The factors affecting the supply and distribution of health services and medical professionals in rural areas – individual submission by Dr Peter Lake

Sir 10th December 2011

I wish to make a brief submission to this Senate Inquiry. My qualifications and experience are as follows: I am a GP at Adelaide Health Care and Pangula Mannamurna Aboriginal Health Service, Mt Gambier. For most of my professional life I have worked in Aboriginal health, for both the community controlled and government sectors, in Adelaide, Port Adelaide and Central Australia. Early in my career I spent two years in PNG as a government medical officer which included 12 months in solo rural practice. This involved running a remote 110 bed hospital in Western Province where I had to care for all inpatients and do obstetrics, surgery and anaesthesia without medical backup apart from a radio link to Port Moresby and occasional specialist visits. Subsequently I was a lecturer in community medicine at Sydney University while researching aspects of the Royal Flying Doctor Service and rural general practice. Before settling in Adelaide I did locums in rural NSW, South Australia and Queensland. I have higher degrees in public health (MPH Sydney), health education (MHPEd UNSW) and fellowship of the Faculty of Public Health Medicine(FAFPHM).

> "It is reasonable that physicians who are considering practising in a rural location should be able to expect a collegial, well-functioning group practice (with appropriate arrangements for time off) supported by a multi-professional team and a modern clinic with appropriate, up-to-date hospital facilities. Rural physicians may also be energised and stimulated by the inclusion of medical students and residents in their practice, which also serves to introduce the students and residents to the joys and challenges of rural practice." [1]

1. **Factors limiting supply of health services and medical, nursing and allied health professionals**

   The boxed quote from a recent Canadian article sums up well the reasonable expectations of Australian doctors and other health professionals working in rural areas. *They are the main prerequisites for acceptable standards of care.* Rural communities are entirely justified in demanding this of their political representatives. Without access to multi-professional primary health care supported by easily accessible specialist advice (phone or video link), these communities will cease to exist. By reason of remoteness, additional emergency and procedural skills are required of country doctors compared with their urban colleagues. Furthermore, they must be able to acquire and maintain such skills despite competition from specialist trainees in the teaching hospitals and administrative and financial obstacles within the health system. As the Canadian quote suggests, to work effectively in country areas doctors need direct access to modern hospital and emergency facilities beyond what is normally available in a doctor's own rooms. It includes a basic surgical/obstetric suite and at least some inpatient beds – there is no escaping this fact. *The political representatives of rural communities have an important role insisting that this be the case.* Moreover, strong support from all political parties should be possible since the very survival of country communities is at stake.

Peer support and maintenance of standards in rural practice are augmented by academic links with teaching hospitals and medical schools. This is already happening and is likely to increase the available pool of new recruits and locum cover.
A recurring theme among country GPs is the importance of both the doctor & their partner becoming involved with the community through service clubs and sporting activities. Many doctors are married to nurses, and communities should try to employ couples rather than individuals where this is appropriate. Social isolation is a common cause of unhappiness among the partners of country doctors, often forcing a family relocation to the city.
Small communities are no place for single doctors. Those who are married with young families are best suited to country practice although many do choose to move away once their children finish primary school. Recruitment into country practice should take account of this window of opportunity in a doctor's career. Another window exists once children are older and more independent. Many doctors, myself included, provide locum relief or "fly-in fly-out" services to rural communities later in their careers. This should be strongly supported and encouraged through financial incentives and easier access to up-skilling courses, particularly in emergency medicine and obstetrics.

2. **Medicare Locals and the provision of medical services in rural areas**
On the whole I agree with the concept of Medicare Locals. However they must accept the fact that doctors are the natural leaders of primary health care teams. This is not to say that doctors should dominate but they must be included as key participants and this is nowhere more true than in the country. My reservation with Medicare Locals is that they are attempting to cover ridiculously large areas – so much so as to risk irrelevance.

3. **Current incentives program**
I agree with Rural Doctors Association's criticisms of the geographical anomalies. Regarding dentists and access, it is very clear dental health is poor among disadvantaged Australians. This is particularly evident in country areas where dentists are scarce. Well funded primary public dental care using salaried dentists should be implemented as soon as possible in Australia, with the first priority being rural areas and disadvantaged suburbs. The present arrangement utilizing private practitioners for people with Chronic Disease Management Plans should not be terminated until a more comprehensive scheme is in place.

4. **Other Matters**
Full fee paying students from other countries should not be given places in Australian medical schools at the expense of adequately qualified Australian nationals who could otherwise be recruited into bonded rural jobs after graduation. The perverse incentives that exist for universities to train non-nationals should be eliminated. Australian medical courses are by and large unsuited to doctors intending to work elsewhere anyway. Australia depends too heavily on OTDs to fill rural vacancies thereby draining human capital away from poorer countries in the region. This situation should deliberately reversed by producing more local graduates.
Rather than training general practitioners, Australian medical courses (the longest of all tertiary courses) have drifted towards producing so-called "undifferentiated doctors" suitable only for further training including that necessary for general practice. This is detrimental and wasteful in my opinion and has contributed to doctor

shortages.
Continuing postgraduate education for practising doctors has largely been left up to the drug companies with government refusing to take responsibility. This particularly affects rural doctors, who are more dispersed and therefore not worth the trouble for drug company programs. It is no surprise that inappropriate prescribing is considered a big problem in Australia, and the cause of many avoidable hospital admissions.

Sincerely,

Dr Peter Lake,

Reference:

1. Rourke J "Increasing the number of rural physicians" CMAJ Jan 29th 2008; 332-325