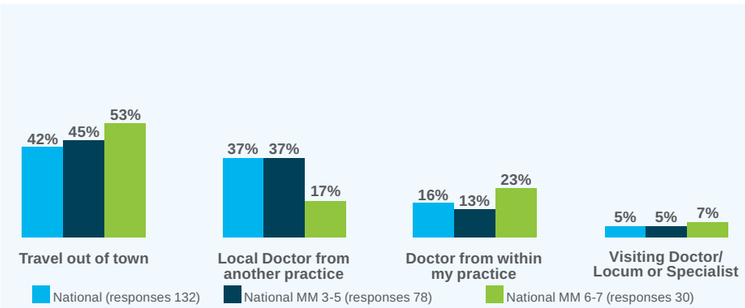

Figure 3. Where respondents received healthcare

Results part 2 – **Personal health status, healthcare and wellbeing**

When asked to indicate the type of healthcare services sought, the most common response was GP (36%), followed by pathology (20%), non-specialist GP care (16%), procedures (14%), counselling (10%) and other services (3%). Results were consistent across varying degrees of remoteness.

Rating the quality of the healthcare they received, the average score was 4.03 or 'good' on a five-point scale where one is 'very poor', and five is 'very good'.

Preferred mode of receiving healthcare

78% of respondents want to receive primary care as a combination of face-to-face and telehealth. More research is needed to understand if there is a desired regular frequency of in-person appointments and telehealth check-ins in between. And also, if there are specific healthcare services that are only suitable to be received in person.

The COVID-19 pandemic has improved options for telehealth services, but while this may increase access for rural and remote areas, medical practitioners are telling us that face-to-face sessions are still essential, in addition to telehealth.

Barriers to receiving healthcare

Reflecting the increasing work pressures experienced by respondents in remote and very remote areas (MM 6-7), 33% said they did not seek healthcare services due to work commitments.

Respondents who had not received healthcare in the previous 12 months were asked to share their reason for not seeking healthcare. 42% of respondents indicated healthcare was not pursued because it was not required, 26% said they had no local access, and 19% were unable due to work commitments.

Of those who had not sought healthcare in rural communities (MM 3-5), 30% indicated there was no local access to the healthcare service they needed. This likely reflects the reduced options for primary or specialist care outside of urban areas.

Reflecting the increasing work pressures experienced by respondents in remote and very remote areas (MM 6-7), 33% said they did not seek healthcare services due to work commitments. 12% of respondents indicated there was no other GP or Specialist services in town, compared to national (6%).

Respondents further specified barriers to accessing healthcare, with the most common barriers being, 'I do not want to be seen by a GP I work with or know' (20%), 'I do not have the time' (17%), 'Concern about privacy and confidentiality' (13%), 'Patient workload' (13%) and, 'There is no-one to replace me' (11%).

Results part 2 – **Personal health status, healthcare and wellbeing**

48% said access was an issue or they needed to be more confident and comfortable with the GP services currently available. 41% indicated that barriers, including workload, time and replacement relief, were an issue.

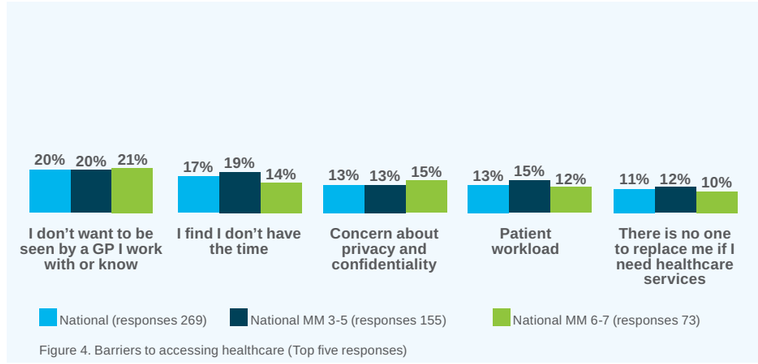

Figure 4. Barriers to accessing healthcare (Top five responses)

Grouping responses into categories showed that 48% said access was an issue or they needed to be more confident and comfortable with the GP services currently available. 41% indicated that barriers, including workload, time and replacement relief, were an issue.

Work relief to receive healthcare

61% of respondents said they did not receive any work relief support to access healthcare for themselves. Lack of work relief increased with increasing remoteness, with 65% of respondents in rural areas (MM 3-5) and 70% of those in remote areas (MM 6-7) receiving no relief support. For some towns, this may result in the community having no access to a GP for an extended period of time.

Distance travelled to receive healthcare

The most telling and significant finding that demonstrates the challenges rural and remote doctors experience in accessing healthcare is represented by the distances respondents travelled to receive essential healthcare. 44% of all respondents travelled over 300km to receive healthcare.

This is significantly higher for respondents in remote and very remote areas (MM 6-7), with 80% reported having travelled over 300km to receive services. Astonishingly, this figure is even higher for remote regions (MM 6-7) in QLD where 90% of people are travelling over 300km (50% travelling over 300km, and 40% over 800km).

