



# AMA RURAL HEALTH ISSUES SURVEY



**AMA**

RURAL DOCTORS HAVE THEIR SAY ON  
KEY SOLUTIONS  
TO IMPROVE  
RURAL HEALTH CARE DELIVERY

May 2007

## FROM THE AMA PRESIDENT



Throughout my Presidency, I have visited many regional centres, towns and villages right across the country to observe and share the experiences of our hardworking rural doctors and their patients.

No matter where I visit, the stories are the same. Hospital closures and downgrading, outdated equipment, long working hours, the continuing reliance on overseas trained doctors who are given little support, insufficient funding for outreach services, and the lack of quality training opportunities for young doctors are all common themes.

The AMA Rural Health Issues Survey has collated all the stories and anecdotes about rural medicine and turned them into a disturbing snapshot of a rural health system in crisis. But there is hope, too.

Just as our rural doctors remain committed to their patients and their communities, so does the AMA. Together, we will do our best to improve health services in rural and regional Australia.

We have a strong track record in rural health. Rural health has long been a dominant feature of AMA Federal Budget submissions and we spend a lot of time campaigning in rural communities, especially at election time. In 2005, we released a Position Statement on Rural/Regional Workforce Initiatives, which has been our benchmark on judging rural health policy ever since.

This Survey is the latest important addition to the AMA's rural health policy lobbying and advocacy arsenal. It will provide policy makers with a clear action plan for better rural health care. The solutions outlined will require resources, commitment and, most of all, cooperation between all levels of Government.

Despite the problems in rural health care, it is heartening to see just how many doctors in the survey highlighted the positive aspects of rural practice. Country practice is a true calling – and a rewarding one.

It is clear that, in many respects, rural doctors simply need more support to do the work they so obviously enjoy – which is looking after the health of their communities.

A handwritten signature in black ink, appearing to read 'Mukesh Haikerwal', written over a large, stylized, looping flourish.

Dr Mukesh Haikerwal  
AMA President

## FROM THE AMA RURAL REFERENCE GROUP CHAIR



In 2005, the AMA established the AMA Rural Reference Group (AMARRG) to provide specific advice to the AMA on rural health care issues.

It was an honour for me to be appointed Chair of this newly formed group, which is made up of hard working medical practitioners from rural and regional Australia. While the AMA has rural doctors on most committees, the AMARRG was the first group within the Federal AMA that is totally dedicated to specific rural doctor issues.

It became obvious to the AMARRG from the outset that we needed to gather more input from rural doctors about the policies and positions the AMA should be pursuing. The AMARRG committed itself to working on an agenda that is important to rural doctors, based on grassroots input.

In March 2007, the AMA conducted an online survey of doctors in rural areas. Developed by the AMARRG, the Survey asked questions about solutions, not just the problems. We sought to identify policy initiatives that rural doctors believed would help improve rural health care.

I believe the results of this Survey provide clear directions on how to improve health care in rural areas.

As a practising rural doctor, the findings of this Survey reflect my daily working life – the highs and lows, the joys and the frustrations.

Importantly, this Survey is not just about doctors, it is about patients and the places where they live and where they get sick. We can only hope this Survey sends a clear message to governments to properly fund and support rural health and rural communities – the lifeblood of the nation.

A handwritten signature in black ink, appearing to read 'David Rivett', written over a large, stylized, looping flourish.

Dr David Rivett  
Chair – AMA Rural Reference Group

## INTRODUCTION

The AMA's Rural Health Issues survey was conducted during March 2007, with an email invitation to complete the survey being sent to 3187 doctors. Doctors had two weeks to complete an online questionnaire – which was the first widespread survey of its type conducted in Australia.

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

Rural doctors were asked to rate the importance of 25 different proposals to improve rural health care. Respondents were able to rate each policy proposal according to the following categories – critical, large, moderate, small, none. Each category was assigned a linear rating, which allowed the AMA to calculate the degree of importance of each proposed policy solution.

Survey participants were invited to provide feedback on the rewarding aspects of rural medical practice and were also given the opportunity to provide additional comments or suggestions.

This survey invitation was independently distributed by the Australian Medical Publishing Company (AMPCo) and went to AMA members and non-members. The Rural, Remote, Metropolitan Area (RRMA) classification system was used as a basis for distribution of emails, targeting RRMA 3–7.

