

Rural and remote health in Australia: how to avert the deepening health care drought

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Many voices proposing innovative strategies — which way forward?

Australia is considered by much of the world as the “great outdoors”, with tourists travelling from afar to see our landmark deserts, rainforests and other natural wonders. Yet we are, in fact, an urbanised nation, with fewer and fewer Australians living outside capital cities. And with the shrinking of our rural population, a growing problem has emerged: increasingly noticeable disparities in health outcomes, with people in the bush generally doing less well than those in the cities.

Over the past decade or so, a range of initiatives have been implemented to try to address the dwindling rural health workforce. To gain some insight into how these initiatives are progressing, we interviewed leaders from key medical organisations with a specific interest in rural health care (Boxes). They shared with us not only their medicopolitical views, but also their personal experiences in rural and remote practice.

Despite much effort, the workforce and health care picture painted is still one of a parched landscape which, in places, is becoming progressively drier. Without much “rain” forecast for the next 10 years, the leaders we interviewed advocated a raft of further innovative strategies which, if introduced sooner rather than later, may help to avert the deepening rural health care drought.

Solving the workforce shortage

Recruitment: the role of exposure

All experts agreed that recruitment into rural and remote practice is a key problem, exacerbated by a national medical workforce shortage. In response, there has been a recent proliferation of new medical schools, and development of rural clinical schools and university departments of rural health. However, there will be a time-lag of 10 years or more before any real effect is seen in the workforce. Until then (and afterwards), exposure to rural and remote practice early on in medical careers, from student years onwards, is seen as the key to long-term recruitment into rural and remote practice. Not just exposure per se, but supported, positive and continuous exposure.

John Graham, Elected Councillor, Royal Australasian College of Surgeons (RACS) and, previously, rural representative to the RACS Council, said, “We know, for instance, from the figures that have come from James Cook University in Cairns, that if you can get your medical students into a rural training program early on, then you’re likely to retain more of them in rural practice”. And the opportunity for rural exposure can only increase, with the need to accommodate the training and early career needs of increasing student numbers. David Campbell, President of the Australian College of Rural and Remote Medicine (ACRRM), is also a director of a regional clinical school in Victoria, which has already been “oversubscribed” by students. Students see a rural placement as an opportunity to “suck it and see”, and to experience the breadth of skills that rural doctors have. Furthermore, Campbell said “the smart ones” also understand that the rural setting is a better

training environment. “They’re not going to be standing at the back of a group of 20 people at a major teaching hospital in the city; instead, they’ll be dealing one to one with clinicians.”

Graham, and Ross Maxwell, President of the Rural Doctors Association of Australia (RDAA), warned that the “exposure” plan can fall down when graduates who have had rural exposure as medical students enter the workforce. Graham extolled the value of rural rotation in the prevocational years of training. David Rivett, Chair of the federal Rural Reference Group of the Australian Medical Association (AMA) and New South Wales AMA Board representative for rural NSW, agreed, saying that the “hub-and-spoke” model, in which a rural hospital has an urban linkage and affiliation, helps “expose” doctors in the early years of their medical careers. However, rural rotations should be given due recognition. “There’s an intrinsic, inbuilt feeling in a lot of tertiary hospitals that rural practice is not second rate, but even third rate”, he said. Maxwell pointed out two other common, important problems with some rural rotations — being too short to allow the doctors to feel as though they belong and, even worse, traumatising relatively inexperienced doctors by sending them out to single-doctor towns without support.

Exposure to rural practice has long been a part of general practice training in Australia. Chris Mitchell, Chair of the National Rural Faculty of the Royal Australian College of General Practitioners (RACGP), says that a lot of people, including him, ended up in rural general practice because they found they liked it during a mandatory rural term in their early postgraduate years. The two specialty college representatives we interviewed would also like to see some sort of mandatory training in the rural setting as part of specialty training programs. However, Paul Bauert, Chair of the Rural Taskforce of the Royal Australasian College of Physicians (RACP), flagged some obstacles. “There’s been a great deal of resistance to it [the mandatory rural term] from the Division of Paediatrics and Child Health trainee committee, and there’s been an absolute resistance to it from the RACP adult divisions from both the Fellows and the trainees.” Graham said that, although there is no mandatory training term for surgery, registrars who take up a rural-based training position go home with both the benefit of exposure to rural and remote practice and an RACS logbook that is better than they can achieve elsewhere.

