



**RURAL DOCTORS
ASSOCIATION
OF AUSTRALIA**

Caring for the Country

Federal Election Position Statement 2007

Under embargo until 7 August 2007

Introduction



The continuing rapid deterioration of health services available to Australians living in rural and remote communities is of extreme concern to the Rural Doctors Association of Australia and to rural families. Rural Australians deserve a health system designed to maintain and improve their health, not one constrained by financing disputes and bureaucracy.

Rural Australians want access to basic health care services in their communities through:

- **Strong and vibrant rural generalist practices** providing a focus for the provision of primary care services and procedural care in hospitals.
- **Rural hospitals which provide essential services** to their local communities including medical, maternity and surgical services.
- **Access to specialist medical services** through either local resident specialists or visiting services.

A Rural Health Obligation mandating the standards to access and services to be provided in rural communities must be established by Australia's next Commonwealth Government in order to achieve these outcomes.

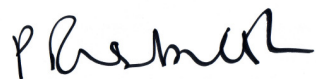
Underpinning the Rural Health Obligation, the Commonwealth Government must improve the support provided to rural practices and hospitals and this must include recognition of the isolation of rural doctors and the higher complexity of cases managed in rural practice. Key initiatives must include:

- **Establishment of minimum standards of access and services**
- **Support for training of rural doctors** including providing infrastructure to support the placement of students, junior doctors (interns) and rural doctors undertaking vocational training in practices and other health services, and increased support for doctors to teach and supervise.
- **Implementation of a Rural Isolation Payment** for all doctors working in rural and remote areas to reflect the isolation and the additional skills and responsibility associated with rural practice
- **Implementation of a rural practice loading** on the MBS for doctors who provide obstetric, surgical, anaesthetic, or emergency on-call service in rural communities

Without the implementation of these key initiatives, patient access to quality health services will deteriorate, the medical workforce will be under increasing pressure and rural Australians will continue to be denied the good health outcomes which metropolitan Australians enjoy. The Federal Government, with the state and territory governments, must put in place an action plan which will stop the decline in rural health care services. The government must work with the states utilising the Australian Health Care agreements to ensure rural health care providers are recognised,

supported, and remunerated adequately, so they are able to provide the care which rural communities deserve.

I commend this position statement to the parties in the federal election and look forward to seeing the policies and initiatives developed which will address the health inequities presently suffered by rural communities.

A handwritten signature in black ink, appearing to read 'P Rischbieth', written in a cursive style.

Peter Rischbieth
President

Rural Health Service Obligation

Community service obligations for rural and remote Australia should not be restricted to telephones. Rural communities also need a minimum health service obligation to ensure they have better access to rural doctors, local hospitals and rural health services. All Australians should be guaranteed access to local health services should they have a heart attack, be injured in a farming or road accident, or if they are having a baby.

The Australian government is the major funder of health services through Medicare and the Australian Health Care Agreements with the States and has a responsibility to ensure rural Australians have access to basic health services.

Rural Australians should be able to expect country towns will have access to a rural generalist doctor, accident and emergency services, maternity services, and essential medical and surgical facilities at their local hospital.

The Rural Doctors Association of Australia (RDAA) calls on the parties contesting the federal election to put in place a Rural Health Service Obligation in relation to rural health services and urges this obligation be the centrepiece of the next Australian Health Care Agreements with the state and territory governments. All levels of government should commit to improving the health outcomes of rural Australians, particularly outcomes for indigenous Australians.

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.

People who live in rural Australia do not accept the division of responsibilities between commonwealth, state and local government as an excuse not to provide coordinated services at local level. They expect the various levels of government will work together to ensure their health care needs are met.

Rural Health Obligation: The Standard

The RDAA has developed a minimum set of standards for healthcare services in rural and remote areas of Australia. These standards provide guidance for funders and providers of health care services in establishing what level of services are required in rural and remote Australia. As a starting point, current services should be retained and these standards should be used in improving and opening services.

Using the standards: Limitations and Environment

Setting standards for service access is fraught with dangers such as the standards being seen as a minimum and used to close otherwise viable services, or being considered inappropriate as they cannot be applied to all sizes of community.

