11

Health

Introduction

11.1 Regional development strategies aimed at promoting strong, sustainable communities must include consideration of social infrastructure and investment in human capital. Internationally, conviction is growing that higher social rates of return will result from investment in social and human infrastructure, such as health, than from physical infrastructure alone.[1] The committee recognises and strongly supports the increased Commonwealth government focus on improving health outcomes in regional Australia, evidenced in initiatives taken over the past two years:

- to increase access to general practice (including retention payments, 'fly-in, fly-out' female medical practitioners and establishment of rural workforce agencies to recruit and retain general practitioners into regional areas);
- to increase access to specialists and aged care; and
- to improve education and training for health professionals in regional areas.

These and other initiatives have contributed to an increase of more than 300 in the number of doctors working in country regions since 1996. The committee considers it imperative that medical authorities responsible for training doctors for practice in rural and regional Australia ensure that the doctors are equipped with skills appropriate for practice in regional areas.

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1 Department of Health and Aged Care, Submission no. 285, p. 3.

11.2 Socio-economic disadvantage contributes to poor health outcomes and declining country communities have been described as 'a health risk for those living and working in them'.[2] The Australian Institute of Health and Welfare (AIHW) has found that social inequality and disadvantage contribute to differences in people's health, influencing the extent of smoking, diet, exercise, self-esteem, optimism and social attachment in ways not yet fully understood. Lack of social cohesion, 'a combination of specific things like employment, income, job and other things' has broad health impacts, the most obvious being much worse morbidity and mortality statistics for those on low incomes.[3] Health services infrastructure, both hard and soft, is thus intrinsically linked to regional development since 'investment in health and aged care services is an investment in human capital'.[4]

11.3 As the National Rural Health Alliance stated:

> Rural development is a health issue. Without it there are declining communities, with little sense of direction, an uncertain future and poorly motivated leaders. These result in poor health directly through the stress, frustration, and alienation that people feel. They also result in poor health indirectly through the difficulty for governments and the private sector of providing health services to areas that have small, sparse or declining populations.[5]

11.4 Present health outcomes for rural and regional areas include:

- higher overall age standardised death rates than for metropolitan areas with the highest death rates in remote areas (due to the proportion of Aboriginal and Torres Strait Islander peoples in the population);
- higher hospitalisation rates; and
- increasing incidence of obesity, smoking and diseases associated with these behaviours with increasing rurality and remoteness.[6]

11.5 The committee was advised that, using indicators derived by the AIHW, behavioural patterns could explain only some of the health inequalities apparent in regional Australia, if any. The inability of separating health

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2 G Gregory, *In support of a blueprint for rural development*, ACOSS Congress, 1998, p. 1.

3 National Rural Health Alliance, Transcript of Evidence, 30 June 1999, p. 59.

4 Department of Health and Aged Care, Submission no. 285, p. 3.

5 National Rural Health Alliance, Submission no. 128, p. 24.

6 *Healthy Horizons, 1999-2003: a framework for improving the health of rural, regional and remote Australians*, A Joint Development of the National Rural Health Policy Forum and the National Rural Health Alliance for the Australian Health Ministers' Conference, March 1999, pp. 37-42.

problems from 'the rural economic recession, unemployment, pre-existing lifestyle and cultural attitudes towards health, low education levels, isolation and lack of transport' was discussed at the Regional Australia Summit.[7]

11.6 The HREOC inquiry into human rights found that inferior health status in rural and remote areas was linked to less accessible, less reliable and often more costly health services in these areas. Their submission to this inquiry stated that 'adequate, purpose-designed infrastructure was (sic) essential to equity in the enjoyment of many human rights...These include the right to the highest attainable standard of health.'[8]

11.7 Lack of social infrastructure, including 'less than adequate health facilities' has been recognised as the key driver of urban drift[9] and a major impediment to attracting families and businesses to regional areas.[10] ALGA argued that governments had 'an obligation where market forces are not the appropriate mechanism for investment' to provide social infrastructure and that 'only the Commonwealth has the level of resources required to achieve equity and meet the community services obligation for regional Australia.'[11]

Shortage of professionals

11.8 While the shortage of medical practitioners in regional areas was well known, the committee was advised of the equally acute shortage of nurses, dentists and allied health professionals.[12]

> … once a community has secured the services of sufficient GPs to properly service the population then other allied health services tend to follow… It is particularly difficult to attract doctors to practice in communities with a population of up to 5,000 …
>
> The NSW Rural Workforce Strategy has identified a number of factors contributing to the rural general practitioner shortage.