The survey response rate was 13 per cent, and the table below shows the distribution of responses according to each occupational category of respondent.

**Table 1 – Survey respondents by occupation**

Category of Respondent	Percentage
General Practitioner	45%
Specialist – Private Practice	23%
Salaried Doctor	14%
Doctor in Training	6%
Other	12%
<b>Total</b>	<b>100%</b>

The survey results could be broken down according to each occupational grouping. For the purposes of this report, the overall survey results are provided as well as information for GPs, specialists in private practice and salaried doctors. The sample size for doctors in training was considered too small.

A number of respondents nominated the 'other' category and, given the lack of information on their field of practice, specific analysis of their responses was not considered.

What follows is a breakdown of the top 10 policy proposals identified by rural doctors to improve rural health care, along with relevant commentary and analysis. The report also presents some of the qualitative information provided – particularly in relation to the attraction of rural practice.

Appendix A provides a full breakdown, in order of priority, of the 25 policy proposals that were surveyed. The score calculated for each policy proposal is also detailed in Appendix A.

## TOP 10 SOLUTIONS FOR RURAL HEALTH CARE

Rural doctors 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 when it comes to identifying key policy solutions and what priority they should be given.

Funding for more staffing in rural hospitals, improved assessment and ongoing support for overseas trained doctors (OTDs), more funding for locum relief to give rural doctors time off, an improved training environment for junior doctors, and better hospital facilities and equipment rated highly among all survey respondents.

That said, there were still some significant variations between occupational groupings. This reflects the particular needs of some areas of practice and does not mean that areas of difference can be ignored. Specialists, for example, gave much higher priority than other groups to beefing up targeted financial incentives, such as the rural retention scheme, and adopting programs to encourage doctors who are 55 and over to remain in the workforce. This is likely to reflect the fact that specialists do not qualify for existing retention schemes and the specialist workforce in rural areas is ageing.

Table 2 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 2**  
**Comparison of top 10 policy proposals according to occupational groups**

<b>Solution*</b>	<b>Overall Ranking</b>	<b>GPs</b>	<b>Specialists</b>	<b>Salaried Doctors</b>
<i>Provision of extra funding and resources to support improved staffing levels at rural hospitals</i>	<b>1</b>	<b>1</b>	<b>1</b>	<b>1</b>
<i>Introduce credible, nationally consistent processes of assessment and support for overseas trained doctors</i>	<b>2</b>	<b>3</b>	<b>2</b>	<b>2</b>
<i>Expand funding for locum relief for GPs and specialists</i>	<b>3</b>	<b>2</b>	<b>5</b>	<b>6</b>
<i>Ensure that rural hospitals have modern facilities and equipment</i>	<b>4</b>	<b>5</b>	<b>3</b>	<b>5</b>
<i>Increase the available infrastructure, resources and supervision to support the training of junior doctors in rural areas</i>	<b>5</b>	<b>7</b>	<b>8</b>	<b>7</b>
<i>Encourage medical colleges to include rural rotations for trainees to rural areas</i>	<b>6</b>	<b>9</b>	<b>9</b>	<b>4</b>
<i>Ensure procedural GPs can access hospital credentialing and facilities</i>	<b>7</b>	<b>4</b>	<b>20</b>	<b>10</b>
<i>Establish more integrated programs in public hospitals to support procedural skills</i>	<b>8</b>	<b>8</b>	<b>13</b>	<b>3</b>
<i>Encourage medical colleges to offer more generalist training places</i>	<b>9</b>	<b>6</b>	<b>19</b>	<b>9</b>
<i>Increase funding for ancillary staff at rural hospitals</i>	<b>10</b>	<b>13</b>	<b>6</b>	<b>8</b>

**1. Provision of extra funding and resources to support improved staffing levels at rural hospitals**

At the top of the list of rankings is the provision of extra funding and resources to support improved staffing levels at rural hospitals, including Visiting Medical Officers (VMO). This reflects ongoing 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 oncall commitments.

## 2. *Introduce credible, nationally consistent processes of assessment and support for overseas trained doctors (OTDs)*

Up to 50 per cent of doctors working in rural areas are from overseas. OTDs are a crucial part of rural health care and Australia must value their contribution. It is not surprising that rural doctors want better assessment and support for this group. Assessment mechanisms for OTDs in Australia are a fragmented mess with standards and processes varying from State to State.

