RURAL DOCTORS ASSOCIATION OF AUSTRALIA
Caring for the Country

Senate Community Affairs References Committee
Inquiry into Suicide in Australia

The Rural Doctors Association of Australia (RDAA) is pleased to submit the following submission to the above Inquiry. In so doing we are responding to the focus of the Inquiry as being: *The impact of suicide on the Australian Community including high risk groups such as Indigenous youth and rural communities*. The terms of reference have guided our response to this inquiry.

The Rural Doctors Association of Australia (RDAA) welcomes the opportunity to contribute to this Inquiry into Suicide in Australia and to be involved in the continuing consultation process.

1. Introduction

This response reiterates our major concerns regarding the ongoing high impact of suicide on rural communities which is exacerbated by the inequitable and poor delivery of mental health services in rural and remote Australia. In response we highlight the urgent need to:

- **Address the issues of inequity in health service delivery and health outcomes** for rural and remote Australians;
- **Enhance the mental health and wellbeing** of rural communities; and
- **Provide an integrated, focused strategy that will result in an expanded workforce**: the increasingly obvious gaps in mental health services will continue to escalate as the problems of the medical workforce in rural and remote Australia worsen.

The current climate of health reform represents the optimum opportunity to develop enhanced support for rural and remote mental health. In "redesigning our health system to meet emerging challenges" [1] every effort must be made to ensure better access to health services for those living in rural and remote Australia.

In tackling the three reform goals for health reform identified in the National Health and Hospitals Reform Commission's Final Report of - access and equity; redesign and a self improving health system - real reform for rural and remote Australians will only be possible if the policy and the measures of progress and advancement are more strategically targeted and tested against their impact on rural health.

Despite the improvement in funding in recent years through the *Better Outcomes in Mental Health Care Initiative* there has been little improvement in the mental health outcomes for people living in rural and remote areas Australia. Indicators, such as suicide rates, clearly highlight that there is little impact of the known and available treatments on the burden of disease because of the lack of access to services and appropriate treatments for people in rural and remote Australia. [2]

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[1] *A Healthier Future For All Australians*, Final Report, June 2009, NHHRC

[2] As identified in A. Dunbar et la, *New Money for Mental Health: will it make a things better for rural and remote Australia?* MJA 2007; 186 (11) 587-589

In response to the ongoing inequity in the provision of health services in rural and remote Australia, RDAA continues to advocate for:

- **Sustainable rural and remote communities** through the provision of accessible and patient centred high quality medical care.
- **Strong and vibrant rural generalist practices** providing a focus for the provision of primary care services and procedural care in rural and regional hospitals.
- **Rural hospitals** which provide essential services to their local communities including medical, maternity, surgical services and mental health.
- **Access to specialist medical services** through either local resident specialists or visiting services. This includes the urgent need for access to psychiatrists and psychological services.
- **Policy and program development responsive to the needs of rural and remote communities** and not disadvantaged by a metro-centric focus.

We support a national approach to enhanced mental health services across the continuum from preventative to tertiary services and the development of policy and program delivery that is evidence based.

The comments contained in this response are drawn from the experience of rural and remote medical practitioners delivering care at the "coalface" within rural and remote communities. Our rural and remote Doctors are at the forefront of primary care and work in partnership with people, their communities and government to deliver the best care available to their patients.

One in three Australians who live in rural and remote Australia are significantly disadvantaged in their access to health services and continue to have poor health outcomes relative to their urban counterparts. In particular we note the higher incidence of suicide in rural and remote populations as also noted in the submissions to this inquiry of those also intimately involved in the health outcomes of rural and remote Australians, for example, the Centre for Rural and Remote Health Queensland, Health Consumers of Rural and Remote Australia, Crisis Support Services Inc, and the state based Commissions for Children and Young People.

The "low to poor" number of medical practitioners in rural and remote Australia is well documented as indicated in, for example, the report of the *Audit of Health Workforce in Rural and Regional Australia*, 2008 and the Productivity Commission Report, *Australia's Health Workforce*.