Marketing: the big picture versus the bottom line

Opinions varied as to how rural and remote medical practice should be marketed to students and new graduates. Mitchell said the lifestyle and clinical satisfaction of rural general practice should be promoted across the whole journey of general practice. “We’re doing it in a piecemeal kind of way, but we’ve got to be targeting schools, medical students, prevocational registrars and also, of course, vocational registrars.”

However, Maxwell saw a problem in pushing a career in rural practice purely on flexibility, mobility, a great lifestyle and



Representative: John Graham

Roles: Elected Councillor, RACS; previously, rural representative to Council, RACS (2000–2006) and Chair, Divisional Group of Rural Surgery, RACS (2004–2006) (also, Co-chair, Rural Specialists' Group, Rural Doctors Association of Australia)

Alma mater: University of Sydney, 1972

Discipline: Vascular and renal access surgeon

Location: Lismore, New South Wales, since 1992

Childhood: Born in Sydney, primary school in Singapore and high school in Sydney

"I was the second resident ever to come to Lismore and I knew that if ever an opportunity came to go to the country that it was something that I could really encompass and that I would enjoy doing."

wonderful practice, when the time commitment is often very full-time. "We really need to make sure that rural medicine has a very good professional profile, so that we can then attract people who may otherwise consider being specialists", he said. Further, Maxwell saw a need to compete with other opportunities for doctors. Since reviewing salary packages and making them more attractive, Queensland has been successful in recruiting enough doctors to exceed the set target. "The fact is that, before, they weren't competing; so, of course, they weren't going to attract doctors — if you won't compete, you'll never win", he said.

Training conundrums

Training for rural and remote practice carries the dual challenges of training the right people and training them in the right way. Mitchell believes that the current general and rural training streams for vocational training for general practice in Australia require urgent review. In his opinion, the rural training stream, with its rules, regulations and restrictions, is far less appealing to Australian graduates than the more flexible general pathway. Although about 40% of registrars in the general stream have an interest in rural training, no incentives or rewards are directed towards the general pathway. Mitchell adds, "We've got to provide incentives for those people who train in rural areas, and those incentives should increase with increasing remoteness, not only financial but also in terms of increased educational resources and increased support". The extra year of skills training in the rural stream will soon be recognised by a rural health Fellowship rather than the existing Diploma.

But there is competition. From as early as 2007, there may be an alternative path to a rural general practice via a Fellowship offered through the ACRRM. Campbell said the ACRRM's position is that the best training environment for rural practice is "in rural areas by rural doctors" and that the RACGP model, in which rural practice is an "add-on", is the wrong model. Instead, the ACRRM's 4-year program involves "immersion" in rural medicine. Doctors will be able to train in a variety of environments relevant to rural practice, including a hospital environment, and will be able to complete requirements in any order they choose. Although most training will be based in the rural environment, it is anticipated that ACRRM Fellows will also be able to work as generalists in urban practices.

Rivett said the specialist colleges also need to train more generalists. "There's a dearth of general physicians and general surgeons, who are core people to provide high-quality services aside from your rural GP. It can't all go on the heads of rural GPs." Bauert concurred that physicians practising in rural and remote areas will need to be trained as generalists, rather than as subspecialists. Rivett added that these generalists will need to be buttressed and given career support. "If you're a generalist for 10 years, maybe you can go back and get a step up to become a gastroenterologist or cardiologist, or whatever. That rural time will be given some recognition and give you some precedence in the system."

According to Graham, from the beginning of 2008, the new RACS training program will select trainees directly into the specialties. We may have to work towards having rural surgery as its own specialty "and, if you like, buy slots in each of the other training programs". "Difficult, untried, but necessary, if we are to train people with the broad exposure necessary for work in rural surgery", he said.