While the vast majority of OTDs are highly skilled, there is significant potential for OTDs with insufficient skills to slip through the net. Taking into account the priority given to this issue in the survey results, it is fair to say that this is already happening and this is causing significant concern among rural doctors. Rural communities need well-trained doctors to deliver safe health care, and appropriate systems must be in place to ensure this happens.

Once OTDs arrive in Australia they are often placed in highly challenging work environments with little or no orientation. The Medical Training Review Panel has reported that up to 72 per cent of OTDs are given no formal orientation when they commence work in Australia, while access to supervision, professional support, and training is highly variable. This is not good for OTDs or their patients.

Clearly, Australia must do much more to support OTDs. All governments need to get on with implementing nationally consistent assessment arrangements as agreed by the Council of Australian Governments in July 2006.

## 3. *Expand funding for locum relief for GPs and specialists*

Third on the priority list is more funding for locum relief for GPs and specialists. Rural doctors often carry a high burden for the delivery of health care in rural 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. The risks of burnout are high and rural doctors are no doubt asking – is it all worthwhile?

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

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

*“It is really hard to get a holiday. I will probably retire early to save my health.”*

*“As we age, after hours and weekends on call become more of a burden.”*

*“Worst thing is the hours and the fact that you can't walk away - I AM the emergency doctor so suffer consequences of any work that I don't stay late to get done.”*

#### 4. *Ensure that rural hospitals have modern facilities and equipment*

Rural doctors consistently tell the AMA that the state of facilities and equipment in rural hospitals lag significantly behind their metropolitan counterparts and, in the worst cases, facilities and equipment are in a state of disrepair. Outdated equipment, leaking roofs, and inadequate facilities are just some of the issues raised with the AMA over many years.

Rural patients deserve the same standards of care as any other Australians. Modern facilities and equipment are essential to delivering on this fundamental premise. 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 outcome as they would have if they lived in the city.

Just as importantly, rural doctors may not have access to a working environment where they can easily update and maintain their skills. In the long term, this makes it very hard to convince doctors to look at a long-term career in rural practice.

#### 5. *Increase the available infrastructure, resources and supervision to support the training of junior doctors in rural areas*

Overseas evidence shows that providing doctors with strong 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 experiences available. There are plenty of opportunities to be part of the whole patient journey and to take on greater responsibility.

Unfortunately, while governments have strived to put more junior doctors into rural areas they have not done enough to back this with better infrastructure, resources, and supervision. This leads to a poor training experience and is totally counterproductive. At the end of a rural term, many junior doctors will leave a rural community disenchanted with rural practice.

Excessive hours, little supervision and support, and no real training focus mean that what should have been a positive experience becomes a negative one – and these stories are then shared with their friends and colleagues. While there is little doubt that there are standout examples of high quality training in rural areas, it is plain from these survey results that much more needs to be done.

#### 6. *Encourage medical colleges to include rural rotations for trainees to rural areas*

This point is consistent with priority 5 above and reinforces the importance of providing young doctors with a strong rural training experience. It also reflects the reality that the ongoing availability of specialty services in rural areas will be dependent on encouraging more specialist trainees to take up rural practice. The comments below from one survey participant reinforce this message.

*“The colleges need to be more flexible in allowing advanced training to take place in regional centres. The medical schools have learnt this already, with greater input from GPs. However, specialist colleges need to be more inventive and devise systems that allow advanced trainees to spend some time in a regional centre, perhaps with only one specialist, providing educational back up via telemedicine. The current system of advanced training encourages people to put down roots in capital cities at a time when they are most able to be mobile.”*

## **7. *Ensure procedural GPs can access hospital credentialing and facilities***

Before any doctor 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 that they cannot utilise these skills in their local hospital.

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

Hospitals must ensure that their credentialing processes are transparent, rigorous, and fair, and that they do not prevent procedural GPs from having reasonable access to hospital facilities.

## **8. *Establish more integrated programs in public hospitals to support procedural skills***

Procedural practice is for many GPs one of the highlights of rural practice. It means variety and provides for 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 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.