These standards have been developed for use as a starting point and as a guide and it is expected they will be used in developing an action plan for addressing the service inequities which exist in rural Australia and in considering the development of new or upgraded services. They are not suitable to be used as a tool in determining the viability of existing services.

The standards have also been developed from the patient or consumer perspective as it is the ultimate goal of any health service to provide a quality patient service and outcome.

Rural Generalist Practice and Primary Care

Rural generalist practice is the principal provider of primary care services to rural communities and as such, primary care delivery should have rural generalist practice at the centre of all arrangements. Most Australians visit their local practice at least once per year and this provides a unique opportunity to provide care not only for acute and chronic health conditions but to engage patients in health promotion and illness prevention activities.

Having good primary care systems in place is the most effective way to improve health outcomes in the community. Evidence shows that primary care centred systems reduce mortality, lead to lower levels of usage of emergency departments and hospitals, provide better preventive care, increase early detection of disease including breast, colon and cervical cancers, have fewer diagnostic tests, higher patient satisfaction and less medication use. Primary care centred health systems whilst producing better health outcomes for patients also have a lower cost compared to specialist and hospital focused

systems. Health disparities such as those experienced in indigenous communities are best addressed through enhancing primary care systems

The following standards should be implemented:

- The rural generalist is the main provider and coordinator of medical care to the rural community.
- All rural communities, regardless of size, should have access to Primary Care Services via a rural generalist practice. These primary care services may take differing forms¹ dependent on the volume of services required in each individual community.
- As a general guide patients should be able to access rural generalist practices for urgent appointments within 1 business day and for routine appointments within 5 business days.
- Use of a team based approach should be encouraged. Other providers¹ in the rural generalist team may provide services for and behalf of the rural doctor.
- Rural doctors should be supported and funded to provide care to their communities which promotes health and prevents illness, particularly chronic illness.
- The demands of rural and remote practice should be recognised through additional financial support for rural practice and support for non traditional models of general practice which may support rural doctors achieve appropriate work/life balance.
- Very Remote communities – it is acknowledged that in very remote communities it may not be possible or viable to provide a local medical service but other arrangements should be put in place to ensure these people have access to adequate primary care services; this may include services provided by regular visiting rural doctors clinics, Remote Area Nurses, Aboriginal Health Workers and remote consultation (telehealth) arrangements.

Hospital Based Services

Rural communities should have as a minimum access to basic hospital services within 60 minutes. These basic services should include:

- Medical and Surgical care including the capacity to:
 - Undertake an emergency Caesarean Section,
 - Provide facilities so that GP surgeons and specialist surgeons can undertake general surgery and minor procedures.
 - Administration of chemotherapy
 - Treat common medical illness e.g. asthma, gastroenteritis, croup, including conditions requiring administration of IV antibiotics
 - Set simple fractures and undertake suturing of wounds
 - Provide of short term inpatient palliative care

¹ May include other health care providers including Aboriginal Health workers, practice nurses, remote area nurses and AHPs working in teams with general practitioners either collocated or in remote locations from the practice

- Provide access to aged care services
- Emergency care that is able to triage, stabilise and provide treatments. Examples of the services which should be provided include:
 - General accident and emergency services
 - Treatment of an Acute Myocardial Infarction with thrombolytics
 - Stabilisation of seriously ill patients prior to transfer to a major tertiary centre
- Diagnostic services including:
 - plain film X-rays
 - ultra-sound services
 - simple pathology services such as troponin levels (test to determine whether a patient has had a heart attack), blood picture (to help diagnose a range of deficiencies, diseases, and disorders involving blood cells), INR (to check how well blood-thinning medications (anti-coagulants) are working to prevent blood clots) and electrolytes levels (to detect a problem with the body's fluid and electrolyte e.g. glucose, sodium and potassium balance).

Maternity Care Services

Maternity Services are an essential component for thriving rural communities. Expectant mothers should be able to have their babies close to home, where they are able to access the support available in their local communities. Rural hospitals should, within a regionalised risk management system², offer maternity care services to a low-risk population. It is expected that small maternity units will be networked with larger regional maternity services to provide a coordinated and high quality maternity service within a region.