Members of RDAA, medical practitioners operating in rural and remote Australia, also anecdotally identify the constraints to delivering appropriate care in mental health because of the lack of psychiatrists, psychologists and other appropriately trained human resources.

This lack of basic health infrastructure impacts on the sustainability of rural communities. Rural communities find it increasingly difficult to attract young working families and professionals such as teachers and police and support local businesses, farming, mining and tourism activities, unless these people can be assured they can access basic infrastructure in their community including health care. Yet rural and remote Australia are critical components of the economic and social development of Australia and in order to sustain communities that

support the economic, social and cultural activities of these areas greater attention must be given to ameliorating the health disadvantage experienced by those living there.

2. Addressing Equity

Inequitable health outcomes and the "personal, social and financial costs of suicide in Australia".
The current operation of the health system across Australia fails in its aim of delivering equitable access to health care for all Australians. The level of funding disadvantage that rural people suffer has been calculated at $917m annually[3]. Rural populations have worse health outcomes, lower incomes, higher health risks, fewer educational opportunities, fewer medical and health practitioners and less access to services than their metropolitan counterparts. However, Australian Governments continue to spend less per capita on the health care of rural people and policy has perpetuated this through a metro-centric focus that fails to provide a coordinated, strategic response to the critical health issues in rural and remote areas.

The submissions of other organisations to this inquiry highlight the research identifying the higher incidence of suicide amongst rural and remote people. In response, evidence also indicates that there are significant gaps existing in service delivery particularly in the areas of tertiary interventions and support[4] and the lack of spending on preventative services in Australia's health.[5]

The main issue facing rural and remote communities is the ability to access health services locally.
Whilst fly in/fly out services, telemedicine and retrieval services offer valuable support to rural health services they cannot replace them. There are genuine and recognizable issues of access including for indigenous Australians as indicated by their very low MBS/PBS spending which is 37% of the level of other Australians.[6]

The increasingly obvious gaps in service delivery, as noted by the Centre for Rural and Remote Health Queensland and as based on their research, highlight the 'sporadic distribution of services', the 'lack of service coordination' and the 'lack of capacity for prevention activities and programs'. This evidence is supported by RDAA members involved in primary care. Those at the coalface also know how hard it is to get people to access mental health services where they are available locally, where they are not available that difficulty greatly increases. Failure to address this inequity that exists in service provision will perpetuate the already escalating cost of suicide in rural and remote Australia. And the answer to addressing this inequity is through a more coordinated and strategic approach to addressing health workforce shortages.

3. Enhancing wellbeing

Enhancing Community Wellbeing (the appropriate role and effectiveness of agencies such as ….general health services in assisting people at risk of suicide.)
Consulting a GP is the most common action related to health care taken by Australians.[7] At a national level General Practitioners provide on average 4.9 consultations per person per year to 87% of the population.[8]

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[3] The under-spend for Medicare funded GP services as estimated in the Prime Minister's presentation at Murray Bridge, SA on 14 October 2009.
[4] Submission to Senate Community Affairs References Committee Inquiry into Suicide in Australia, Centre for Rural and Remote Mental Health, Queensland, 2009.
[5] As indicated in the Prime Minister's address at Murray Bridge, 14 October 2009, less that 2% of the health expenditure budget is spent on preventative health.
[6] Podger, A, Inaugural Menzies Health Policy Lecture, March, 06.

The substantial evidence that supports the effectiveness of strong primary health care in delivering improved population health outcomes is well understood by RDAA.[9] Primary health services are the first point of contact between an individual and the formal healthcare system and are the gateway to other parts of the system. In terms of best patient outcomes primary health care and care coordination is best positioned around the general practitioner. In rural and remote Australia the rural generalist practitioner is critical to ensure accessible health care with continuity of care and resulting better health outcomes. The evidence clearly supports Primary Care systems as the most effective way to improve health outcomes in the community and this is well documented in the National Health and Hospital Reform Commission's (NHHRC) Report, *A Healthier Future for all Australians*. Rural generalist practice, the principal provider of primary care services to rural communities, needs to be at the centre of all healthcare arrangements. We also know that patients with psychological problems represent 8% of the problems presenting to General Practitioners (as compared to 13.5% - the highest – with respiratory disease) and that dealing with mental health is increasingly a priority within the primary care setting.[10]

