# Rural Practice in Australia - Lessons for South Africa

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## Summary

This article, the final one in a series on general practice in Australia, looks at issues related to rural health. It looks at the positive responses of the Australian government to pressure from rural doctors, the development of academic rural health and appropriate training for rural general practitioners, and initiatives in recruitment and retention of rural doctors, before and after qualification. Some difficult issues for Australia are highlighted, as well as lessons for South Africa.

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## Introduction

Australia is a vast country with a relatively small population. A significant number of these people live in small rural towns or remote settlements. It is not surprising that rural health is a significant issue on the agenda of Australians. What is surprising, however, is that the Government, on the one hand, has taken major steps in creating incentives for doctors to work in rural areas and to support training for rural practice, and, on the other hand, that general practitioners in Australia have taken the lead in ensuring that rural health gets a high profile. As South Africans, there is much we can learn from this focus on rural health, and how it is achieved. A brief overview follows.

## Rural Pressure

The achievements noted have not come easily. Faced with the well-known problem of recruitment and retention of doctors (and other health personnel) in rural areas, Australian doctors began to form Rural Doctor Associations and Rural Support Networks, culminating in the formation of the Rural Doctors Association of Australia (RDAA). This body played a vital role in lobbying the government, training institution, and health authorities, slowly bringing about a change in attitudes.

As a result of this lobbying, and of a series of National Rural Health conferences, the Australian Health Ministers' Conference produced a National Rural Health Strategy in March 1994[1], updated in 1996[2], which made far-reaching proposals regarding health care delivery in rural areas. Some of the guiding principles in these reports include the following[1]:

- "Consideration of equity and access to quality health care are foremost in guiding the provision of rural heath services." (The same sentiment is expressed in the principles of the District Health System in South Africa.)
- "The provision of health services is guided by need as opposed to demand."
- "Rural health care should be based on generalists who have broadly based competencies with specialist support as required."

The most recent strategy document, *Healthy Horizons*[3], was launched in March last year. These strategic planning documents, and others, demonstrate how effective the lobbying process has been, and how seriously the Australian government (at national and at state level) now take the issue of rural health. This certainly impressed me.

## Developing Rural Practice

In 1991, the first Chair of General Practice and Rural Health was established within the new North Queensland Clinical School. Professor Richard Hays, the first incumbent, had a vision to integrate general practice medical education in one unit, by combining the resources of the university and the RACGP[4]. In 1992, the first academic Centre for Rural Health was formed by Monash University, based in the small town of

Moe, Victoria, under the leadership of Professor Roger Strasser, a rural general practitioner. What is particularly significant is the multi-disciplinary nature of the centre: the co-director Associate Professor Elaine Duffy is a Nurse Practitioner involved in the international nurse practitioner movement as well as the Association of Rural and Remote Nurses. Other staff members have included a dietician, a pharmacist, a sociologist-journalist, an engineer and a community health specialist. Furthermore, the Centre is located in a regional hospital in a rural area. Following on the Monash lead, and under pressure from the Federal government, most medical schools now have Professors of Rural Health. We eagerly await the step forward of the first academic Rural Health Centre linked to a South African university.

At the same time frustration was building up amongst rural doctors over the granite-like inflexibility (as they saw it) of the Royal Australian College of General Practitioners. It was felt that the vocational training programme was inappropriate for rural practice, with insufficient focus on procedural skills, especially surgical and anaesthetic skills, and on public health issues. Also, the examinations focussed on urban problems. As a result of this pressure, however, the College did begin to change. A fourth year of the program (see previous article) was introduced, which focussed on advanced rural skills, and trainees were given the chance of completing a Diploma in Rural Health. A national director of Rural Training was appointed, as were a number of state directors of rural training, and Rural Health Training Units (RHTUs) started to appear all over the place. Many of these are multi-disciplinary in nature. Government pressure ensured more graduates were selected from rural areas.

These changes did not happen quickly enough. As a result, the Australian College of Rural and Remote Medicine (ACRRM) was born, with a vision of providing appropriate training for rural doctors. Although they run numerous workshops around the country, they have been limited in their ability to be directly involved in vocational training through lack of recognition by government. Their main role has been to force changes in the RACGP program. Recently, however, a general practitioner training board (known as the Joint Venture Board) was set up by the government to oversee training and dispense funds, which includes ACCRM with the RACGP. Negotiations between the two bodies seem, however, to be an on-again off-again affair.

We in South Africa should learn from this: there are enough divisions in our country without the rural doctors seeking to go their own way from other generalists, with respect to education and training, as much as we need the political lobbying force of the Rural Doctors' Association (RuDASA).