Small Communities

- RDAA recognises it is not possible to have a maternity unit in every small town and in these cases where there are a small number of births each year mothers should have access to a maternity unit not more than 90 minutes travel from the town.
- Where a local community and rural generalist obstetrician does decide to support a maternity service, even where the number of births may be relatively small, then additional continuing professional educational and infrastructure support should be provided to the midwives and rural generalist obstetrician(s) who provide that service.

² System that identifies mothers at risk of complications associated with pregnancy and manages that risk in association with higher level regional maternity services, this may include sharing human and physical resources to provide and/or enhance maternity across a number of maternity units

- Even where a maternity unit does not exist within a small rural hospital, emergency facilities including CTG monitoring³ should be available to deal with unexpected maternity emergencies. The hospital staff should be provided with training in obstetrics emergencies and access to advice and assistance from the regional services should be facilitated preferably through the use of tele-medicine facilities.
- Antenatal care and education will be available locally via local primary care facilities and rural generalist practices. However, it is recognised that expectant mothers may have to travel for some antenatal checks⁴ which require access to facilities such as ultrasound or consult with the rural generalist obstetrician or specialist obstetrician in the maternity service where they expect to have their baby. Where possible telehealth should be used to facilitate local care in a maternity team that may include rural generalists, practice nurse or Aboriginal Health Workers (AHWs), rural generalist and specialist obstetricians.
- Consideration should be given to how support will be provided after the mother returns home to their community after giving birth. As a minimum advice should be available via telephone from a midwife and the preferred model includes regular community nurse/midwifery visits.

Larger Communities

- In communities with a larger number of births, expectant mothers should be able to access a local maternity service.
- It is recognised that some town/hospitals may combine to offer maternity services in these cases the expectant mother should not have to travel more 45-60 minutes to access that service.
- Community midwifery services and rural generalist obstetricians should be available for post natal care.

Emergency capacity and Higher risk pregnancies

- In all hospitals and multipurpose centres which do not offer a maternity service there should be arrangements to deal with emergency births, this includes ensuring staff of the hospital are trained and appropriate equipment (e.g. CTG monitoring facilities) to deal with maternity emergencies. These staff should have access to support through a regional maternity service provider and tele-medicine services should be used where possible to provide this support at the bedside.
- Women at higher risk for adverse maternal and/or perinatal outcomes should be identified as early as possible in their pregnancy and arrangements to deliver in centres with the facilities to manage the complications of labour and delivery. Notwithstanding that these women will usually be transferred, as much on their antenatal care as is possible should be delivered locally.

³ Cardiotocography (recording the foetal heartbeat and the uterine contractions during childbirth) particularly for use in emergencies where hospital does not have a maternity service.

⁴ Usually at around 18 and 36 weeks

- Where an expectant mother has to travel away from her local community then appropriate assistance should be provided with transport and accommodation for her and her immediate family members.

Mental Health Care Services

Rural Australians suffer from a significant relative disadvantage in relation to accessing mental health services compared to metropolitan areas. Provided they receive appropriate ongoing support and treatment, most people with mental illness recover well and are able to lead fulfilling lives in the community. However, in the bush many don't receive the support and care they need and consequently have worse outcomes than if they were in a city.

Arrangements should be in place to support and enhance the capacity of primary care providers in rural communities, in the first instance rural generalists, allied mental health professions and community health services, to recognize and treat mental health problems and disorders more effectively, via the provision of education, training, and secondary consultation.

High prevalence disorders (including anxiety, depression and substance use)

As a minimum, patients should have access to focused psychological strategies. This service may be provided by appropriately trained rural generalists or by other mental health professionals.

Rural generalists should have easy access to shared-care arrangements with specialist mental health services to assist them in managing patients with more complex mental health conditions.

Psychotic illness – including schizophrenia and bipolar disorder

Patients who suffer from a psychotic illness in rural communities are significantly disadvantaged compared to metropolitan patients as access to support and treatment by specialised services is very limited and only usually available in large regional centres.