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7 Dr L Bryant, and Prof R Strasser, *The delivery of sustainable rural and remote health services*, paper given at the Regional Australia Summit, October 1999, p. 1.

8 Human Rights and Equal Opportunity Commission, Submission no. 87, p. 2.

9 Bega Valley Shire, Submission no. 192, p. 5.

10 Riverina Regional Development Board, Submission no. 126, pp. 3-4.

11 Australian Local Government Association, Submission no. 131, p. 12.

12 For example, National Rural Health Alliance, Transcript of Evidence, 30 June 1999, p. 54; and A Ross, Submission no. 102, p. 5.

> These factors include inability to access hospitals, the financial cost of relocating from the city, lack of professional and personal support, lack of sufficient allied health services, lack of employment opportunities for partners and wider level of overall skills required.[13]

11.9 The 'chronic maldistribution of doctors and shortage of rural and remote GPs across Australia' has been quantified as a shortage of between 500 and 1900 doctors, with about 30 per cent intending to leave within two years and about 400 graduates required to meet ongoing needs, not to fill deficits.[14] Lower levels of health services in regional areas are illustrated by Medicare levy rebates for general practitioner items of $92 per person per year in regional Australia compared with $145 per person per year for metropolitan areas.[15]

11.10 The lack of specialists in regional areas is greater still and the submission from the Great Southern ACC argued that more specialists in regional areas would reduce waiting lists in cities.

> The government should allocate funding to encourage more specialists and special units to be located in Albany and other regional centres. Some Albany patients waiting in Perth hospitals for operations have recently been transferred back to Albany for surgery to reduce the Perth waiting lists. If there were more specialists in Albany and other regional centres, Perth would not have such long waiting lists.[16]

11.11 In March 1999, Commonwealth, state and territory health ministers developed a framework titled *Healthy Horizons 1999-2003*, to provide direction for governments to improve the health and well-being of people in rural, regional and remote Australia. The framework noted that few rural centres have populations large enough to support a full range of specialists, about 12 per cent of whom are located in regional Australia. It spelt out the need for more specialists to be trained as generalists with a sub-specialty and for linkages with Specialist Colleges and University Departments of Rural Health, to get specialists more involved in service planning and development for their area of specialty.[17]

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13 NSW Farmers' Association, Submission no. 228, p. 5.

14 Dr P Mara, *Health*, paper given at the Regional Australia Summit, October 1999, p. 3.

15 National Farmers Federation, Transcript of Evidence, 21 June 1999, p. 27.

16 Great Southern Area Consultative Committee, Submission no. 165, p. 19.

17 *Healthy Horizons 1999-2003*: a framework for improving the health of rural, regional and remote Australians, A Joint Development of the National Rural Health Policy Forum and the

11.12 Recent initiatives to increase access to specialists in rural and remote locations include:

- *Advanced Specialists Training Posts in Rural Areas* – 37 specialist training posts will be established in major rural centres in the 1999 clinical year;
- a five year *Rural Surgical Training Program* to support specialist training for trainee surgeons wishing to practise in a rural location; and
- the *Rural Specialist Locum Program* to support access to leave and self-development for rural medical specialists.[18]

The committee supports these initiatives but considers that more needs to be done to ensure continuing, affordable access to specialist services for people in rural and remote areas.

