Rural Health into the future - building on firm foundations

The story of rural health in Australia is one of passion and persistence. In the spirit of John Flynn, our indigenous people and our pioneers, rural people and rural health workers have adapted to the Australian environment and sought to shape solutions for rural health that have been in tune with the isolation of rural Australia. In doing so we have built on evidence initially from overseas and then from Australia. The story of rural health is one of preparation, patience and persistence. Australia has become the unquestioned leader in rural health policy – leading the way in many initiatives but with much work still to do.

Background

Amid concerns about a rural health, a conference was held in 1978 heralding an increased interest in the plight of rural communities. The 1980s saw a flurry of enquiries. The Thomson Committee[1] inquiring into the future needs and training for medical practice in Queensland for the Medical Board of Queensland 1981 took specific interest in rural practice.

Overseas the first books on rural health were published. Roger Rosenblatt [2] espoused principles that still ring true today

- Planning must be population based
- The rural health system should be based on generalists
- All functions of the health system should be integrated
- Rural communities must build 2 way cooperative arrangements with other rural and urban communities
- The structure of the reimbursement system must reward appropriate rural health services
- There are thresholds in rural health care – certain levels of service require external subsidy

The NSW Rural Doctors 1986 dispute resulted in Shehadie Report [3] from the Committee of Enquiry into Services provided by General Medical Practitioners in Country Hospitals in Sept 1987.

In December 1987 Max Kamien (Founding Professor of the first chair in General Practice in Australia) was called on to chair the Ministerial Enquiry into the Recruitment and Retention of Country Doctors in Western Australia[4]. He recognised
"They need to be recognised for what they really are – the elite troops of the rural health care system"

Associations of remote nurses (CRANA) and rural doctors (RDANSW and RDAQ) were formed and support structures such as the Rural Doctors Support Network RDRN (NSW), Cunningham Rural Training Unit (Toowoomba QLD) established.

The 1990s were heralded in by the first National Rural Health Conference which endorsed a rural health strategy which was, in large part, based on the findings of these enquiries and the evidence from the US and subsequent Australian research and

enquiry. The world's first professor of Rural Health and two journals of Rural Health based in Australia helped to develop that evidence.

This evidence identified that factors associated with rural medical practice included:

- Rural origin 2.5X (1.68 to 3.9)
- Rural schooling 2.5X (2.2 to 5.42)
- Rural spouse 3.5X
- Rural undergraduate 2.05X (0.7 to 3.0)
  plus anecdotal - seem to want to stay on
- Rural Intern 3X (Peach et al, Ballarat 2004)
- Rural Training 2.5X (Rural Stocktake, Jack Best)
- Rural upskilling/support - Stay longer (Hays et al, Wilkinson et al)`

Initiatives during the 1990s and 2000s included a range of important government programs

- **Educational Programs**
  - High school student recruitment of medical students
  - Rural Undergraduate Support Committee (RUSC) targets including 25% rural origin medical students and every student having at least 4 weeks exposure to rural practice
  - National Rural Health Network (NRHN) of rural student clubs
  - John Flynn Scholarship Scheme (JFSS) facilitating a series of visits to a rural site
  - Rural Clinical Schools (RCS) in which a quarter of medical students spend a year in rural or regional areas
  - University Departments of Rural Health (UDRH
  - Regionally based universities such as JCU
  - Continuous Longitudinal programs such as the Flinders University program
  - Rural scholarships – Rural Australia Medical Undergraduate Scholarship (RAMUS**)** for rural students, Commonwealth Scholarships (RMBS)(MRB) and State scholarships such as Queensland's
- **Interns**
  - Rural and Remote Area Placement Program (RRAPP) which became the Prevocational General Practice Placement Program (PGPPP)
- **Registrars**
  - General Practice Education and Training (GPET) - Regionalised through Regional Training Providers
  - Remote Vocational Training Scheme (RVTS) allowing doctors already in rural communities to finalise vocational training
  - General Practice Registrars Rural Incentives Payments Scheme (GPRRIPS)
  - Rural Generalist Pathway – initially in Queensland and now being replicated in other states
- **Rural Doctors**
  - Australian College of Rural and Remote Medicine – formation and AMC accreditation