## Rural Incentives

An important part of the attempts to improve retention and recruitment of general practitioners to rural areas has been the Rural Incentives Program. General practitioners wishing to relocate are given, inter alia, an incentive in the form of a lump sum, which varies between $20 000 and $50 000, depending on remoteness and the GP's family responsibilities. This programme now falls under a Rural Workforce Agency in each state. Furthermore, in some areas, especially in Western Australia, locum support programmes and assistance in attending CPD programmes have complemented this. This is particularly because of the work of the Western Australian College of Rural and Remote Medicine (WACRRM), originally proposed by Professor Max Kamien, who is well known in Australia for exposing many of the glaring health inequalities experienced by Aboriginal Australians, who are mostly located in rural areas. WACRRM was essentially the first of the rural workforce agencies, which now exist in all States and function along similar lines. It is thus obvious that the carrot approach, rather than the stick, dominates in the strategies that are used.

Towards what are these agencies working? The Australian Medical Workforce Advisory Committee (AMWAC) has established doctor-population ratios towards which all heath agencies should be aiming, viz. 1:1500 for urban communities, 1:1100 for rural communities, and 1:500 for remote indigenous communities[5]. It is recognised though that such ratios can only be estimates, because factors such as age distribution, morbidity of the community, population density, distance, permanence versus transience of the population, etc., have major impacts on health care needs[6]. While any South African ratios would need to include nurse practitioners, it would nevertheless be useful to know what we are aiming for in this country.

Another positive feature is the Rural Medical Family Network (RMFN), which recognises the importance of spouses and children in retaining rural doctors (unlike those who organise the community service programme in this country). They produce information booklets, assist families to meet, organise programmes at conferences, and try to help partners find employment.

## Undergraduate Initiatives

The attempts to improve rural staffing levels have gone into medical schools. Apart from schemes in most schools to increase the intake of rural students, many have rural student clubs, supported by State governments, which give students an ongoing link with and involvement in rural practices. Some have more formal rural monitoring schemes. The South African Rural Support Network, mainly based amongst students in the Western Cape, is a step in this direction.

Another initiative is the John Flynn scholarship scheme funded through the Federal Government. Set up in memory of an inland flying doctor, this has allowed students to visit rural communities for 3 years in succession, by paying accommodation and travel costs. The students who arrange their own placements hold the funds. The local areas appreciate the chance to see the development of the student and the student appreciates the chance to see continuity and change at a community level.

Particularly exciting are newer programmes for increasing the amount of training that takes place in rural areas. Flinders University, in South Australia, offers two years of its four-year programme in the "Top End" (Northern Territory); although students are based in Darwin, they get a lot of exposure to rural and primary care settings. Also, a small group of students have the chance to spend the entire third year in small towns of the Riverland region of South Australia, working with local general practitioners and in small hospitals, and receiving education y distance. Initial hesitation about this programme has been swept away by students out-performing their urban colleagues during exams. The plan is to extend this to Alice Springs in central Australia. Cohorts of University of Queensland students spend their final 2 years in Northern Queensland, including 8-week blocks in remote towns working with general practices. Now, in the year 2000, the new James Cook University Medical School has opened its doors, in Townsville, under the leadership of its rural general practitioner dean, Professor Richard Hays, with the specific aim of training doctors closer to the rural context they need to work in.

## Other Funding

In addition to the initiatives described, many other projects have been implemented throughout Australia with funding from the Rural health Support Education and Training (RHSET) Program, a Commonwealth Government grants programme established in 1990 to enhance the access of rural communities to effective health service, mainly through dealing with workforce issues. Up to December 1997, A$37 million was allocated for a wide variety of projects under this umbrella[7]. The particular usefulness of this programme is seen to be its ability to encourage new ideas and foster creativity in addressing the needs of rural health workers[7]. The reports from these projects provide a wealth of material for those interested in issues of rural health.

## Problems

All is not rosy, however. By Australian standards, rural areas are still very under-served (which is why we always see the recruitment advertisements in the SAMJ). A controversial proposal to improve doctor distribution, which generates much heat amongst doctors, is geographically-linked Medicare numbers, so that doctors will not be able to get access to the Medicare system in overserviced areas, but will be able to do so from underserviced areas. This is an alternative form of coercion to community service.

Also, many small town hospitals are closing, as State governments seek to economise. This removes an important aspect of the general practitioner's work, and restricts his or her range of practice, leading to movement of general practitioners to bigger towns. Patients thus often have to travel further for medical help, even though there are more doctors. Nurse practitioners are willing to fill these gaps, but many general practitioners feel threatened by them and will not provide the support they require, in Australian law, for independent practice. And, finally, the health of Aboriginal Australians, who make up a small and important proportion of rural people, is still way behind that of their non-Aboriginal counterparts.

## Conclusion

This article does not do justice to the amount of strategizing, lobbying, planning and experimenting that has taken place in the arena of rural health care in Australia. It could be argued that Australia has greater resources and fewer rural people than South Africa, and thus such a focus on rural practice is more feasible than in our country. Conversely, though, I would argue that the extent of our rural population and the lack of resources make it vital that attention is given to this problem, so that appropriate South African solutions can be found. At the same time, there is much we can learn form the broad range of initiatives and programmes implemented in Australia.

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