However enhancing primary health care will only be possible if there is a more coordinated strategic response to workforce shortages. Across the sector it is well documented that in order to enhance workforce numbers in rural and remote Australia these areas need to become attractive places to live and work. RDAA continues to advocate for a more systematic approach that is embedded in the highest levels of health care reform. We also continue to advocate that such reform will only have an impact if such incentives are implemented as have been identified in **the RDAA/AMA Rural Rescue Package** put to Government in 2007.

The RDAA has also called for both Federal and State governments to implement **a Rural Health Obligation** in the Australian Health Care Agreements. This would establish minimum service obligations to ensure rural Australians have better access to rural doctors, local hospitals and rural health services including mental health. People living in rural Australia should be guaranteed that when they have depression it can be treated effectively and they have access to health services locally.

The objective of the Rural Health Obligation should be accessible every day rural medical care for rural Australians. The Rural Health Obligation should be a statement of the standard of access and care that can be expected by rural Australians and would provide a framework by which the level of access can be defined and measured.

The Rural Health Obligation must address:

- General Practice and Primary Care
- Hospital Based Services
- Maternity Care Services
- **Mental Health Care Services**
- Specialist Services
- Indigenous Health
- Ambulance and Retrieval Services.

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[7] **Australia's Health 2008**, Australian Institute of Health and Welfare (AIHW)

[8] Ibid p297. These figures are based on Medicare funded services and do not include those funded in other ways, for example through Aboriginal Medical Services or the Department of Veterans Affairs.

[9] Ibid.

[10] *General practice activity in Australia.* 2008-2009, BEACH, AIHW, 2009, P.51

4. Expanding and Better Supporting the Workforce

Workforce remains at the core of establishing and maintaining an accessible system for health care in rural and remote Australia. Building, supporting and upskilling a well trained health workforce in rural and remote areas will enable the health disadvantage currently being suffered by rural women, men and children to be addressed. At least 17,000 additional health professionals—including 1800 additional doctors—are needed urgently in rural and remote Australia just to ensure basic access to healthcare in the bush.

Ameliorating the disadvantage of a metro-centric focus

Understanding that it is their right to have access to the best and most appropriate health care available, and not be jeopardized by a model of health that is forged from within a metro-centric focus, is critical to advancing mental health in rural and remote areas. Key policy decisions are currently made from within the context of those residing within our capital cities and this has skewed both the focus and strategic response of past policy frameworks away from addressing the issues and needs of mental health in rural and remote Australia. For example, despite the focus on primary health care reform, we still have no specific strategy for rural primary health care.

RDAA reiterates the following as key to addressing disadvantage in rural health:

1. Introduction of a **Rural Health Obligation** that defines the health care services that Australians who live in the bush should be able to expect.
2. **Workforce incentives** that will:
    1. attract Australian medical graduates to take up rural practice and support those currently practicing in rural and remote areas so that people have greater access to services and support;
    2. emphasise support for rural health professionals to educate and train the next generation of rural health professionals and encourage the increasing number of women medical graduates to take up rural practice.
    3. emanate from a systemic approach that forms part of a **national rural health workforce strategy**.
3. **Health funding models** that build viability, capacity and capability in rural health services.
4. **Inclusion of people from rural and remote communities in the decision making** related to their health and well being and inclusive of transparency and accountability.
5. Building **comprehensive data** of rural and remote health that reflect the results and accountability of health policy.
6. Greater support for **rural procedural services** delivered in rural hospitals such as obstetrics, anaesthetics, surgery and emergency.
7. **Enhancing health services in indigenous communities**.
8. **Enhancing support to access centres of specialist care regardless of where they live**.
9. **Address the social determinants of health** including education, employment and housing.