44% of all respondents travelled over 300km to receive healthcare

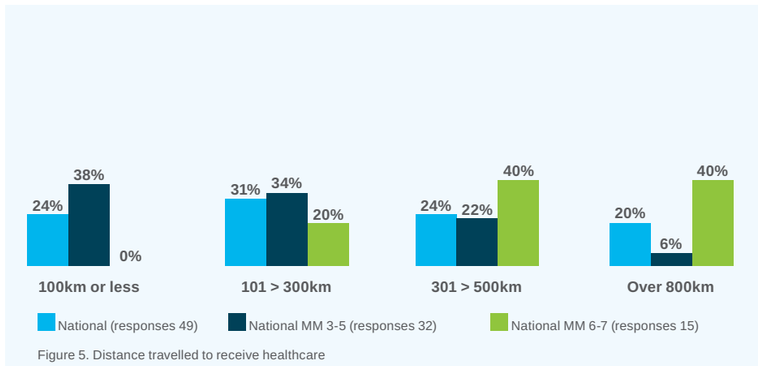

Figure 5. Distance travelled to receive healthcare

Distance to available services

Drilling down on access, 32% of respondents in remote and very remote areas (MM 6-7) indicated there were less than two GPs within 50km, and 50% had less than two practices within this distance. Medical practitioners in rural and remote areas have limited options to see a GP outside of their own practice.

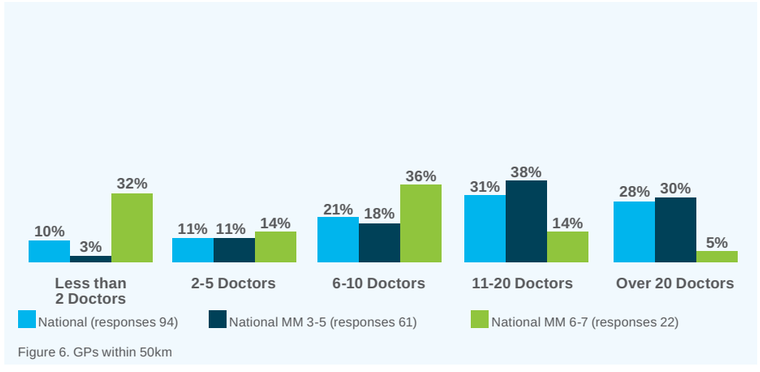

Figure 6. GPs within 50km

Quality of healthcare received

When asked how they would rate the current level of healthcare they received, the average rating was 4.03 out of a five-point scale where one was very poor and five was very good.

The degree of remoteness was a factor again, with respondents in rural areas (MM 3-5) scoring quality of care slightly lower at 3.95 and remote and very remote locations (MM 6-7) at 3.92.

Results part 2 – **Personal health status, healthcare and wellbeing**

Interestingly, when asked about the quality of healthcare their staff receives, they rated the quality of care lower overall, at an average score of 3.81 nationally, 3.89 in rural areas (MM 3-5) and 3.46 in remote areas (MM 6-7).

44% of respondents felt the health practitioners in their town did not receive best practice continuity of care.

44% of respondents felt the health practitioners in their town did not receive best practice continuity of care.

Impact of lack of healthcare

When asked about the impact of being unable to access healthcare, 31% reported it would impact their physical health. 26% said it may potentially impact their personal life and family. 23% of respondents indicated concern about their mental health and wellbeing if unable to access healthcare. Combined, 54% were concerned about the potential impact on physical and psychological health from lack of access to healthcare.

Of concern is the figure that 17% of all respondents and 19% in rural areas (MM 3-5) indicated the impact of not being able to access healthcare would affect their ability to continue practising. For a rural community, losing a doctor could be devastating, particularly with significant health workforce shortages.

Results part 3 – **Health services and community needs**

Part 3 seeks participants' perception of current level of health service provision within their town to measure whether services meet community needs and what additional services are required to help meet current health service gaps. Rural GPs, are uniquely positioned to understand community needs. Rural Generalists operating within a broader scope of practice, including emergency medicine, obstetrics, anaesthetics or mental health services, and primary care services, see firsthand the need for services that are most in demand.

The final questions measured the respondent's interest in additional services to enhance primary care available to health practitioners, including GPs and their teams.

Meeting current community healthcare needs

When asked to rate the current level of healthcare services against community needs on a five-point scale where one is 'very poor' and five is 'very good', the average score was 2.80, or poor to average. Respondents from urban areas and large regional centres (MM 1-2) rated their area's current services at 3.50 or average to good; rural areas (MM 3-5) felt current services were much poorer at 2.65, and the remote regions (MM 6-7) scored 2.62, lower than the national average.

Additional community healthcare services

Survey participants were asked, based on their community's healthcare needs to select what additional services they would like to see made available. The top five most selected additional services nationally were 'Mental health and counselling' (15%), 'Primary healthcare' (14%), 'Psychologist' (14%), 'Dental' (9%) and 'Occupational therapy' 8%.

Rural areas (MM 3-5) scored their preference for services in the same order as the national result, but remote regions (MM 6-7) prioritised 'Psychologist' (14%), 'Dental' (12%), 'Mental health and counselling' (11%), 'Primary healthcare' (10%) and 'Occupational therapy' (9%) to meet their community's needs.

