Rural outreach by medical specialists in Australia

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Why outreach?

- Medical specialists travel to provide services and professional support in rural and remote areas
- 22,249 of our 26,347 specialists (around 85%) live metro
- Many specialist services not viable full-time

Policy and planning background

- Outreach endorsed as global strategy – WHO
- Commonwealth policy support since 2000
- State policy – e.g. hub and spoke
- Organisational perspectives
  - meeting regional and remote healthcare needs

Workforce background

- Medical specialists:
  - interested and invested in outreach
  - adaptable provision
- Continuity of practice:
  - >5+ years

This presentation

- What is the extent of rural and remote outreach by the medical specialist workforce?
- How do individual characteristics influence outreach work?

Methods

- MABEL Wave 1, 2008
- Outcome defined
  - Outreach: *Travel to provide services in at least one non-metropolitan location – ASGC-RA category >1*
  - Remote outreach: *Travel to provide services to at least one remote area, category >3*

Analyses

- Proportions to measure extent of outreach
- Logistic regression
  - Age, sex
  - Location (metro/inner/outer-remote)
  - Practice arrangements (public only, private consulting room, private hospital only)
  - Specialist type

Extent of outreach

- Sample: 4596 medical specialists
- Around one in five medical specialists provide rural outreach (n=909, 19%)
- Less than 5% medical specialists provide remote outreach (n=149)

Characteristics of specialists providing outreach

	Outreach	%	MV Odds Ratio
Sex			
Female	194	15	Reference
Male	715	20	1.38 (1.12-1.69)
Location			
Metropolitan	616	17	Reference
Inner regional	208	33	2.07 (1.68- 2.54)
Outer regional	78	43	3.40 (2.38- 4.87)
Rural Background			
Nil	618	19	Reference
0-10	54	22	1.21 (0.93- 1.56)
11+	174	25	1.24 (1.00- 1.55)
Practice arrangements			
Public only	198	18	Reference
Private - hospital and consulting room	525	22	1.24 (1.01-1.53)
Private – hospital only	135	15	0.78 (0.60-1.02)

Key findings and implications

- Specialist outreach is not uncommon
  - This suggests there is unmet need/ demand.
- Propensity to provide outreach:
  - Male
  - Living in a rural location
  - Private consulting rooms

Challenges and opportunities

- Potential to add capacity to rural health service delivery
  - Recognise hubs of supply
  - Role of outreach services (professional support / service delivery/ both) in different locations
  - How to mobilise according to need
- Professional autonomy is a viable driver
  - Communication and systems to coordinate effort

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