Given that psychotic illness represents only a small proportion of mental illness the emphasis in providing services to these patients should be on shared care arrangements and supporting rural mental health providers manage these patients in their local communities. It is essential that close links develop between specialist units and rural practitioners and that appropriate communication channels are available including appropriate discharge planning and facilities for tele-psychiatry

Specialist Services

Access to resident specialists in regional centres is a vital part of the health care services that Australians who live in rural communities should be able to expect.

Support for 'fly in fly out' services, such as the Medical Specialist Outreach Assistance Program is also vital in ensuring access to good quality care; however, the support for these services should not be at the expense of specialists who are resident in rural communities and who have, in many cases, been providing outreach services to small communities for years.

Through the provision of appropriate support, including financial incentives, the development and retention of specialist services should be encouraged in rural communities and regional centres. In some cases remuneration models for specialists may need to include a sessional or salaried component as the traditional fee for service arrangements may not support the viability of a remote service.

The lack of generalist specialist training places in Australia is a major impediment to providing rural health services. The Government needs to recognise that the decline in general specialists in favour of sub specialisation ultimately disadvantages rural communities as these 'super specialists' are confined to the city where that can access larger tertiary referral hospitals. The government needs to support the training of Generalist Specialists and provide support to attract and retain them in rural communities.

Those specialists involved in teaching and training of students and junior doctors should receive appropriate remuneration, infrastructure facilities, and administrative support. Resident specialists should also be able to access support through the Rural Retention Program as an incentive for them to continue to provide services for rural communities.

Indigenous Health

The RDAA finds it totally unacceptable that in this day and age the average length of life for an indigenous person is 17 years less than the general community. The appalling health outcomes for many indigenous Australians demand commitment from government and the following areas need to be addressed urgently:

- high incidence of chronic diseases like renal failure & diabetes and other diseases rarely seen in other Australian communities such as rheumatic fever & trachoma;
- Higher infant mortality and low birth weight infants
- High levels of middle ear infections and eye conditions;
- Poor health behaviours including substance abuse; and
- Poor access to health services and particularly good quality primary health care.

The current initiatives to address child health in indigenous communities in the Northern Territory need to be followed up with a long term and strategic plan of action. The federal government, with state and territory governments, needs to address the health outcome inequities across the whole of the indigenous population so that indigenous Australians can look forward to outcomes on par with the rest of Australia within a generation. This plan should be across sectors and departments and address not only health services but factors which are considered determinants of health such as housing, education, and employment.

Ambulance and Retrieval Services

Acute services need to be well supported by ambulance and retrieval services. Access to assistance from these services should be easy e.g. through a single assistance phone number to facilitate easier communications between health units to avoid delays in the transport of critically ill patients.

Rural emergency departments should also have access to immediate advice from emergency and trauma centres in major hospitals when rural doctors are treating complex life threatening cases, where possible this should be provided through the use of telemedicine and teleconferencing facilities within the rural hospital emergency department.

All Rural hospital emergency rooms should be supported to meet basic standards for provision of equipment for resuscitation and acute emergency treatment.

In communities where the local doctors provide the only access to emergency care through their practices, these practices should be supported through the provision/funding of basic emergency and resuscitation equipment and medications including:

- automatic defibrillator and cardiac monitor,
- pulse oximeter,
- intubation equipment inc laryngoscope, hand ventilation circuit and endotracheal tubes and oro/naso pharyngeal airways,
- Oxygen & suction system,
- IV sets, cannulae and fluids.

Commitment required to implement a Rural Health Obligation

The parties need to make a 'fair dinkum' commitment to addressing the inequities rural communities suffer in relation to access to basic health services. This commitment starts with recognising basic services are lacking and setting a standard which communities can expect in relation to health care services. Unless rural communities are able to attract appropriately trained and skilled rural doctors, and support rural health services and hospitals these communities have a bleak future.

Outlined below are the areas which need to be addressed. Additional detailed information can be obtained from the RDAA website in RDAA budget submissions and policy documents.