11.13 Other major concerns conveyed to the committee included:

- long waits for medical and dentist appointments;
- long waits for assessments, for example, for paediatric services, aged care, speech pathology and occupational therapy; and
- refusal of doctors to bulkbill in many towns.[19]

11.14 The committee supports government initiatives to provide incentives for graduates to practise and remain for extended periods in rural and regional areas, and to facilitate employment of overseas trained doctors in these areas. It is aware that four states, Queensland, Western Australia, New South Wales and Victoria, have now implemented arrangements for employment of overseas trained doctors, who must meet equivalent standards of practice as Australian graduates. The committee was advised on several occasions, however, that, while overseas trained doctors were filling the gaps at present, doctors trained in Australia were needed.

11.15 The National Rural Health Alliance told the committee that the redistribution of medical practitioners and the possibility of basing provider numbers on geographic areas needed to be considered in light of the government's commitment not to increase the total number of doctors.[20] Charles Sturt University supported this view.

National Rural Health Alliance for the Australian Health Ministers' Conference, March 1999, p. 47.

18 Department of Health and Aged Care, Submission no. 285, p. 7.

19 Human Rights and Equal Opportunity Commission, Submission no. 87, Attachment: *Bush Talks*, pp. 4-10.

20 National Rural Health Alliance, Transcript of Evidence, 30 June 1999, p. 54.

> An over supply in metropolitan areas suggests that no more provider numbers be provided in those areas such that if the doctors want to practise they go where the jobs are – every other profession does that. In addition, Governments have been very slow in creating a "training in the country for the country" opportunity.[21]

11.16 **The committee considers it incumbent on governments to ensure an equitable regional distribution of health services, including availability of medical practitioners, dentists and allied health professionals. It is clear that the problem of maldistribution of medical practitioners and other health professionals to regional areas is still critical and that further investigation of innovative ways to attract professionals to regional areas is required.**

11.17 **The committee supports recent initiatives to encourage medical practitioners to practise and remain for longer periods in regional areas. However, the problem of attracting medical practitioners into regional areas remains.**

Recommendation 85

11.18 **The committee recommends that the Commonwealth government allocate a percentage of provider numbers to regional geographic areas.**

Recommendation 86

11.19 **The committee recommends that the Department of Health and Aged Care develop incentives to attract dentists, visiting medical specialists and allied health professionals to regional areas.**

Royal Flying Doctor Service

11.20 The Royal Flying Doctor Service (RFDS) employs 460 staff including medical officers, nurses, allied health professionals, indigenous health liaison officers, communications operators and a range of technical, managerial and support staff. It operates 19 bases across Australia from

21 J E Pratley, Submission no. 44, p. 5.

which a comprehensive range of health services is provided to regional communities. RFDS services 'provide the security needed to survive and remain in many locations.' The RFDS suggested to the committee that, in addition to using its health and communications infrastructure as a cost-effective alternative to developing separate aerial services (for example, for Fly In/Fly Out schemes), its infrastructure could also be used 'in the short term to relieve the crisis due to the lack of permanent medical officers on the ground.'[22]

Role of private sector

11.21 The committee is aware that the lack of private sector health service provision throughout sectors of regional Australia means that the benefits of the private health system are unavailable to many areas, for example, the Geraldton region. Differing views on the role of the private sector were put to the committee. On the one hand, the establishment of private sector hospitals was supported:

> … the community, through government funded initiatives, should actively encourage the establishment of private hospitals in large country centres such as Albany to enhance specialist health care in country regions … lead to employment growth and provide opportunities for some professionals to return to their hometown.[23]

11.22 On the other hand, the National Rural Health Alliance urged that encouragement of private sector provision in the health sector include measures to ensure an equitable geographic spread of private sector services:

> … private hospital beds are much less equitably distributed, particularly for smaller centres and more remote areas. This raises the question of current policy directions encouraging a greater role for the private sector in health service delivery - given the maldistribution of private medical providers, such an increased role could be at the expense of generating even further inequality in access to health services and hence health outcomes.[24]