With the specialist colleges becoming more and more specialised, Bauert believes the ACRRM's original proposal to look after all doctors who were going bush, not just GPs, could work well. The ACRRM could be an overarching body, taking on the mantle of responsibility for trainees and supporting Fellows from all colleges. "You could have an ACRRM member, who may be a Fellow from a different college, providing support and most of the supervision, and then you would have regular video links with your formal supervisor — a Fellow of your own college, in a nearby centre or hospital", he said.

Campbell has an even broader vision. He believes that if we can support and start to champion the rural environment as an ideal medical training environment, it has the potential to change the way health services are delivered across the nation by restoring the role of the generalist, "if we get a large enough cohort of doctors being trained in rural practice, with the range of skills that rural doctors have got". Maxwell came to a similar conclusion; he said that while we are yet to see if rural clinical schools can help address the workforce problem, if nothing else, they will hopefully give a generation of graduates an experience which leads to a more generalist practice.

Overseas-trained doctors

The Australian rural workforce now relies heavily on international medical graduates. No longer considered as temporary solutions, in some towns, overseas-trained doctors (OTDs) have become part of the community. Much progress has been made in terms of



Representative: David Campbell

Roles: President, ACRRM (also, Director, East Gippsland Regional Clinical School, Monash University, Bairnsdale, Victoria)

Alma mater: University of Adelaide, 1978

Discipline: Rural general practice

Location: Lakes Entrance, Victoria, since 1983

Childhood: Adelaide (“a big country town”)

“For as long as I can remember, I wanted to go into rural practice because I saw that as probably the only opportunity within the profession to develop and retain a whole range of skills.”

their initial assessment; however, orientation, support and supervision are further challenges that have yet to be adequately met.

Rivett pointed out that if a supervisor is the OTD's employer, he or she may have a vested interest in not reporting problems, for fear of losing a valued employee. “The supervisor needs to be a more independent person, actually supposed to sit in with them for some hours on a regular basis. And for that to happen, it would need to be properly funded”, he said. Further, in terms of support, OTDs do not have the same “network of mates” to ring for advice; Rivett said they need to be given an artificial network to support them. Graham suggested that overseas-trained surgeons ought to first spend time in a larger hospital close to their designated practice location, so that they understand the Australian hospital system and network with the surgeons with whom they are going to be relating.

Retention: essential

Maxwell said the health care system in most rural communities is relatively fragile — very much dependent on a small team of people with the right skills mix. Sustaining this requires constant regeneration of the workforce, which is proving to be a challenge. Apart from not bringing young Australians into rural medicine in anything like adequate numbers, older doctors who have broad experiences and procedural skills are being replaced by a cohort of doctors who may not have those skills. Graham's greatest fear is that, if 35% of our rural surgical workforce retire in 5 years, as has been suggested, the surgical workforce will be depleted before the problem starts to be addressed. Thus, there is a current urgency to retain as many rural and remote doctors as possible over the next 10 years. Rivett advised increasing grants for the retention of ageing rural doctors: “. . . generous retention grants or tax breaks to try and keep those people in the workforce till we get new people there”.

More generally, most of the leaders we interviewed identified similar elements that can help lead to longevity of a doctor's career in rural medical practice, including a reasonable workload, access to a local hospital and having a variety of work, including procedural work. Adequate cover and improved locum support were stand-outs, for both professional and lifestyle reasons, as was recognition, both professional and financial, of their efforts.

Rivett suggested that GPs and specialists be provided with locum support to go to a tertiary centre for some months to up-skill in any area they choose. Also, they should have a “leg up” if they want to go back to that tertiary centre at some time to further their career. He thought state governments could, fairly easily, overcome the “indemnity barrier”, where hospital administrators have vetoed planned up-skilling because of concerns about the adequacy of medical indemnity provisions.

