Access to rural general practice and primary care: Time now for more equitable and sustainable solutions?

Australia has the resources to provide reasonable primary medical and health care to all of its population. It is a particularly worthwhile expense, with positive social and biophysical outcomes (Jarman et al., 1999; Starfield, 1998). In many aspects of health care, primary care provides most of the benefit and almost all of the value. Why, then, don't we provide this basic service to all Australians?

Rural doctors have led the charge to address medical workforce shortages in rural and remote Australia, proposing a range of strategies. Supporting recruitment and retention through rural workforce agencies has provided some money and support to ply doctors to work in rural and remote settings—and this has made a great deal of difference in some areas. The need for nursing, midwifery and other health professionals is now acute and government strategies are becoming more inclusive. These strategies do not address the needs of outer metropolitan areas, refugees or other groups and are spread far too thin to have any impact on the needs of most of rural Australia.

Further, the recruitment of doctors from countries that need them far more than we do raises moral and ethical issues. This open gate policy, in stark contrast to our approach to refugees, may console our citizens, but is an irresponsible act in a world of great disparity in health care. Suddenly, there are no checks on the standards of these international medical graduates by the Australian Medical Council —as doctors, as general practitioners or in regard to other attributes required to function effectively as a doctor in a community. The majority are excellent clinicians but some are not suitably trained. Given the situation and resources available it is inevitable that this recruitment will continue unless there are some negative political implications to its continuation. The WONCA position statement on this issue (WONCA, 2002) written by rural doctors is now flouted.

The responsibility for general practice training has moved to GPET and its government-appointed board. The hope remains that local control and a more even spread of training throughout the country will have a positive impact on workforce. However it is very disappointing to see that the number of Australian graduates entering general practice training has fallen dramatically. Further, the number seeking rural training (as opposed to taking up the incentives to train in rural areas) is probably at an all time low. So, in the current climate and with this approach, recruiting Australian graduates to train and work in general practice is proving difficult. The RACGP has a major role to play in nurturing young doctors who are interested in general practice.

It is time to drop the rural focus on workforce in favour of a universal approach—all Australians require access to primary medical care. I believe that the current bureaucratic solutions—workforce agencies, bonded scholarships, regionalised general practice training—are two-edged swords, and, while assisting in the short term, they are not proving helpful in even the medium term. The answer has to be that general practice in Australia, wherever practised, is rewarding and sustainable—financially and socially (Rural Workforce Agency, 2001). The approach has to work with the community—if they want to be involved—and allow for recruitment and retention of nursing and other staff.

How to do this? It is time for a more radical approach. The walk-in, walk-out model of general practice is much touted. It is attractive when you have no doctor or one who is not liked; but communities generally seek continuity. Further, in some of the "coordinated care trials" in the Northern Territory the actual cost of not having a doctor in a small township became apparent—and it is at least double the income of a highly paid rural GP.

If Australians are to have access to primary medical care, the lifestyle of the general practitioner must be reasonable. I believe that a GP should not be expected to be on call for more than two nights per week and one weekend per month. This means that new arrangements have to be made for

practices or groups of fewer than four doctors covering a geographic area. Such approaches require highly trained nurses, good telephone support and ambulance and/or evacuation services. Patients have to be prepared to travel a reasonable distance to see a doctor. This will vary depending on geography and local culture. A general practitioner must also be able to have six weeks off each year regardless of the ability to recruit a locum.

Financial sustainability means that the general practitioner should have the resources to recruit nursing, midwifery and administrative staff as required. The way to keep this in check is to reimburse the practice or organisation for a fixed percentage (60-100%) of such salaries. This money is not wasted; it is already being spent in the communities, or more often lying idle, dedicated in budgets but with unfilled places. Allied health practitioners could also be employed on such a basis. Such an approach will not suit all—either communities or practitioners—but it is likely to suit a lot more than the present arrangements.

Finally, I would suggest a practice establishment grant, which is an annual grant made available to the practitioner until their personal income reaches a ceiling agreed at the time of recruitment; it is then renegotiated. This would include "ring-fenced" monies to recruit a basic team of staff.

Achieving access to primary medical care for all Australians is a reasonable goal for an industrialised nation. All major industries recruiting to remote areas make this commitment. Further, I suggest it will, if carefully planned, save money and be of great benefit. In any event, even a slight commitment to equity on an international basis must put a stop to our present approach. We can't live with it.

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