22 Royal Flying Doctor Service, Submission no. 184, p. 3.

23 Great Southern Area Consultative Committee, Submission no. 165, p. 19.

24 National Rural Health Alliance, Submission no. 128, pp. 14, 17.

Transport

11.23 The importance of transport to the health sector in regional areas was highlighted in submissions and in *Healthy Horizons 1999-2003*, which stated that 'if access cannot be local due to the scarcity or complexity of the service then transport to distant services is a part of appropriate health care.'[25] With the increasing concentration of specialists and the provision of more complex, clinically advanced procedures in larger provincial centres and capital cities, the committee considers it imperative that people without access to private transport can access affordable and equitable transport to health services. The committee was advised that transport should have a higher profile in terms of health planning, in particular, that:

- patient assistance travel schemes needed review; and
- standardisation of policies across jurisdictions in relation to eligibility criteria, escorts, return travel, cross-border issues, pre-payment and access to allied health, dental and other non-medical services was needed.[26]

Recommendation 87

11.24 **The committee recommends that the Department of Health and Aged Care work with state and territory governments to review patient assistance travel schemes, particularly in relation to eligibility criteria, escorts, return travel, cross-border issues, pre-payment and access to allied health, dental and other non-medical services.**

Telehealth

11.25 There was much support for telehealth and telemedicine initiatives in regional areas, with emphasis on the need for adequate bandwidth to enable the provision of such services.

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25 *Healthy Horizons 1999-2003*: a framework for improving the health of rural, regional and remote Australians, A Joint Development of the National Rural Health Policy Forum and the National Rural Health Alliance for the Australian Health Ministers' Conference, March 1999, p. 5.

26 *Healthy Horizons 1999-2003, op cit,* pp. 21-22.

> Telehealth is defined as: a health delivery system which: enhances or provides health-related activities; at a distance; between two or more locations; involves the transmission of images, voice and data; and uses telecommunication networks … It is seen as important that the Federal Government provides the necessary telecommunications infrastructure to implement this valuable service to all remote rural regions.[27]

11.26 Benefits included cost savings in relation to travel for treatment; greater opportunities for training delivery, professional development, more efficient administration and informal skills development among local practitioners; and earlier detection and hence treatment for patients.

11.27 The need for strategic planning of telehealth facilities is important. At a private meeting in Meningie, the committee was advised that regular medical services were provided to about 400 Aborigines in Meningie without the benefit of telehealth facilities. On the other hand, teleconferencing facilities offering 'untrained' health services to Aborigines and telepsychiatry were available at Murray Bridge, but Aborigines were less prepared to attend there.

11.28 The committee supports strategic planning on a regional basis for telehealth facilities and considers that communities, health professionals and the private sector must work in partnership with governments to determine the most appropriate location of telehealth facilities and establish networks that will deliver required services. A good example is Tasmania's statewide telehealth network, set up to improve access to healthcare for rural and isolated communities, with telehealth facilities linked to urban hospitals and community healthcare centres. The network was showcased at the Regional Australia Summit.[28]

11.29 The National Rural Health Alliance argued that every community supporting a physical telehealth facility needed access to at least 128 kbps, the minimum bandwidth required for videoconferencing.[29] While supporting the maximum exploitation of telehealth service delivery as vital to improving health outcomes in regional areas, the Alliance considered that telehealth 'should be an adjunct to personal contact and not a replacement for it.'[30]

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27 Great Southern Area Consultative Committee, Submission no. 165, p. 19.

28 Telehealth Tasmania Network, *Information for Community Members: Providing health care at a distance,* Department of Health and Human Services, Tasmania.

29 National Rural Health Alliance, Submission no. 128, pp. 14, 17.

30 National Rural Health Alliance, Transcript of Evidence, 30 June 1999, p. 56.

11.30 The committee was advised that changed Medicare funding arrangements were needed to allow development of infrastructure such as telehealth networks. At present, rebates were available 'only where the practitioner was physically present', although this was about to change for telepsychiatry. The National Rural Health Alliance argued that the 'continued absence of Medicare rebates would (sic) limit telehealth applications to public sector environments.'[31]

11.31 Detailed consideration of bandwidth issues and recommendations in relation to telecommunications infrastructure can be found in chapter 5.