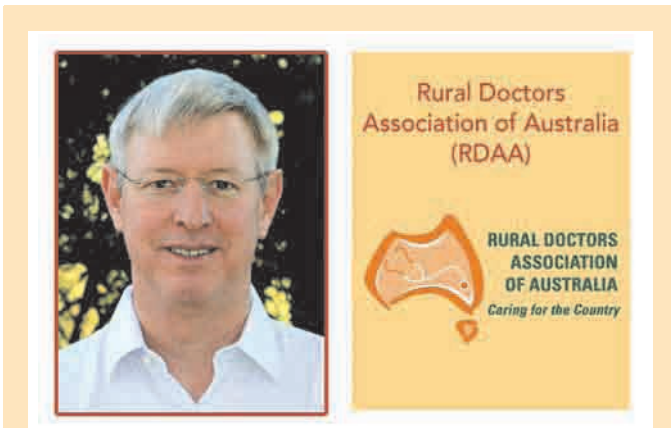
Although the rural lifestyle is often touted as one of the desirable things about rural practice, it can be a drawback when workforce shortages lead to long hours and difficulty in taking leave. Rivett said there should be an agreed core number of doctors for each rural location, a number that allows people to have a lifestyle. “Generation X and Y certainly don't want to work the crazy hours that us dinosaurs have worked in the past”, he said. If a town needs four doctors for them to have a reasonable lifestyle, and if patient numbers are not sufficient for a fee-for-service Medicare Benefits Schedule income to support them, then subsidies are needed so that the town becomes an attractive place to work. Mitchell works in a well staffed general practice of “part-timers” in a town of 7000–8000 people. There are usually between four and five doctors working at any one time; they are all involved in the after-hours roster, and they cover their own leave.

“Family friendliness” was seen as crucial, as was access to educational services. Maxwell said that although only about 30% of GPs in rural and remote areas are women, compared with more than 50% nationally, most young doctors moving to rural Australia are women, and Mitchell pointed out that nearly 60% of new medical graduates are women. Hospital obligations are very difficult to fulfil when there are no facilities to assist doctors with families — what do you do if you get called in to deliver a baby while you are out shopping with the kids? Mitchell said we need both adequate on-call allowances and adequate leave provisions for visiting medical officers (VMOs); these issues apply to specialists as well as to VMO-GPs.

Workforce efficiencies

Information technology (IT) was generally seen as a potential tool that is yet to be fully utilised, particularly in the clinical setting. Rural-based physician trainees can link in with their training program in Melbourne, and Bauert has used IT to link with doctors in a smaller hospital, providing supervision and finding out what may turn up at his hospital over the next few days. Mitchell's practice routinely keeps copies of high-quality evidence-based guidelines on its server to assist in quick searches for relevant information.

Maxwell thinks that remote doctors would have stronger drivers to use IT. However, it seems that IT use in clinical practice is still struggling with some fundamental teething issues. Despite its huge potential as a workforce solution, there has not been a commitment to providing the required IT infrastructure, or an appropriate fee structure for the time and expertise involved. For example, there is



Representative: Ross Maxwell

Roles: President, RDAA (also, South West Area representative, Queensland AMA Council; and Board member, Health Workforce, Queensland)

Alma mater: University of Queensland, 1982

Discipline: Rural general practice

Location: Dalby, Queensland (on the Darling Downs), since 1989

Childhood: Rural Queensland

"I grew up on a sheep and cattle property 50 km west of Winton. Fantastic childhood, spent a lot of time working the property with my mum and dad."

no system to pay for specialists or rural doctors to give or receive opinions over the phone or electronically. Campbell pointed out that there are international models which we should consider adopting. "There's a really good model in Alaska being run now, whereby small, isolated rural health teams are provided with what they call an IT cart — where the health worker can do an ECG, do spirometry, take a photograph of a tympanic membrane of the ear, load that onto the system, and then send an email to the clinicians back at the base hospital, who will then give them a report about that patient. Now, it's not real-time, but they get a report within a few hours and they are able to deliver care in that way. It works extremely well."