Building capacity to support and teach undergraduates, junior doctors and supervised international medical graduates in rural practice

With the significant increase in university medical places, attention must be focused on supporting rural doctors to increase their capacity to host and teach medical students and junior doctors.

Rural doctors recognise their professional responsibility to assist in teaching but are often hamstrung by workload, infrastructure, and business pressures which make it difficult to support the clinical education of medical students and junior doctors. With a current heavy reliance on international medical graduates we also need to ensure rural doctors are supported and encouraged to mentor and supervise new international medical graduates to ensure they are able to provide a safe and high quality service to their communities. Specific measures which should be developed in this area include:

- **Support for clinical infrastructure** for teaching including assistance with the costs associated with accommodation/facilities required to undertake quality teaching
- **Support for teaching** by changing the current Practice Incentives Program payment so it covers the true costs associated with teaching and broadening the eligibility for this payment to all practices accredited by the university medical schools or the Regional Training Providers to teach students/registrar. The change should also include the establishment of a separate Teaching Incentive Payment (TIP) that is paid directly to the

practitioner providing the supervision and teaching. The TIP payment should be equal to a 25% loading on the MBS that reflects the productivity loss associated with teaching.

- **Support the training of general specialists**, additional training places should be established for specialist training that is broadly based and is generalist in nature. Rural hospitals cannot support specialists who have narrowed their speciality down to the extent that they do not deal with the full ranges of cases covered within their general speciality area.
- **Support for supervision of International Medical Graduates**, the large numbers of International Medical Graduates (IMGs) in rural communities who require supervision, mentoring and support from rural doctors is placing a significant financial and professional burden on these doctors. Financial support should be provided to the supervising doctors and they should be fully indemnified in relation to both their clinical supervision and other supervisory responsibilities such as preparing reports and undertaking assessments.

Attracting more doctors to the bush

There has been almost no success in attracting graduates of Australian universities to take up rural practice. Recent figures available for NSW and Queensland Universities indicate less than five per cent of medical graduates over the past 15 years are in rural practice. Even with the larger numbers of medical graduates, it is unlikely they will even be able to replace the current members of the medical workforce who will leave rural practice in the next five years. At least 1000 new rural doctors are required today to even match the doctor to patient ratio in metropolitan Australia and this figure will increase during the course of the next government. Additional initiatives need to be put in place to ensure rural communities retain access to medical services. Both procedural and non procedural doctors need to be recruited; however, specific incentives for doctors to undertake procedural training need to be put in place. Specific measures which should be implemented include:

- **Additional rural clinical school places** - additional places should be made available and opportunities for funding the establishment of new clinical schools associated with new medical schools should be taken.
- **Increase the number of medical scholarships** - the number of John Flynn Scholarships and Rural Australia Medical Undergraduate Scholarships be increased in proportion to the increased number of medical undergraduate places
- **Better targeting and indexing of PIP payments** - review the PIP payments system so it better targets improvements in workforce and primary health care outcomes. In particular, there is a need to examine how payments can be targeted to employed doctors, international medical graduates and new medical graduates to provide incentives to undertake rural practice. The real value of the PIP payments relating to rural practice should be restored through indexing them to appropriate indicators including average weekly earnings and CPI.

- **Improved targeting of rural retention payments** – The government should implement the recommendations of their own report on the retention payments scheme including increasing and indexing payments and making them tax free. The eligibility waiting period should also be reduced to improve the attractiveness of rural practice. Resident rural specialists should also have access to rural incentive payments.
- **Provide incentives for doctors to obtain procedural skills** - The numbers of rural doctors who have procedural skills (obstetrics, surgery and anaesthetics) continues to decline. There is no real incentive for registrars to undertake procedural training. The federal government, with the states, should provide real incentives for doctors to undertake procedural training. These incentives should compensate the doctors for the loss of income they incur compared to that which they would achieve in a general practice. The incentives should target both registrars and established rural doctors.
- **Commonwealth funding of procedural training places** - State governments currently have responsibility for procedural training, however, the number of places and training arrangements vary dramatically and are generally considered inadequate to maintain the rural procedural workforce. The Commonwealth should take responsibility for funding procedural training places and ensure all training places, where possible, are located in regional and rural centres where rural proceduralists are most needed. It is recognised that positive rural training experiences will lead to long term rural doctor recruitment and retention rates as such additional procedural training places should also be established in rural hospitals.