Recommendation 88

11.32 **The committee recommends that the Department of Health and Aged Care:**

- **provide funding for appropriately located telehealth facilities; and**
- **approve Medicare payment for telehealth services.**

Case study – knowledge-based health industry cluster

11.33 An outstanding example of community leadership and initiative involving the health sector and building on the potential of new technology is the establishment of Hunter Medical Research (HMR) in the Newcastle region. This unique partnership between Hunter Health, the University of Newcastle and the community aims to make the Hunter a centre of excellence in medical research and education that will foster the growth of a cluster of knowledge-based industries and increase employment opportunities in the Hunter. It enjoys strong business and community support.

11.34 The committee met with HMR representatives who advised that groups already established were conducting research across a wide range of areas from biomedical mechanisms through clinical care and public health to health service management. Potential exists for development of telemedicine facilities including telepathology, diagnostics, teleradiology, psychiatric consulting, interpreter services, and education and training for staff and the community. As well as being available to western and

31 National Rural Health Alliance, Submission no. 128, p. 17.

northern NSW, telemedicine services and advice could be provided to Queensland, the Northern Territory and Asia.

11.35 The committee was advised by HMR of plans for clustering of the basic science, public health and health service management groups and of funding assistance needed to house the clinical research groups (seed funding of $4.5 million to assist with proposed $9 million clinical research centre).

11.36 Expected benefits for the region included:

- employment opportunities in research and the ancillary services that link to research;
- improved health outcomes;
- development of biotechnology and other knowledge-based industries in the region;
- strong collaborative links and exchange programs with leading research centres in Australia and overseas and with biotechnology and pharmaceutical industries; and
- stimulation for tourism, education and hospitality courses to cater for people attracted to post graduate education and training courses and conferences.

Changing nature of health services and regional needs

11.37 The key issue confronting regional Australia in terms of health service delivery, in the committee's view, is the changing nature of health service needs, and appropriate modes of delivery, for regional areas. It agrees with the view put to it at a private meeting in Geraldton that metropolitan models of health services delivery fail in rural and regional areas.

11.38 In many regional areas, communities are aging and diminishing in size and their needs are for continuing care, rather than acute care. According to *Healthy Horizons 1999-2003*, the focus of new demands is 'illness prevention, long term care and readily available services before and after hospitalisation.'[32] The more complex, clinically advanced techniques now

32 *Healthy Horizons 1999-2003*: a framework for improving the health of rural, regional and remote Australians, A Joint Development of the National Rural Health Policy Forum and the National Rural Health Alliance for the Australian Health Ministers' Conference, March 1999, p. ii.

used for surgery and acute care require sophisticated facilities that will generally be located outside local communities in the larger provincial centres and result in shorter hospital stays. Local community hospitals will increasingly have fewer acute episodes but longer hospital stays by older patients, resulting in less revenue under casemix payment provisions.

11.39 The changing role of hospitals over the last 10 to 15 years has created unease in some regional areas because of the historical attachment of local residents to local community hospitals as the basis of health care. Some submissions argued that 'access to adequate hospital services are a vital factor in determining whether a doctor will choose to practise in a particular country area'. The committee considers, however, that, given the recent changes in medical technology, demography and health financing, a hospital in every town [is] not sustainable and that support for an appropriate mix of care, including home-based care, must be provided.

11.40 Meningie, with only two doctors, is experiencing problems common to much of regional Australia. In addition to its Aboriginal patients, it provides medical services to about 4 500 regular patients. At a private meeting, the community advised the committee that the town's most urgent requirement was a new medical centre and surgery that would meet Commonwealth government accreditation and attract funding and doctors to the town. The committee was advised of likely difficulties in generating a sufficient volume of services to maintain casemix funding. Nursing staff and doctors already provided many services without payment. Meningie is competing with larger population centres for funding and acute patients often have to be transported to Adelaide.

11.41 ICPA referred to the need for more flexible service delivery rather than 'overly prescriptive' delivery or a 'one size fits all' approach to health services in rural and remote areas.[33] The need for flexibility within and between services was also supported by the Department of Family and Community Services.