Developing the role of practice nurses has helped to take some of the pressure off doctors. However, while there was strong support for health care teams headed by doctors, this did not extend to health care workers replacing doctors. Rivett recalled an instance where a nurse practitioner was sent by the state government into a country town to help the solo GP. The GP's practice was decimated to the point where he left town; the nurse practitioner left some months later, and the town was left with no primary health care worker. Bauert is aware that remote area nurses supported by visits from district medical officers have sustained remote communities in the Top End of the Northern Territory, but his personal feeling is that the level of care cannot be the same as if there were a full-time GP or viable general practice service there. Nevertheless, all agreed that task substitution or, at least, collaboration rather than competition, remains a way of keeping the doctor's workload tolerable. For example, Graham said surgeons in rural towns could be supported in their on-call commitments by appropriately trained GPs.

Economic incentives matter

Remuneration was perceived to be a huge barrier to the recruitment and retention of rural and remote doctors. Although all

representatives were aware of oft-proposed geographic provider numbers, in the main they preferred rural incentive and retention packages. Bauert pointed out that Darwin has recently been experiencing the "Vortex to Queensland", achieved not via geographic provider numbers, but through location allowances and incentives — the further from a major centre, the higher the incentive. Maxwell reminded us how industry copes with a workforce problem; for example, the mining industry — if they want a workforce in a certain area, they provide the economic and professional conditions that will attract the workforce. They make the incentives clear and specific and they present them up-front.

Maxwell reasoned that the argument for geographically determined enhanced Medicare rebates had foundered around the question of whether the intrinsic intellectual content of consultations in rural and remote practice is different. However, GPs who work out bush do feel there is a context around what they do that is different — because they manage not just the primary kind of care, but also hospital-level care and serious emergencies. Another key difference between metropolitan and rural practice is the additional on-call commitment without any extra financial incentive, and with accompanying family and general lifestyle issues. Mitchell did not consider rural and urban practice to be very different. "When you look at BEACH [Bettering the Evaluation and Care of Health] data, the vast majority of work done by rural GPs and city GPs is very similar. I'm not suggesting that there isn't a need for procedural competence in certain contexts of rural general practice, but those contexts are basically confined to working in RRMA [Rural, Remote and Metropolitan Area classification] 4 and 5 towns, where there is a hospital appointment. There are about 1000 proceduralists out there, but about 5000 rural general practitioners." He saw the remuneration problem as applying to both rural and urban general practice. "It's certainly just as difficult a specialty as any other", he said. The key problem, as he saw it, is that the reward for general practice is "pathetic" compared with the financial reward for some other medical specialties. "This is affecting the choice that medical graduates make when they're coming through with a huge HECS [Higher Education Contribution Scheme] debt", he said.

Keeping rural communities alive

Although some rural communities, particularly those on the coast, are growing, many others are crumbling, experiencing the progressive loss of infrastructure. Bauert believes that the rural GP is really the "glue" that can hold a lot of remote communities together. Rivett thought a GP in a town would be vitally important in maintaining an aged care facility and in allowing people with chronic diseases to be cared for in the community, without having to shift to a city location. Although Mitchell did not want to suggest that rural GPs are not a linchpin in their community, he did consider that communities need more than GPs; they need an entire infrastructure. "It's very challenging for rural communities when they lose their GP, but it's also very challenging for the GP to remain in a rural community that's losing its school, that's lost its accountant and its bank and all of the infrastructure that allows it to function."

Mitchell saw the plight of dying communities as irreversible without investment. "What is required is a proper resourcing of these communities and a push to get people in other careers going to the bush, like bankers and accountants." There also needs to be better and more equitable resourcing of education, as well as



Representative: David Rivett
Roles: Chair, AMA Rural Reference Group (federal); New South Wales AMA Board representative for rural NSW
Alma mater: University of Melbourne, 1972
Discipline: Rural general practice
Location: Batemans Bay, NSW, since 1975
Childhood: Mostly spent in Melbourne and Adelaide, with 2 years in Switzerland
 “Holidays in Deniliquin, NSW, as a 10–12-year-old, playing in irrigation ditches and being chased by sheep and cattle was enough to give me a love of the country.”

health. “We balance a lot of issues in terms of schooling — like balancing physics to English. Well, I think we need to really look at some sort of balance for rural origin versus city students, as well.” Going further, he asked: “Is there any real reason why government departments have to be in completely overcrowded cities? There are lots of regional centres crying out for that sort of capital investment.”