We support the views of the NHHRC's Report which identifies a number of important initiatives to improve care for people with a mental illness through expanded early intervention for young people, more sub-acute care, better links between acute care and community care, including through rapid response teams working

from acute care settings in the community. What is also needed is the provision of sufficient acute care support to assist diagnosis, support and stabilization under clinical supervision. Lack of medical expertise such as psychiatrists in rural and remote areas and closure of rural hospitals has greatly reduced the capacity for this level of acute care.

5. Summary

- Despite the stimulus to mental health services in recent years the burden of disease is still unacceptably high and the personal, social and financial costs continue to escalate. The response of the **current health system is disconnected and spasmodic particularly for those living in rural and remote areas.**[11] , [12]

- The **establishment of a rural health obligation** is required as part of the current ongoing health reform process to ensure a coordinated approach to service delivery in rural and remote Australia.

- Front line health and community services will only expand if more attention is given to making rural and remote Australia more attractive areas to work. **Workforce issues must be addressed in a more systematic way** so as to facilitate the efficacy of current programs targeted at addressing the burden of disease in mental health. The piecemeal initiatives that have operated to date will not become effective unless there is more specific attention to developing the response of policy and program to the realities of service delivery in rural and remote Australia. We particularly refer to the deficit in medical specialists in the area of general practice, psychiatry and psychology and the lack of enhanced mental health skills training opportunities for current medical practitioners. In addition workforce audits have noted the increase in overseas trained doctors (OTDs) operating in rural and remote Australia and our “anecdotal” evidence from RDAA members clearly highlights some of the OTD’s lack of knowledge, specific skills and the inappropriate cultural responses when dealing with the increased number of patients presenting with mental health problems.

- The **current inequity must be addressed with the fairer allocation of resources** so that the current underspend in Medicare is targeted towards addressing the needs of people in rural and remote areas, particularly in providing enhanced mental health training and financial supports to rural and remote medical practitioners.

- **More appropriate positioning of the Australian Government’s Office of Rural Health** to a position of real influence and decision making capacity within the Australian Government Department of Health and Ageing is an urgently required action. The lack of an integrated strategy to address the rural and remote workforce is evidence of the lack of a coordinated and strategic focus this area receives.

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[11] The 2009 -10 Budget included changes to the Better Access initiative regarding Mental Health Treatment Plans for people with a diagnosed mental disorder:

1. changing the name of the "GP Mental Health Care Plan" to "GP Mental Health Treatment Plan" to better reflect what it is intended to do (from 1 July 2009)
2. requiring that GPs document a diagnosis of a mental disorder in the Plan (from 1 July 2009) and
3. introducing a new Medicare item for GPs who have not completed Mental Health Skills training (from 1 January 2010).

[12] New money for mental health: will it make things better for rural and remote Australia?. J.A.Dunbar et al, MJA; 186 (11)

- **Greater use of the evidence base** that exists is required to enhance the provision of services including the establishment of multidisciplinary models providing clinical networks, shared care and collaborative care, telehealth, enhanced internet access and self help sites. [13]

6. About RDAA

Our Role: A federated advocacy body with the specific mission of supporting the provision of high quality medical services to rural and remote communities.

Our Vision: The provision of excellent medical care in rural and remote communities in support of healthy, thriving, sustainable communities.

Our Objectives

The main objectives of RDAA are to help ensure that:

***people in rural and remote Australia*:**

- have **access** to optimum health care regardless of where they live or their life circumstances;
- are **not disadvantaged by a "metro-centric" approach to policy** that can fail to strategically address the needs of those living in rural and remote Australia;
- **have equitable access** to healthcare through the provision of:
    - **high quality primary and secondary care**,
    - **a sustainable and expanding workforce**; and
    - **viable and flexible models of service delivery**.
- **benefit** from ideas, actions and outcomes of current best practice;

and are supported by

- **research** that discovers, interprets and develops the most effective strategies for supporting and expanding medical services in rural and remote Australia;
- a **multidisciplinary approach** to the provision of healthcare in rural and remote communities; and
- **professional development and ongoing education and training** for the rural medical workforce.

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[13] We note for example the submission to this inquiry from the Centre for Mental Health, Australian National University.