> A frequently expressed concern is that rural and regional locations miss out on government services because they lack the critical mass of clients to sustain standardised service models which are generally defined according to parameters appropriate to metropolitan or larger urban areas. A further concern, also related to the critical mass issue, is that government services are generally

33 Isolated Childrens' Parents' Association of Australia (Inc), Submission no. 94, p. 9.

> delivered through program structures with a specific focus, and inevitably there will be cases which fall outside, or between program boundaries … .
>
> There is a need for greater flexibility in the design and operation of government services, particularly in the area of social infrastructure, in order to address the above concerns and better meet the diverse needs of people and communities in rural and regional areas. In addition to flexibility within services, there is a need for flexibility between services, such that various program activities can better work together to provide holistic responses to local needs.[34]

11.42 **The committee believes that linkages between acute and community aged care services are particularly important in regional areas.** The National Rural Health Alliance argued that the government should 'seek to apply its targets for aged care facilities on an equitable geographic basis, implying a need for special measures to bring rural and remote provision of those facilities up to metropolitan levels.'[35] The committee is aware that a review of the aged care planning process for rural and remote areas is being undertaken over four years, including on-ground support for local level planning for the provision of quality, aged care services.[36]

11.43 In Meningie, the committee was advised that nursing home services are provided at the hospital (five Commonwealth and two State beds) and at a 24 bed hostel. Although an Aged Care Assessment Team (ACAT) had assessed Meningie as having enough beds, staff disagreed with the assessment methodology and considered that more beds were required to fill existing and expected increased demand. They argued for broader consideration of how services could be delivered, including:

- the need for more Home and Community Care packages to allow patients to be cared for at home;
- the potential role of Multi-Purpose medical centres;
- greater flexibility in the use of Commonwealth respite beds; and
- greater funding flexibility.

11.44 The committee believes that the process of accrediting nursing homes lacks the flexibility needed to accommodate the needs of local residents in

34 Department of Family and Community Services, Submission no. 250, p. 10.
35 National Rural Health Alliance, Submission no. 128, p. 27.
36 Department of Health and Aged Care, Submission no. 285, p. 9.

regional communities. The present ACAT formula is not suitable for regional areas.

Recommendation 89

11.45 **The committee recommends that**

- **the accreditation process for aged care facilities be made more flexible; and**
- **a new version of the Aged Care Assessment Team assessment formula be developed for regional areas.**

11.46 The committee considers that the solution to health care access in regional areas lies in alternative models of delivery, rather than a larger medical workforce. It agrees with the focus of *Health Horizons 1999-2003* on developing partnerships and the need for effective collaboration between communities, government, health professionals and the private sector to develop and implement strategies for health service delivery based on maximum community involvement in priority setting and decision making. This was supported in submissions and on regional visits.

> … The Government, at both State and Federal levels, has a responsibility to ensure that adequate health infrastructure is provided to deliver basic health care… this may involve a partnership between one or more levels of Government, including Local Government, medical professionals and the community.[37]

11.47 As in all other areas of this inquiry, intergovernmental cooperation and coordination is essential but there is also an urgent need for strategies that practitioners in the field can employ to develop more collaborative arrangements among groups of service providers at the local service level. The pace of change in home and community care arrangements and the complex system of delivery in regional areas have contributed to the need for reform at the grassroots level. Development of more effective linkages through a genuinely participatory approach would reduce territorial rivalries, for example, between hospital staff and community care providers.

37 NSW Farmers' Association, Submission no. 228, p. 5.

11.48 The committee considers that the key to effectively addressing priority health concerns is effective community leadership. While leadership from states is needed for the development and enhancement of rural health services, communities themselves must provide leadership so that the changed arrangements and services receive local ownership and ongoing support.