Retaining and supporting rural doctors

Getting doctors into rural practice is one thing but retaining them for significant periods of time is quite another.

Higher complexity of clinical practice and isolation are just two of the many challenges faced in rural medical practice. Unlike their metropolitan colleagues, rural doctors have to deal with every medical condition that comes through their doors or presents at the local hospital, often without support from their specialist colleagues.

Rural doctors rarely have support from deputising services, they have to provide 24 hour medical cover to their communities and major tertiary hospitals can be many hours away, even by air. Many rural doctors also provide procedural medicine to their local communities in areas such as obstetrics, surgery, anaesthetics, emergency care, etc; this places a significant additional burden on the doctor, their practice and their family.

The work undertaken by the RDAA in its Viable Models Study identified three areas which need to be addressed if a viable, and thriving, rural medical workforce is to be maintained, these are:

- **Economic issues** – the economic viability of rural practice remains in doubt. The medical benefits schedule has failed to keep pace with changes in general practice and cost structures, and many rural practices have to supplement their income from other sources to keep their doors open.
- **Professional issues** – workforce remains a significant problem in rural Australia. Practices are unable to recruit doctors and when they are recruited they are often faced with excessive workloads, lack of relief and little access to support from other members of the health workforce such as specialists and allied health practitioners.
- **Practice organisation and infrastructure** –The needs and requirements of rural communities' are changing, professional standards levels are being raised and small rural practices are disadvantaged by their size and isolation as they strive to continuously improve the quality of their practice and to support quality practice and teaching. The costs associated with building and maintaining high quality infrastructure are very high and the return on investment (ROI) is very low. In addition to ensuring adequate ROI, practices need support in ensuring they have adequate planning and systems (both human and information/communication technology) in place to support the future needs of their communities.

Economic issues

- **Implementation of Rural Isolation Fee For Service incentives** - implementation of fee for service (FFS) incentive items for medical practitioners working in rural and remote communities to act as systemic incentives to recruit and retain practitioners and to compensate them for the professional and family isolation, and the increased skills and responsibility, of rural and remote practice.
- **Implementation of a Rural Practice Payment**, in addition to Medicare A1 rebates, for consultations for all practitioners who meet defined service obligations including the provision of a minimum level of obstetric, surgical or anaesthetic (procedural) services and/or primary accident and emergency on-call services. The payments would be on a sliding scale dependent on RRMA3 and would range from 15% for RRMA3 through to 50% for RRMA7.
- **Implementation of a simplified medical benefits schedule.** The government should implement a new seven-tier medical benefits structure for attendance items and a realistic system of indexation which will assist in rural doctors continuing to provide high quality care.
- **Access to appropriate emergency care items** for rural doctors who are rostered by their hospital to provide emergency care.
- **Development of nurse consultation items** – nursing items (parallel to the current MBS items) for consultations taken for and on behalf of a rural doctor by a practice nurse.
- **Payment of retention incentive payments to specialists** – Retention payments should be put in place for specialists who undertake the bulk of their practice outside of the metropolitan setting similar to the GP retention payment arrangements.

- **Locum item number** – the government should put in place a specific locum item number that reflects the costs associated with practices employing locums, these costs have risen markedly in recent years due to workforce shortages and many practices incur financial losses when employing locums. The item could be a virtual item that is paid through a loading (based on current PIP loadings) on current attendance items.
- **Support for non traditional practice models** including community owned practice models that facilitate the employment of 'Gen Y' and female doctors who may not wish to buy into the practice and may have a preference for salaried positions.