  - Rural Procedural Medicine incentives including direct grant funding, training support and retraining incentives which have stemmed the decline in this workforce
  - PIP incentive grants rewarding immunisation, afterhours care (recently removed), IT, student teaching
  - Retention grants
  - State Rural Medical Family Networks (RMFN) and National RMFN
- **Communities**
  - Rural Health Support Education and Training (RHSET)
  - Multipurpose Health Service (MPHS)
  - Regional Health Service (RHS)
  - National Rural and Regional Health Infrastructure Program (NRRHIP)
  - General Practice Rural Infrastructure Program (GPRIP)
  - More Allied Health Services (MAHS)
  - Medical Specialist Outreach and Assistance Program (MSOAP)
  - GP Divisions including rural divisions
  - Rural Workforce Agencies

International bodies including the WHO and Wonca have confirmed the importance of these initiatives with consensus and evidence based documents [5-7] Most programs continue although some have been renamed or merged.

Australia has positioned itself well to foster and sustain rural health care. Much of the preparation that has been done is envied internationally.

Despite the progress there have been disappointments and setbacks.

1. Ill-conceived policy of restricted medical student numbers precipitated a workforce shortage that has had to be filled (and thankfully was) by international recruitment
2. Infrastructure – loss of rural hospitals and reduction in their capabilities means a loss of the opportunity for rural doctors to practice procedural medicine (anaesthetics, surgery and obstetrics) and a loss of maternity services
3. Change from the RRMA to ASGC RA rural classification system resulting in the loss of graded incentives based on medical service need to a classification system based on a measure of purely geographic distance from capital centre.
4. The merging of Divisions of General Practice into Medicare locals has the potential to dilute the important rural focus
5. The relative dominance of specialisation over generalism and city based solutions over appropriate rural based ones

What not to do.
There are a number of strategies that are proposed that I would not suggest as viable options

1. Rely on retrieval services alone – 97% of rural hospital admissions are dealt with locally – replacing this further is just not possible nor economically sensible and further reduces the role of rural facilities
2. Rely solely on the pressure of numbers of medical students.

We have, what has been called, a tsunami of medical students coming of medical school and we must ensure that unlike a physical tsunami, this spreads well inland. Without appropriate support and training this will not happen.

3. Force students to the bush without training or incentive – this just lowers the level of service and creates discontent
4. Relying on distant triage services to reduce after hours – the local hospital, staffed 24 hours is the appropriate facility to perform this function – with staff knowing circumstances of both patient and geography

The next decade needs to see us build on the initiatives that have gone before. We need to maximise the benefit gained from these initiatives and maximise the utilisation of rural health facilities.

I would recommend the following to achieve this

1. Recognition of different needs of rural patients
    a. Rural communities require generalists with a broad range of skills. The ASGC RA classification, on which current doctor incentives are based, recognises only the geographical isolation from the large capital centre. A large centre like Townsville is rated as rural as a small isolated town like my town of Theodore. If we are going to attract generalists to provide services where specialists are not available we must recognise this difference
    b. Appropriate technology – bedside pathology, digital x-ray, video consulting and web-based support need to be supported and tailored to rural areas and practical rural research on these needs to be undertaken
    c. Establishment of a formal consultation process with the Australian College of Rural and Remote Medicine, the Rural Doctors Association of Australia and other rural clinical stakeholders to ensure that national policies and guidelines are appropriate for rural areas. Examples of this that need consideration in the rural context include:
        i. Average length of stay and hospital in the home – these are not appropriate performance measure where 2/3 of rural community live out of town on dirt roads
        ii. Stroke guidelines mandate early CT scan – this is not possible and an alternate approach should be recognised for rural areas

    An example of the successful implementation of a process such as this has been the agreement between Australian Red Cross Blood Transfusion Service (ARCBS) and Queensland Health (QH) to support Emergency Donor Panels for Queensland after other options were found, by a consultative process involving all stakeholders, to be not implementable in rural areas.