11.49 **Restructuring and redevelopment of health services in rural communities is painful and difficult and the committee considers that communities and local management must be supported to ensure their active engagement in the restructuring process.** It is aware that successful transitions from traditional acute service delivery by rural hospitals to more broad ranging service delivery have occurred. For example, the Corryong District Hospital became one of the first Victorian pilot Multi-Purpose Services, the Upper Murray Health and Community Services. Critical to this transition were engagement of:

- an outside facilitator who understood community anxieties and expectations but was aware of the potential of non bed-based services for the community; and
- a CEO with a vision for the future and understanding of the need for change.[38]

11.50 Multi Purpose Services (MPSs) and Regional Health Service Centres (RHSCs) are initiatives developed over the last two years for regional rural and remote areas, to offer a range of health, aged care and community services in the one location, with information technology access to telehealth and teaching hospitals. The facilities will be based on community need, with an emphasis on primary health care, and funding has been provided for 30 MPSs and 30 RHSCs.[39]

11.51 MPSs are a means of achieving the flexibility required to deliver adequate health services to regional areas, especially for populations of less than 5 000. They allow the collapsing of separate funding programs operated by the Commonwealth and the states. Recognising the difficulties faced by small rural communities due to rigid program boundaries, they allow funds to be used for health and aged care services in response to communities' changing needs. In short, MPSs offer the opportunity to provide services that 'much better match the emerging technology of home based intervention and decreasing reliance upon bed-based care, the

38 Dr T Keating and Dr R Calder, *Rural communities and structural changes in health care*, Rural Social Work, vol 4, April 1999, p. 17.

39 Department of Health and Aged Care, Submission no. 285, pp. 4-5.

preference in the market place for less resource intensive interventions, and the changing social and cultural dimensions of health care.' It is important to note that MPSs will be jointly managed by federal and state governments and their development assumes:

- the coordination of all local services through the MPS to achieve economies of scale, efficiencies of service provision and cost, and continuity rather than fragmentation of care; and
- resolution of any historic enmity and confusion of function between hospital based domiciliary services and local government based home care services.[40]

11.52 Although the MPS initiative was supported in submissions, the committee was advised that retention by MPSs of acute care capacity was of central concern to communities:

> Multiservice places must retain capacity for acute care – 'one thing that rural and remote people obviously feel most concerned about is that they lose the immediate access to someone to staunch the bleeding or intervene in a really serious health event.'[41]

11.53 The committee strongly agrees with the increasing focus on community oriented and controlled health service solutions for regional areas, based on local leadership and involvement of health service staff at the local and state level. It supports expansion of the notion of health care to include additional community health services that complement acute health services and urges much better cooperation and coordination between local government and regional service agencies to achieve integrated, community focussed solutions. It considers that networking and encouragement of 'clustering' of towns will be needed in some areas and that development of MPSs can encourage communities to work together within a regional framework. For example, solutions could include service provision by larger towns for smaller towns, better integration of locums and greater use of and better support for health professionals such as 'nurse practitioners.' The committee was advised that many nurse practitioners worked with visiting medical practitioners, especially in remote areas, and that more support was needed for these and other health professionals.

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40 Dr T Keating and Dr R Calder, , *Rural communities and structural changes in health care*, Rural Social Work, vol 4, April 1999, pp. 11-12, 17-18.

41 National Rural Health Alliance, Transcript of Evidence, 30 June 1999, p. 52.

> Clearly, there is a case for nurse practitioners in remote areas to be properly recognised, properly trained and properly indemnified. … There is certainly a role for nurse practitioners in Australia, and the alliance believes that the first place where they should be used more extensively, as indeed is happening in some states, is in the remote areas where there will never be a doctor.[42]

11.54 The committee supports recent government initiatives for nurses working in rural and remote areas:

- to support training 'to enable them to better assist victims of emergencies and trauma' when remote from modern life-saving equipment and backup emergency transport; and
- to enhance professional qualifications and skills through the *Australian Remote and Rural Nursing Scholarship Scheme.*[43]

11.55 The committee considers that recognition must be given to communities that have accepted the challenge of, and are working with, change. For example, local government has taken the initiative in Katanning to provide infrastructure rather than salary packages to attract doctors. Meningie is considering a future managed service with surgery and equipment provided, to attract doctors on short term contract.