Exploring models of health care delivery

Hub-and-spoke

Bauert thought the “perfect world” of rural health care delivery — a good hub-and-spoke model, involving programs like the Medical Specialist Outreach Assistance Program, in which specialists go out to remote communities several times a year, providing support to the district medical officers, GPs, nurse practitioners and Aboriginal health workers — was shattered by the poor funding arrangements for such outreach programs. Although largely from a single source (the federal government), money for various programs seems to be inefficiently doled out from separate “buckets”, instead of being centrally administered, with considerable “wastage” as various federal and territory bureaucrats decide how best to distribute it. Also, conditions under which practitioners can access the money are not determined by practising doctors, but seem to be engineered by bureaucrats to show accountability. Rivett concurred: “If you look at the Specialist Outreach Assistance Program, it’s a great concept, poorly funded and poorly administered.” He said specialists are providing a great service, but not getting proper support; for example, they may not be being funded for travelling expenses.

Maintaining small rural hospitals

The steady decline and loss of rural hospitals and access to procedural services were of major concern to all leaders we interviewed. Campbell said that the decline is not necessarily linked to the viability of a rural town. “It seems to be an independent process really, related to lack of funding support and lack of adequate training for people with the skills to be involved with those services.” Hospital services are being repeatedly downgraded, or not upgraded to match the growth of towns. Doctors leave centres when frustrated about not being able to get rostered time off or time to attend training courses, having too many commitments, or lack of access to theatres — whenever there is a financial crisis, theatre lists are cut back.

The problem may lie in the different goals held by health bureaucrats compared with health practitioners. Rivett put it bluntly: “If you want to be a successful bureaucrat, you’ve got to have an underspend in your department’s budget for the year. That’s how success is measured. Not what [health-related] results you achieve, but how well you do at saving dollars.”

Campbell has found trying to provide a medical service in an environment where the nearest hospital is 40 minutes away extremely difficult and costly. His practice has self-funded a very large three-bay emergency area to deal with the “things that turn up at the door”. A state-run community health facility in the same district shuts its doors at 8pm. Campbell has waged a long, unsuccessful campaign trying to convince the Victorian state government to direct more resources to his town. “I’ve famously been told by one health minister, when I said that Lakes Entrance was the largest town in the state without a hospital, ‘Well, not for long, we’re going to close some’.”

Whatever the cause of the hospital closures, Rivett said that he would like the next Council of Australian Governments agreement with the states to lock in rural hospitals where they are, prevent further downgrading, and look at federal funding to maintain rural health care. “We need some sort of buttress and a guarantee that these facilities will be available into the future”, he said. “There’s got to be some vision from health bureaucrats as to what’s going to happen in rural health care in years to come. You can’t just have patients getting flown 100 km for treatment all the time. It affects their families enormously.”

Primary care infrastructure

Campbell does not think that the model of the doctor-owned practice is necessarily suitable for rural practice in the future, particularly small town practice. Why would anyone want to put some capital input into something that is going to lose value as time goes by, rather than gain value? “Local government or state government or maybe universities could own the infrastructure and actually take responsibility for managing the practices, and just provide an opportunity for doctors to come in and do their job without having to worry about capital input or the management side of things”, he said. Mitchell also thought it was important to have “easy entrance, gracious exit” sorts of models, whereby the practice infrastructure is owned by a third party.