2. Infrastructure
   The majority of infrastructure investment has concentrated on regional centres. Rural hospital infrastructure needs support especially with

regard to the provision of birthing facilities. Accommodation for students is needed to support longer stays. Staff accommodation needs subsidy especially in higher cost of living centres such a mining towns

3. Recurrent funding for both doctors and hospitals needs to be a mix of block, incentive and activity based funding
   Base funding has been provided recognising that small hospitals and small practices are a reality in the widely dispersed populations of the Australian bush.

   Incentive funding for the increased complexity of rural practice (Viable Models Study[8]) needs to be provided and I would suggest that this should be in the form of specific Rural item numbers or higher rebates in the Medicare Benefits Schedule (MBS)

   With respect to rural hospitals, the National Health and Hospitals Network Agreement [9] provides "block funding paid against a COAG-agreed funding model, including for agreed functions and services and community service obligations required to support small regional and rural public hospitals" While this provides some assurance with respect to some base funding it has the potential to see rural hospitals doing less and less if the relative funding shrinks. Base funding growth needs to be agreed and additional Activity Based Funding for rural hospitals should be provided to encourage these facilities to provide vital care of more complex patients who are best cared for locally e.g. birthing, inpatient medical care, some chemotherapy and other appropriate services.

4. Support for generalist practice through
   i. Career support for the Pathway to Rural Generalist practice
   ii. A "Grow your own" incentive program to help rural towns grow promising local people into health professionals with a minimum of time away (supported by appropriately tailored education programs)
   iii. Retention strategies that reward those that stay. Locums in many jurisdictions earn over $2500 per day – 2-5x the income of resident rural doctors

5. Innovative models
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   a. Teamwork
      Rural doctor's practices have, in many cases, been the model GP Superclinic with nurses and allied health all working from one facility. Programs should seek to enhance this
   b. Maximising economies of scale
      Multiskilling that enhances the viability of practice in small communities such as GP dispensing should be encouraged

I would like to finish this submission with the full version of a familiar quotation:

> Jack of all trades
> Master of None
> But oft times better
> Than master of one