Professional issues

- **Better Training and support for Temporary Resident Overseas Trained Doctors** - including immediate access to training/fellowship programs and support for health and education expenses for them and their families is essential if these doctors are to be encouraged to remain in Australian rural practice.
- **Support for specialist and rural generalist obstetricians** – Continuation and expansion of the Specialist Obstetricians Locum Scheme (SOLS) and expansion of SOLS program to rural generalist obstetricians, anaesthetists, surgeons and physicians.
- **Support for rural specialists in continuing education**, the highly successful procedural training grants program should be expanded to cover resident specialists who provide procedural or emergency on call services in rural and remote communities.
- **Locum support** – many practices are finding it increasingly difficult to obtain locums, meaning their doctors cannot take leave or undertake professional development. Additional supports including improved orientation procedures and standards should be provided which will facilitate the availability of locums and this includes additional incentive payments for locums and the development of a nation-wide rural generalist locum scheme modelled on the successful specialist obstetrician scheme pilot.

Practice organisation and infrastructure

- **Reform the Rural Medical Infrastructure Fund** – introduce changes to the fund which will increase the availability of funding support for marginal rural practices and remove the excessive red tape associated with accessing the fund.
- **Introduce a practice infrastructure grants program** – The programs would fund projects such as extensions/fit out to allow for practice nurses or allied health professionals to work within practices, replacement of essential equipment and changes to practice infrastructure that will enable practices to meet professional and community standards. Specific supports for those practices involved in teaching and training is required to

recognise the true costs involved in training the health workforce of the future.

- **Support for practice planning** – provide funding support to practices to undertake strategic planning, within and between practices in the same area, to develop practice plans that will assist the practices manage their services which will ensure viability into the future.
- **Encourage and support flexible models of practice** – This may include models of practice which support parents in the workforce who wish to undertake part time work or fly in/fly out general practice clinics in small communities where it is not possible or unviable to recruit a resident doctor.

Maintaining and enhancing rural health capacity

Access to services provided by small rural hospitals is essential if rural communities are to survive. These hospitals are often the largest employers in the town and are an essential part of the local economies. The closure or downgrading of rural hospitals will also often result in the closure of medical practices in the town as the procedural doctor no longer has access to hospital facilities.

- **Quarantine the funding for hospitals in RRMA 4-7** in the next round of the Australian Health Care Agreements and ensure appropriate incentives are put in place to ensure small rural hospitals continue to provide high quality health care services. The government also needs to put into place arrangements to monitor the funding of, and access to, services in small rural hospitals. Community impact statements should also be required before there is any reduction in services or closure of health services/units such as maternity unit. This impact statement should include the impact of the costs to the community of the closure, the effect on other health care services, the impact of increased travel costs to families, and the effect on the social capital of the town.
- **Provide support for small maternity units** - Incentives should be made available directly by the Commonwealth to small rural hospitals for the maintenance of maternity services, and to provide those hospitals that may have reduced or ceased providing the full range of maternity procedural services with support to again provide these services to their local community.
- **Provide support for surgery and anaesthetics** – payment of incentives to small rural hospitals recognising the additional costs in continuing to provide or enhancing these services. This includes appropriate remuneration and support for training and continuing education for theatre and emergency nurses and other staff who are an integral part of the rural health team.

Improving Indigenous health

Despite some signs of a small improvement in some health outcomes these improvements are still well behind the non-indigenous population. Indigenous Australians born in the period 1996-2001 are expected to live nearly 20 years less than the rest of the population.

Indigenous Australians face a higher burden of disease particularly in chronic and lifestyle related disease. For example, cardiovascular disease was the leading cause of death for indigenous males and females living in Qld, WA, SA and the NT, with rates at least 3.2 and 2.8 times those of males and females in the general population. This sort of pattern is reflected across all the major chronic disease groups with the incidence in some disease groups at more than seven times the rate they occur in the general population.