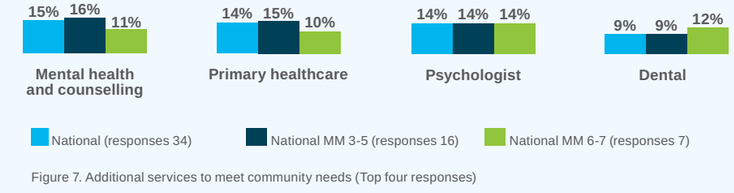

Figure 7. Additional services to meet community needs (Top four responses)

Results part 3 – **Health services and community needs**

Need for dedicated primary care services specifically for health practitioners

When asked about whether there is a need for a GP service to support health practitioners in rural communities, 57% indicated 'yes', 34% were 'unsure', and only 9% felt there was not a need. The need was higher in QLD, with 63% indicating 'yes' and increasing to 71% of QLD respondents in remote and very remote areas (MM 6-7).

Interest in a GP service for rural and remote health practitioners was further expressed, with 90% of respondents willing to make a consulting room available for a visiting GP. 25% of survey respondents also said they would be interested in a doctor exchange program, with a further 40% wanting more information about the program.

77% of respondents indicated that they would like to be informed about new services that could improve access to healthcare for themselves, their team and their community.

Conclusion

People living in rural and remote areas and the health practitioners that support them face barriers to accessing healthcare due to challenges of geographic spread, low population density, limited infrastructure, and the higher costs of delivering rural and remote healthcare.

Critical health workforce shortages deepen despite some 642,000 health practitioners working in registered professions in Australia. Of these, 105,300 were medical practitioners, an increase of 19.7% from 2015 . However, there is a marked decline in the rate of full-time equivalent medical practitioners outside of major cities, with 2.5 doctors per 1,000 people in rural and remote areas vs. 4.1 per 1,000 people in urban areas.

Just over a quarter of the medical practitioners who responded to the survey were working part-time hours (26%), which aligns with trends for medical practitioners who have reduced their hours to achieve greater work life balance, many due to burnout. While this may make the profession more sustainable for individuals, more towns will be left without adequate access to a GP and further health services.

To improve medical professionals' ratings of the current level of healthcare services to meet their community's needs, we must prioritise the health of our dedicated rural practitioners.

Providing an accessible and confidential GP service specific to rural health practitioners will make a significant difference to their health and wellbeing, and to the communities in which they live and work.

Further research into community needs and additional services is required.

Recommendations

1. For the Rural Doctors Foundation to fund, with additional support from our partners, a three-year pilot project and evaluation to provide a continuity of care confidential GP service to rural practitioners in selected towns. Delivered by visiting GPs trained in doctor-to-doctor practice.
2. For the Rural Doctors Foundation to conduct the rural and remote health practitioners and community needs survey on a regular basis, to continue to elevate the voices and needs of rural doctors and to highlight the critical community health needs for future investment.
3. For Rural Doctors Foundation to continue advocacy, along with peak professional bodies including associations, medical colleges, and health networks to:
   - commission further research to identify critical workforce shortages, quantify impacts to the health and wellbeing of medical practitioners and their communities, and to assess the demand for additional services in rural and remote areas
   - influence government health policy to meaningfully address critical workforce shortages and increase incentives to recruit and retain doctors in rural and remote Australia
   - achieve recognition of Rural Generalist Medicine as a specialised field within general practice.

APPENDIX 1

Methodology

State/Territory	Respondents
Queensland	76
Victoria	16
New South Wales	14
Western Australia	7
South Australia	5
Northern Territory	4
Tasmania	1

Table 1. Respondents by State.

MMM Classification	Respondents
1	10
2	13
3	16
4	26
5	29
6	15
7	13

Table 2. Respondents by Modified Monash Model classification.

Survey design

The primary research survey was aligned with the Health Workforce Queensland Survey, “Medical Practitioners in Rural, Remote and Regional Queensland”.

Additional questions were added to understand the health needs of GP and to test the need for GP services for GPs and Health Practitioners. The draft survey was tested with telephone interviews with Dr Michael Rice, Professor Tarun Sen Gupta, Dr Dan Halliday, Dr Michael Clements, and Dr Konrad Kangu. Based on their invaluable feedback, minor amendments were made.

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https://www.handnhand.org.au/

Health Workforce Queensland
https://www.healthworkforce.com.au/

Lifeline
https://www.lifeline.org.au/

National Rural Health Alliance
https://www.ruralhealth.org.au/

Primary Health Networks
https://www.health.gov.au/our-work/phn/your-local-PHN

Queensland Health
https://www.health.qld.gov.au/

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https://www.racp.edu.au/fellows/wellbeing/resources

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https://www.racgp.org.au/racgp-membership/member-offers/the-gp-support-program

Rural Doctors Association Australia
https://www.rdaa.com.au/

Rural Doctors Association Queensland
https://www.rdaq.com.au/

Suicide Call Back Service
https://www.suicidecallbackservice.org.au/

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