Mitchell’s view was that what the community needs is health services and, while throwing dollars at doctors will help, it will not necessarily address the lack of services for rural communities. “We actually need to look at some other models. I really think that we need some primary care infrastructure to be built, so that rural GPs can be working at the centre of teams”, he said. Extended



Representative: Chris Mitchell
Roles: Chair, National Rural Faculty, RACGP; Vice-President, RACGP; (also Chair, North Coast GP Training, New South Wales)
Alma mater: University of Newcastle, 1986
Discipline: Rural general practice
Location: Lennox Head, NSW, since 1991
Childhood: Born in Brisbane, grew up in Hobart
 “I got sent up here as my first basic GP term . . . came up and basically just fell in love with rural general practice.”

practice teams should be made up of nurses, advanced nurses, medical assistants and allied health workers, all working under the delegation of GPs. “The reality is, whether you’re talking about city general practice or rural general practice, it has been starved of funds for infrastructure investment. It is far more efficient in my view to deliver community health services through general practices than it is through a side-wing on a public hospital.” Mitchell added that we also need a primary health care strategy, to allow for strategic rather than ad-hoc investment of resources, with all organisations involved. “I think we need to stop the fixation that we’ve got on secondary and tertiary care in Australia and seriously start investing in primary health care facilities. And, in particular, we need to do that in rural areas”, he said. “There are flexible ways to set up your services, but it does take a lot of effort to find your way through all of these things. At the moment, our practice has to find the program that we can slot into, like cardiac rehab and pulmonary rehab. What we need is a system-wide approach that doesn’t rely on [individuals’] enthusiasm.”

Matching services to needs, and supply to growth

Several of the doctors expressed frustration at the difficulty of getting government to invest adequately in growing communities. Mitchell said one of the issues particularly facing coastal areas is population growth that outstrips the supply of doctors and health services. Much of the population growth is in the over-65-years age group — people who require a lot of care.

Graham said that regional hospitals identify strongly with one another. “Although we seem similar to a small metropolitan hospital, there is a quantum leap between the resources we have and the resources they have.” He said the major problem that regional hospitals face is funding the work they are able to do and expected to do, leading to bed shortages and theatre closures, with more than 50% of rural surgeons reporting that they

consider their working environment to be fragile. An associated, important issue is that the medical community that practises in the country is generally not involved in the governance of its own resources.

Graham also said that being part of a larger health area can cause its own problems. Despite differing needs, hospitals can find themselves competing with other hospitals in their area for funding. “There was a time when we felt that the needs, for instance, of Lismore would be considered in terms of the Lismore surrounds, but now we’re all tied in the one big area. We do keep spending money at a higher rate than Coffs Harbour or Tweed or Port Macquarie, and so there’s sort of a move to try and downgrade us and build them.” He acknowledged that a greater political imperative may be at work — “swinging seats” may be influencing funding distribution.

Campbell said that the issue of economic viability of rural health services is based on a false premise. “If you’re talking about equitable delivery of services then you shouldn’t really be inserting comments of viability as well. I mean, you’ve got to understand that perhaps sometimes these services, per capita, are going to cost a bit more in rural areas.”

The critical role of government

There was much frustration with fragmentation of health funding and with bureaucracy. Campbell said, “underpinning all of our issues is the problem with the Commonwealth–state funding structure”. He said that when teasing out all problems, the brick wall “we run up against” is the Commonwealth playing off against the states or vice versa. Mitchell said, “I think I understand the frustrations of the Commonwealth when they throw money in and the state government pulls it out. I also understand the frustration of the state government providing services under their signature that could be done much more cost-effectively in a community setting”. Fighting aside, Campbell said the problem is the fairly piecemeal approach to issues at both federal and state level, which represents a “band-aid” approach without any major affirmative policy initiatives to address the issues at either level of government.

A very stark exposition of the state–federal divide in health care delivery in a small rural community is having a hospital sitting at one end of town, which is funded by the state, and a general practice (funded fee-for-service by Medicare) sitting at the other end. How can towns, instead of having two competing and not always complementary systems, actually have one health system which works really well? Mitchell personally thinks it would be really sensible if the “federals” took it over and stopped funding the state for some rural health services. As an example of inefficiency, he considered that, rather than having four or five different on-call services run by various practices in a small town, it would be far more appropriate for the doctors to be delivering their services in the safety of the hospital facility, using the infrastructure that is already there, while continuing to bill Medicare for their services.