The future of rural health is generalism and the support of this

Assoc Prof Alan Bruce Chater OAM
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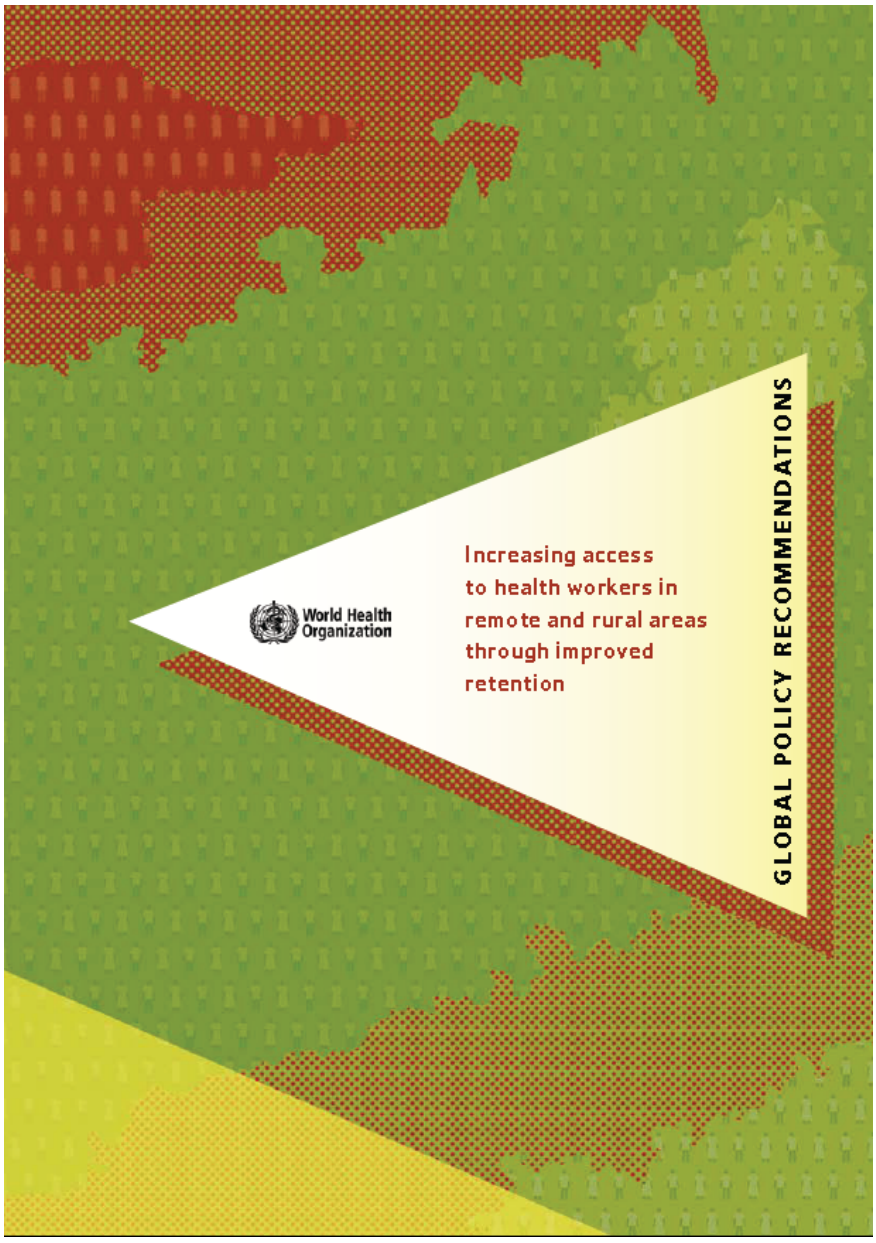
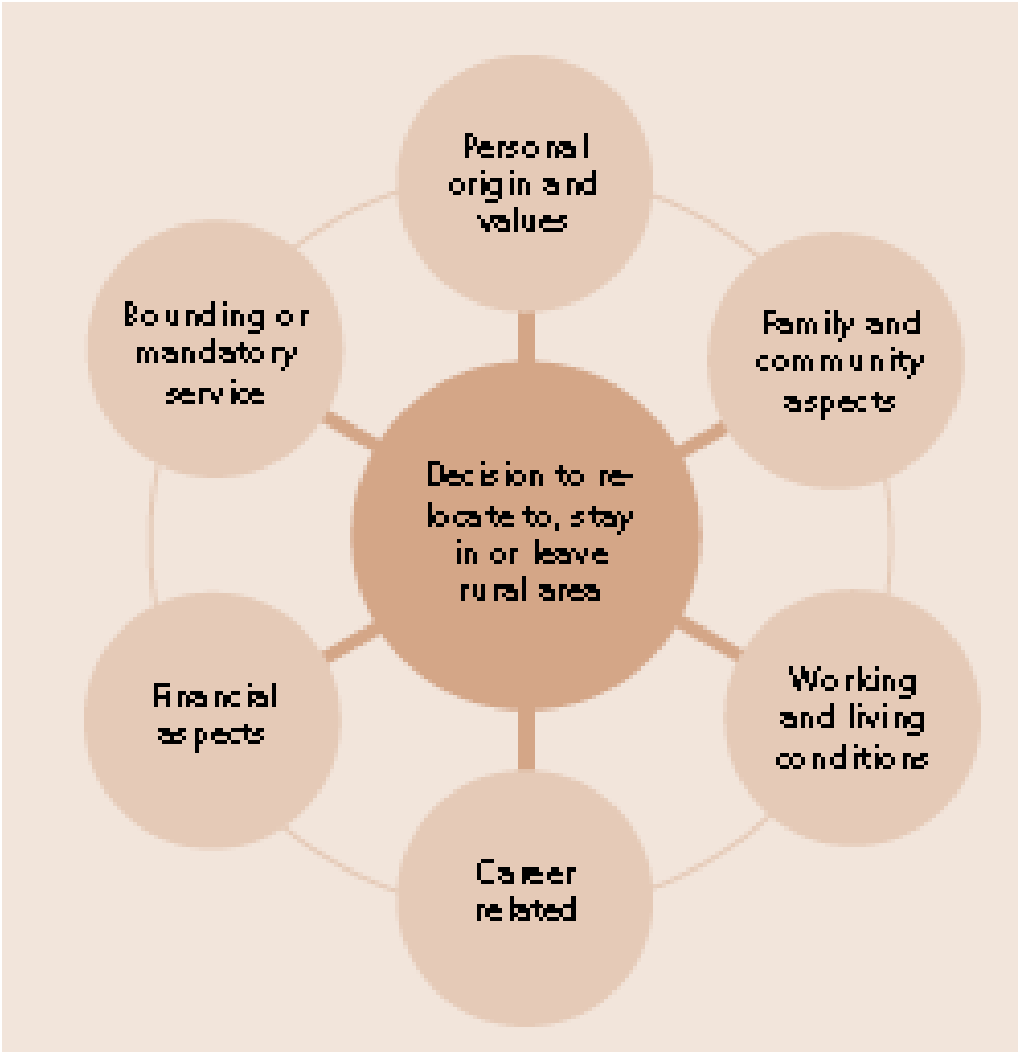
3. Shehadie, N., *Report of the Committee of Enquiry Into Services Provided by General Medical Practitioners to Country Public Hospitals.* 1987, New South Wales Department of Health: Sydney.
4. Kamien, M., *Report of the Ministerial inquiry into the recruitment and retention of country doctors in Western Australia*, in *Department of Community Practice, University of Western Australia*. 1987.
5. Working Party on Training for Rural Practice, *WONCA Policy On Training For Rural Practice.* 1995.
6. WONCA Working Party on Rural Practice, *Policy on Rural Practice and Rural Health*. 2002, Monash University School of Rural Health: Traralgon, Vic.
7. WHO, *Increasing access to health workers in remote and rural areas through improved retention: global policy recommendations.* 2010, World Health Organisation.
8. Rural Doctors Association of Australia, *Viable models of rural and remote practice: Stage 1 and Stage 2 report*. 2003, Canberra: RDAA.
9. COAG, *National Health and Hospitals Network Agreement* 2010.

Appendix
Increasing access to health workers in remote and rural areas through improved retention: global policy recommendations. WHO 2010
[7]




Personal origin and values
Family and community aspects
Working and living conditions
Career related
Financial aspects
Bounding or mandatory service
Decision to re-locate to, stay in or leave rural area

Category of intervention	Examples
A. Education	A1 Students from rural backgrounds
	A2 Health professional schools outside of major cities
	A3 Clinical rotations in rural areas during studies
	A4 Curricula that reflect rural health issues
	A5 Continuous professional development for rural health workers
B. Regulatory	B1 Enhanced scope of practice
	B2 Different types of health workers
	B3 Compulsory service
	B4 Subsidized education for return of service
C. Financial incentives	C1 Appropriate financial incentives
D. Professional and personal support	D1 Better living conditions
	D2 Safe and supportive working environment
	D3 Outreach support
	D4 Career development programmes
	D5 Professional networks
	D6 Public recognition measures