Australia develops national strategy for bringing physicians to rural areas

Janet Brooks

Résumé : La formation inadéquate des médecins, les heures prolongées, l'isolement professionnel et l'absence de relève par des médecins remplaçants contribuent depuis de nombreuses années à la mauvaise répartition des services médicaux en Australie. Reconnaissant que le problème nécessite une action concertée, le gouvernement australien et la collectivité médicale ont créé une stratégie nationale pour fournir des services médicaux adéquats aux collectivités rurales. De nombreux problèmes qui se posent aux Australiens reflètent ceux qui sont vécus au Canada.

The first "professor of rural health" in Australia, perhaps in the world, still can't quite believe his job exists.

"If you'd told me 2 years ago that there would be a professor of rural health in Australia, I would have laughed in your face," said Dr. Roger Strasser, who holds that position at Monash University's newly established Centre for Rural Health at Latrobe Regional Hospital, Gippsland, in the state of Victoria. "The world seems to have been turned upside down in the last 2 years."

Perhaps it needed to be. Statistics indicate that rural Australians consult doctors less frequently and are less healthy than urban residents, and have long been coping with a shortage of physicians. While about 25% of Australians live outside urban centres, they are served by only 13% of the country's general practitioners and virtually no specialists.

Inadequate training, not a shortage of physicians, is seen as the main reason for the maldistribution. Australian medical schools produce well-trained graduates, but they lack the special training, skills and confidence to undertake rural practice. Those who do attempt to practise in underserviced areas are often driven out by the professional isolation, long hours and lack of relief from other doctors.

These conditions sound familiar to many Canadian physicians: 25% of Canadians live in rural areas where there are fewer than 10 000 residents, but they are served by only 11.3% of the country's physicians, according to the results of a 1990 CMA questionnaire on physician resources. As in Australia, distribution of physicians, not the number of medical personnel, is the problem. Canadian doctors say the situation is caused by long hours of work, a lack of personal opportunities and insufficient professional support in rural areas.

In Australia, the shortage of rural doctors and the problems of nonurban health services have been documented and studied by numerous inquiries and task forces over the past two decades. But only in the last couple of years has Australia taken serious steps to address these problems. The recent formation of the Rural Doctors' Association of Australia has given these doctors a common voice, and the newly established National Rural Health Alliance, representing health workers, administrators and consumers, actively lobbies to improve rural health.

Two years ago a major conference on rural health was held in Toowoomba, Queensland, and Queensland Health Minister K.V. McElligott asserted that "rural health has never had the ear of government to the extent it has today." Brian

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—Drs. Max Kamien and Ian Buttfield, writing in *The Medical Journal of Australia*

Howe, then federal health minister, challenged delegates to be "intelligently adventurous" in their quest for solutions to rural health problems in order to take advantage of "this window of opportunity."

The solutions proposed at that conference became the framework of an integrated strategy designed to tackle Australia's problems. The National Rural Health Strategy (NRHS) aims to relieve the shortage of rural doctors by improving medical training, then by reducing the disincentives and increasing the rewards of rural practice.

Australian undergraduate medical students currently receive only a token introduction to rural practice. The NRHS says medical schools need to recruit more students from rural areas, teach more about rural medicine in undergraduate and postgraduate courses, and provide more training time with rural practitioners. Doctors who hone their skills in urban teaching hospitals where supervision and support are readily available are usually not comfortable working without specialist support in small community hospitals with limited facilities. Undertrained graduates attempting rural practice "live in a constant state of apprehension, get easily scared, turn tail and leave," wrote Drs. Max Kamien and Ian Buttfield in a four-part series on the shortage of rural doctors published in *The Medical Journal of Australia.*

Other disincentives to rural practice are fee schedules that do not reflect the work being done. Rural doctors need broader skills than their urban colleagues, have the added responsibility of working alone, and are on call more often. They pay more for locum relief, often bear the cost of sending children to boarding schools, and could be the sole family breadwinners if spouses are unemployable away from urban areas.

One of the NRHS's six recommendations for immediate action calls for the federal government to examine fee schedules that pay specialists more than general practitioners for identical procedures. Rural doctors resent being paid less to perform procedures for which they have years of training, especially when there are no specialists nearby to refer patients to anyway. Medicare payments, in general, favour the specialist; a rural South Australia GP who sees 112 patients a week would gross the same as a dermatologist who consults on and freezes 16 skin cancers.

Other suggestions for making rural practice more attractive economically include giving rural doctors tax rebates, allowing them exemptions from capital gains taxes, or letting them deduct boarding school fees.