Recommendation 90

11.56 **The committee recommends that the Department of Health and Aged Care work with state and territory governments, local governments, communities and health professionals to assist with redevelopment of health services in regional communities by:**

- **facilitating establishment of Multi Purpose Services or similar models;**
- **improving coordination and cooperation within and among agencies and jurisdictions; and**
- **supporting and encouraging the development of community leadership to ensure local involvement in and ownership of regional health solutions.**

42 National Rural Health Alliance, *op cit*, pp. 62-63

43 Department of Health and Aged Care, Submission no. 285, p. 7.

Recommendation 91

11.57 **The committee recommends that the Commonwealth government extend the services provided by nurse practitioners in regional areas.**

Rural health professionals – trends, education and training issues

11.58 In addition to the changing nature of services and regional community needs, the committee was advised of changing priorities for health professionals. There is a focus amongst younger, recent graduates on practice style and lifestyle issues including hours worked, the availability of continuing medical education and training, opportunities to practise public health and leave arrangements.

> … the issues for attracting doctors to country towns in the future may not be so much related to the loss of access to the hospital in which to do other things, but due to lack of a locum, lack of a holiday, lack of certainty and so on.[44]

11.59 The committee was advised that well-designed, supported and integrated education and training, including postgraduate and continuing education, would help to retain doctors for longer periods of time in regional areas. The Regional Australia Summit was advised that a change of attitude was needed by all stakeholders if health practice in regional areas was to be a real career choice. Incentives needed to be 'explicit and mainstreamed' so that young graduates could 'recognise the professional and economic benefits of working in an area of need, to which all stakeholders were (sic) committed to supporting.'[45]

11.60 Initiatives such as the establishment of medical and clinical schools in regional areas, John Flynn scholarships, accommodation and support funding assistance for medical students from rural areas, undergraduate curriculum changes and the establishment of university departments of rural health to provide training for a wide range of health professionals are strongly supported by the committee.

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44 National Rural Health Alliance, *op cit*, p. 60.

45 Dr P Mara, *Health*, paper given at the Regional Australia Summit, October 1999, p. 8.

11.61 At a private meeting in Burnie, Professor Judi Walker of the University of Tasmania's Department of Rural Health advised the committee that the curriculum was multi-disciplinary in approach with an underlying focus on public and population health and improvement of health service development. With the first graduates from the degree all electing to practise in regional areas, a small step towards increasing the rural health workforce had been taken.

11.62 Critical to the functioning of the university's Department of Rural Health was a network of distributed rural health teaching sites, set up in close consultation with and at the behest of local communities. Objectives were to enhance rural health services and address rural health professional workforce issues by providing a focus for university-based teaching, learning and population health research, and to share infrastructure for delivery of health services. The committee was advised that ongoing funding to maintain the rural health sites was not assured, nor was funding for a coordinator. Professor Walker emphasised the need to build on the potential for telehealth, citing development of national and international partnerships. An example of a successful initiative is the establishment of Queensland's Department of Online Help. Development of partnerships with research bodies such as the National Heart Foundation, the Menzies Centre for Population Research and the National Health and Medical Research Council to attract funding for research that could be based in regional Australia was also critical to the continuing viability of rural health education.

Rural pharmacists

11.63 The number of pharmacists in regional areas has decreased rapidly in recent years and the committee was advised that this trend was continuing. It was advised that a new rural pharmacy course with training specific to regional community demands and including business skills would be offered at La Trobe University's Bendigo campus from 2000. It supports recent government initiatives to encourage more pharmacists to work in rural areas, including:

- scholarships for students from rural areas to undertake pharmacy training and placement; and
- the Rural and Remote Pharmacy Workforce Development Program.

Recommendation 92

11.64 **The committee recommends that the Department of Health and Aged Care:**

- **develop partnerships with the private sector to fund and develop tertiary training and placement for health professionals, including medical practitioners, nurses, pharmacists, health service managers and other health professionals; and**
- **extend the rural medical scholarship scheme to cover all health professionals.**

Fran Bailey

Committee Chair

24 February 2000