Maxwell believes that, rather than there being any political conspiracy to not support rural health care delivery to the fullest degree, what looks like inactivity may actually be inertia and the fact that people “see the world in the context of their own street”. He regards it the work of organisations like the RDAA to try to remind politicians and bureaucrats that they have to have policy constructs that are workable and will deliver services in rural



Representative: Paul Bauert

Roles: Chair of Rural Taskforce, RACP; Council of Division of Paediatrics and Child Health, RACP (also, President, Northern Territory AMA; Federal Councillor, AMA; NT representative, Australian Doctors' Fund)

Alma mater: University of Queensland, 1977

Discipline: Paediatrics

Location: Darwin, NT, since 1977, with periods away for training and family reasons

Childhood: My father was in the army; I got used to moving between different locations and changing schools

"I was attracted to rural practice by a sense of adventure, something different."

Australia. We wondered if this problem could be overcome by specific representation, and asked several of the leaders whether they thought a Federal Cabinet Minister for Rural Health could assist in implementing specific rural health policies. Most had not considered the idea, but Campbell was open to the suggestion. "To do something meaningful for rural health, there may need to be someone with a focus solely and wholly on improving rural health and education for rural health, unaffected by the needs and the power of the metropolitan or centralist driven policy", he said.

Prime Minister, I think you should . . .

When we asked the leaders which two problems they would advise the Australian Prime Minister to address to improve the rural health situation, there were some consistent priorities. Almost all raised Indigenous health. For example, Bauert said, "Until we decrease the disparity between access to health by Indigenous people compared with non-Indigenous people, Australia as a nation isn't going to grow. If we can do that, we as a country would become a little more supportive of rural communities and more, if you like, compassionate". Campbell said, "The major issue with regard to rural health in Australia is Aboriginal health. The first thing I would do is set up state-based systems of community control for delivery of Aboriginal health services, appropriately supported on an equitable basis". Mitchell said, "The preoccupation with Indigenous health is essential. The problems, in many ways, are similar; they're just far worse for Aboriginal communities".

Among other key recommendations were: an affirmative action policy to ensure equitable provision of infrastructure for rural communities, including access to local hospitals that provide a

comprehensive range of services and integrated primary care facilities; and making general practice a career-of-choice again, via recognition and reward for general practitioners. There was also a call to be more attuned to the voice of the people in rural Australia, and in particular, the voice of the rural medical community. Graham said, "Really, at the end of the day, the medical community reflects the needs of the community at large".

Breaking the drought

In speaking with these leaders in rural health, we were struck by their different but equally innovative responses to the rural health care crisis, many of which they have implemented in their own practices: responses that often rely on the goodwill of those directly involved and which are not necessarily sustainable. Thus, not surprisingly, nearly all the leaders we spoke to called for the systematic application of strategies not only to increase the rural workforce but also, just as importantly, to ensure ongoing health care delivery in rural and remote Australia. Now that we have heard these many voices, it may be time to seek unity on a strategic direction forward.

Underpinning Australia's rural health care crisis is the concept of access. As Campbell put it, "I think we can directly equate health status to access. We know that where we improve access, we improve health. There's no doubt about that". The key strategies proposed by these leaders for improving access include: a hub-and-spoke model for secondary and tertiary care; the sustenance of small rural hospitals; the recognition of general practice (including rural practice) as a specialty in its own right; and the development of an innovative, collaborative primary health care infrastructure.

Our Prime Minister, John Howard, has said of the current drought affecting Australian farmers, "When the bush suffers, all Australians feel their pain". While our government can only wait with other Australians for rain to fall on the land, they can and should act now to promote the flow of health services to our rural heart, otherwise it will go into terminal failure. In the land of the "fair go", it is time to decide upon and implement the best strategies on offer, in the interests of equality and better health for us all.

Competing interests

None identified.

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