Burnout is another major cause of turnover among rural doctors, who work long hours and carry heavy caseloads. Rural doctors in Western Australia and South Australia reported working an average of 45 to 55 hours a week and were on call 2 or 3 nights a week; 35% were on call every night. Furthermore, their families suffer "secondhand stress" because of the physical and mental stresses of rural practice.

All states should immediately review their locum relief programs to ensure that rural doctors are able to find replacements so they can "attend relevant training courses and take reasonable holidays," states another of the National Rural Health Strategy's priority recommendations. The NRHS also suggests that communities find ways to better integrate doctors and their families to lessen their sense of isolation.

Another key recommendation called for the establishment of a fellowship scheme to allow rural doctors to update and extend their skills, as well as to increase undergraduate exposure to rural medicine. The federal government responded by establishing a Rural Incentives Program (RIP), which spent $8 million in 1992 and will almost double spending this year. Through it, rural practitioners apply for grants to pursue continuing medical education and to provide locum relief. Grants are also available to begin or expand undergraduate programs that encourage students to practise in rural areas. RIP also provides grants of up to $20 000 to urban doctors willing to relocate to rural areas, and recipients qualify for training grants of up to $50 000 to update skills before leaving the city.

The NRHS also called for professional associations to develop better rural training and continuing education programs. Accordingly, the Royal Australian College of General Practitioners recently cre-

ated a Faculty of Rural Medicine, the first of its kind in the world. It offers a 4-year training program specifically tailored for rural practice; doctors enter it after internship. "Rural practice is not a rural version of city practice," says Dr. Mark Craig, the faculty's censor (a censor generally monitors, supervises and administers certification programs). "It's a different discipline."

Candidates for the program are carefully evaluated on their potential for success in rural practice. Favourable factors include a strong rural background, undergraduate and hospital experience in rural areas and, if married or living with someone, a partner who is interested in rural life.

In the final 2 years of the program, the faculty wants to offer trainees the option of studying the special skills of obstetrics, anesthesia or surgery that are required in rural practice. Specialist bodies, however, are reluctant to allow GPs to be trained in certain procedures, even though they must often perform them anyway since specialists are rarely available in rural areas. Anesthetists, for example, refuse to allow GPs to be trained to perform epidural anesthesia. If specialist guidelines were strictly applied, huge numbers of expensive evacuations and referrals to urban areas would be required.

The differences between specialist bodies and the Faculty of Rural Medicine run so deep that resolving them might require third-party negotiations, warned Michael Raid and Sane Solomon in their 1992 background paper, "Improving Australia's Rural Health and Aged Care Services."

Strasser's new job as professor of rural health is another direct result of the NRHS. The Centre for Rural Health that he runs will try to reduce the shortage of doctors in rural areas by developing a rural medicine stream for Monash University undergraduates, arranging more undergraduate rotations at rural hospitals and expanding the number of rural health attachments available to Monash students. (The university is in Clayton, Victoria.)

Before the centre was established, Strasser had watched Monash medical students develop an attitude of "learned helplessness" that encouraged reliance on specialists, the accompanying technology, and the safety net provided by the teaching hospital.

"The students started picking up the attitude that going into rural medicine was almost a failure," said Strasser. "My aim is to turn that around and create an image of rural practice as being a positive and rewarding career. Eventually, I'd hope students will see a career in rural medicine as aiming at the top, not ending up at the bottom." ■

Concours de dissertation en éthique médicale Logie

Date limite : le 1er juin 1994

Le *JAMC* parraine de nouveau le Concours de dissertation en éthique médicale Logie ouvert aux étudiants de premier cycle en médecine des universités canadiennes. Cette année, les prix sont de 1 000 $ pour le lauréat, de 750 $ pour la deuxième place et de 500 $ pour la troisième, mais le *JAMC* se réserve le droit de suspendre certains prix ou la totalité de ceux-ci si la qualité des textes est jugée insuffisante. Le jury est formé d'un groupe de rédacteurs de l'équipe scientifique et de celle des informations générales du *JAMC* qui choisiront les lauréats en fonction du contenu, du style de rédaction et de la présentation des manuscrits. Les dissertations doivent être dactylographiées à double interligne et compter au maximum 2 500 mots, y compris les références. Les citations et les références doivent être conformes aux «Exigences uniformes pour les manuscrits présentés aux revues biomédicales» (voir *J. Assoc. Méd. Can.* 1994; 150: 159–167). Les auteurs choisis devront remettre leur dissertation sur une disquette. Les dissertations choisies seront remaniées quant à la longueur et à la clarté, et conformément au style de la revue. Les auteurs recevront une copie remaniée avant la publication. Veuillez faire parvenir vos textes à l'attention du Rédacteur aux informations générales, *JAMC*, CP 8650, Ottawa (Ont.) K1B 0G8.