## **9. *Encourage medical colleges to offer more generalist training places***

Rural areas generally do not have the facilities to offer highly-specialised services, and nor can the clinical caseload support such services. Rural areas require doctors with a range of skills that allow them to deal with a broad range of presentations.

Rural doctors are vocal critics of the increasing specialisation of the medical workforce. There is no doubting the amazing technical skill levels of highly-specialised medical practitioners, but this specialisation means that a career in rural practice is simply not a consideration.

There appears to be a growing realisation among medical colleges that they must offer more generalist training positions and the AMA hopes that recent reforms to the surgical training program, for example, will in future produce more general surgeons. The clear message from rural doctors is that other colleges must follow this lead in order to ensure that sufficient future specialists have a skill set that is suited to rural practice.

## 10. Increase funding for ancillary staff at rural hospitals

This priority area fits neatly with the top priority area – more funding for improved staffing levels. 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 – being doctors. The comment below from one rural doctor sums the situation up neatly.

*“Huge frustration is lack of good management and admin support from within the Health Dept structure to assist clinical practitioners to provide healthcare. This means we get paid a lot to do admin type work when we should be doing clinical work.”*

## ARE THESE THE ONLY SOLUTIONS?

The AMA has highlighted the top 10 overall policy solutions – as rated by rural doctors. That said, it must be noted that there was very little difference in the value placed on the top ten policy solutions compared to those just outside the top 10.

### Targeted Financial Incentives

In the survey, there were three questions that touched on this area. All three questions made it to the top 10 responses among specialists who completed the survey, which indicates that this area must be looked at. Overall, rural retention payments only just missed out on making the top 10 policy solutions.

The Commonwealth has in place a rural retention scheme that is limited to general practitioners. The value of payments under this scheme is not properly indexed so they do not keep up with the costs of running a practice. There is a view among many rural doctors that the economics of rural practice are becoming increasingly less attractive.

Existing incentives do not encourage older doctors to remain in the workforce. At a time when so many rural doctors are approaching retirement, more innovative arrangements are clearly needed. Not only do these doctors play a central role in the delivery of health care, they are a critical teaching resource that we need to train the next generation.

### Outreach Programs

The Medical Specialist Outreach Program (MSOAP) provides funding to support the delivery of ‘fly-in fly-out’ specialist services. Additional funding for specialist outreach services ranked 15 in the overall list of priority areas. This indicates that the service is valued by rural doctors.

Funding under MSOAP is fully allocated through until 2008 and many worthwhile proposals are being denied assistance. This survey result provides a strong basis for the Government to adopt the AMA proposal to immediately lift funding for this program by 25 per cent.

## *Dedicated Commonwealth funding for rural hospitals*

Rural hospital issues feature prominently in the top 10 policy solutions outlined above. Staffing, equipment, facilities and access are recurring themes. The question is what needs to be put in place to support changes in these areas?

The AMA survey asked participants to consider whether dedicated Commonwealth funding for rural hospitals and/or rural maternity services would help. The answer is obviously yes as both questions made it to number 16 and number 14 respectively on the list of rankings.

If State/Territory Governments will not devote more funding for rural hospitals then it is time for the Commonwealth to consider stepping in and including more funding for rural hospitals in future Australian Health Care Agreements - and attach specific performance benchmarks to this money so that the States and Territories can be held to account.

## **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*

Under this heading several themes emerged, with participants identifying a number of attractions of rural practice as being:

- autonomy
- less administrative obstacles
- holistic care
- personal interaction with patients and staff
- close and rewarding professional relationships
- satisfaction of serving a rural population
- *esprit de corps* in small hospitals and practices
- greater responsibility

The comments below are typical of the feedback provided:

*“Maybe there's an element of being big fish in a little pond too – certainly you feel like you are an important component of your local medical community.”*

*“A real sense of community. A collegiate medical fraternity much better than seemed to exist in a capital city.”*

*“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.”*

*“Stimulating, challenging, teaching, gratifying”*

## Challenge and variety of work

There is little doubt that rural practice offers a challenging work environment with a variety clinical experiences. Rural doctors said they valued:

- procedural work such as surgery, anaesthesia, obstetrics and pathology
- emergency medicine
- diversity of practice
- real and diversified problems
- variety of medical conditions to treat

The comments below are typical of the feedback provided:

*“I really enjoy the variability of medicine in rural practice, the challenges of emergencies as well as the chronic conditions – with difficulty accessing specialists I enjoy the better understanding that then has to come with management of certain conditions.”*

*“The often challenging clinical problems of classical 'old-fashioned medicine' now rarely seen in the big urban centres.”*

## Lifestyle

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

- quality of rural life
- clean environment
- short commuting times
- lower house prices
- able to spend more time with family
- better environment to raise children
- security

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

*“No traffic lights and beautiful stars at night!”*

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

## 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:

- total care of patients and their families
- continuity of care
- appreciative patients
- knowing patients

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

*“I enjoy the variety of work and the professional relationship with patients. The long-term relationship with people. The respect of patients.”*

*“The patients are known to you and there is a personal relationship that develops in the country. Some patients are very grateful to have a doctor in their community.”*

*“... personally I find country people in general more resilient, and less likely to be unnecessarily critical and devaluing.”*

## 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:

- being a valued member of the community
- providing service to the rural community
- working in a supportive community
- treating people where they live

The comments below are typical of survey responses:

*“I become part of the community, actually part of the identity of the community”*

*“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.”*

## TIME FOR ACTION

Unlike many surveys, the AMA Rural Health Issues Survey did not attempt to focus on simply identifying what's wrong with rural health care. That question has been asked time and time again and the AMA needed to know more about the broad policy directions it should pursue.

At the end of the day policy makers need to know what solutions are available, how effective they will be, and what should ultimately be the priority areas for action.

The AMA Rural Health Issues Survey asked rural doctors for their views and got remarkably consistent responses. Improved funding for rural hospitals (directed at more staffing and better facilities and equipment), more help for overseas trained doctors, time off to prevent burn out, improved training arrangements, support for procedural skills, and better programs to encourage the retention/attraction of rural doctors.

None of these is an unrealistic proposal, and they would do a great deal to improve patient care. There is no doubt that others will come forward with different ideas and strategies that are worthy of future consideration. However, this survey reflects the grassroots input of rural doctors and should form the basis for future work. These are commonsense steps towards delivering better health care in rural communities that have broad support – all that is now required is action on the part of policy makers.



## 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 a possible 100.

Proposed solution	Score
Provide extra funding and resources to support improved staffing levels at rural hospitals, including core Visiting Medical Offices, to allow workable rosters	89.75
Introduce credible, nationally consistent standards and processes governing the assessment and support of overseas trained doctors going into areas of need	85.25
Expand funding to ensure locum relief for rural general practitioners and specialists	84.25
Ensure that rural hospitals have modern facilities and equipment	84
Increase the available infrastructure, resources and supervision to support the training of junior doctors in rural areas	80.75
Encourage medical colleges to include rotations for trainees to rural areas – subject to appropriate experience and supervision	80.75
Ensure general practitioners with recognised procedural skills can access appropriate hospital credentialing and facilities	80
Establish more integrated programs to allow rural doctors to maintain and upgrade their procedural skills in public hospitals	79.75
Encourage medical colleges to offer more generalist training places for trainees	78
Increase funding for appropriately trained ancillary staff at rural hospitals	77.5
Increase incentives, such as rural retention payments, to recruit/retain doctors to work in rural areas	76.25
Provide better and simplified support for patients (including their carers) who must travel long distances for hospital treatment	75
Expand eligibility for the rural retention program to include specialists	74.25
Introduce dedicated Commonwealth funding for rural maternity services	74
Allocate additional funding for specialist outreach services, appropriately integrated with local services	74
Introduce dedicated Commonwealth funding for rural hospitals, which require the States/Territories to meet agreed performance benchmarks	73.5
Develop specific initiatives to improve access to specialist services	73.25
Improve access to educational support for rural doctors including continuing professional development and mentoring	73.25
Give all overseas trained doctors and their families the same access to treatment under Medicare and public education as permanent residents	72.75
Provide more funding to support high-speed broadband for medical practices, encompassing general practice and specialist practice	71.75
Develop targeted incentives to encourage doctors who are 55 and over to delay retirement	69.75
Improve access to education for rural doctors' family members through better infrastructure or financial support	69.25
Improve access to employment opportunities for rural doctors' partners and/or family members	68.25
Development of programs to encourage the utilisation of technology such as video-conferencing and on line tools	64.25
Provide more funding to support telemedicine	62.25

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