The Australian Government must develop and implement an action plan agreed with significant stakeholders to improve the health outcomes of the indigenous community with the goal of matching the life expectancy of other Australian within the next 15 years. The plan must include targets/milestones and mechanisms to monitor and report on the achievement of these targets. Key areas of the plan should include:

- **Access to primary care** including measures to improve access to culturally appropriate primary health care and increasing the number of doctors and other health workers working with aboriginal communities
- **Access to specialist care** even where indigenous patients may have access to primary care services; they are rarely able to access specialist services such as ENT specialists and paediatricians.
- **Development and training the Indigenous health workforce** including increases support for indigenous students undertaking medical, nursing and allied health training
- **Supporting mainstream practices and health services** provide services to their indigenous communities through appropriate funding models which recognise the complexity of providing care to a very disadvantaged population.
- **Identification and funding of health promotion and disease prevention interventions** to address chronic disease and child health issues in the indigenous community.
- **Identification and funding of public health interventions** to ensure indigenous communities can access clean water, good nutrition, and quality affordable housing
- **Identification and funding of interventions to build social capital** particularly in the area of employment.

The Government must follow up the plan with a significant investment in improving the health of indigenous Australians and it is expected that this

investment is expected to be in the vicinity \$400-460m pa for a number of years.

Background Information

The Rural Doctors Association of Australia (RDAA) is the national body representing the interests of rural medical practitioners right around Australia. Our vision is for excellent medical care for rural and remote communities. RDAA is committed to building and maintaining a workforce of highly skilled and motivated rural medical practitioners.

Approximately 34% (6.7m) of Australians live outside of major cities in regional, rural and remote areas. The proportion of the population who are indigenous is much larger in the rural and remote parts of Australia, with 70% of the total indigenous population of Australia living outside of major cities.

Australians who live in rural and remote areas have the same right to quality health services as their counterparts who live in metropolitan centres. However, this is not the reality and Australians who live in country areas access health services at very much lower rates than metropolitan residents and have significantly worse health outcomes.

All Australians are facing a health crisis caused by increasing rates of serious chronic diseases such as diabetes and by the increase in health conditions that accompany an ageing of the population. Australians living in rural and remote locations are more likely to be smokers; to drink alcohol in hazardous quantities; to be overweight or obese; to be physically inactive; to have lower levels of education; and to have poorer access to work, particularly skilled work which adversely affects their health status and health outcomes.

Over the past five years the Federal Government has put in place a number of initiatives to assist in building and maintaining a viable rural medical workforce. Many of these initiatives have been proposed and supported by the RDAA; however, there remains much work to be done in ensuring the rural population of Australia has reasonable access to quality health care.

The rural health workforce shortage remains the main area of concern to the RDAA and despite significant increases in the numbers of medical and other health graduates produced by universities throughout the next five years, the RDAA has yet to see any real evidence that this will be effective in rebuilding a severely depleted rural medical workforce. Rural medicine, in particular, requires strong procedural skills, with primary care practitioners representing the backbone of rural health care.

Rural generalist practice is the backbone of rural health care and provides whole-of-patient, focused, continuing care which is responsive to a community's needs and circumstances. Rural practitioners provide this wide range of services with limited and/or remote access to specialist or allied

services and resources. In many cases rural generalists will have enhanced skills in areas such emergency medicine, obstetrics, anaesthetics, surgery, indigenous health, and mental health.

Questions for the parties contesting the federal election

What specific new initiatives will your party put in place to address:

- Shortage in both procedural rural generalists and office based rural generalists?
- Inability to attract Australian graduates to remote and rural practice?
- No recognition of the isolation and complexity of rural/remote practice in the Medicare fees
- Decline access to maternity care and closure of rural maternity units in many communities?
- Threats to the continued existence of small hospitals and the emergency, surgical and other procedural services provided?
- Shortages of nurses and midwives?
- Shortages of allied health professionals particularly mental health professionals?
- High levels of preventable chronic disease amongst indigenous communities and life expectancy that is 17 years shorter than the average for non indigenous Australians?
- Higher costs of practice and reduced whole of life returns for most rural/remote practices?
- Lack of specific recruitment and retention measures for rural medical specialists?
- Heavy reliance on overseas medical graduates in an international market where demand is expected to exceed supply in the next few years?
- Little or no support for IMGs and their families and the inability of temporary visa holders to access appropriate health and education support?

Will your party commit to providing a basic standard of health care services and support in all rural communities which address the relative disadvantage suffered by those communities both in access to services and health care outcomes?