Submission to the Productivity Commission on Health Welfare.

Focus.

A Strategy for Improving Health Services for Patients Remote from Capital Cities and Towns with Available Specialists.

The Writer.

A recently retired country GP after 37 years in Naracoorte,SA.
Two years in the UK in hospital and General Practice.
Two weeks in Missouri where small towns have always been well served.
I am also a thinker, a writer with an interest in behaviour when I am not gardening.

The Past and Present.

Health in small isolated towns was provided simply by GP's and hospital-based nurses.
The best services were wide in scope and excellent in quality but the worst were unacceptable.
It has always been difficult to encourage young doctors to come to the country and even harder to get them to stay.
The skills areas of obstetrics and surgery, anaesthetics and emergency medicine are declining – particularly obstetrics and surgery.
Skills in behaviour and psychiatry were never good enough – they may be a little better now.
Young doctors feel ill-equipped to practice away from specialist help and I agree that we are all under-trained for the job.
The movement of more specialists into regional centres is useful to those centres and the patients within 30 minutes by road. Outside, conditions for patients are worse than they have been for over the last 40 years.

What Do I Mean by Isolated?

Patients who live more than 1 hour from a capital city or 30 minutes from a regional centre providing 24 hour care.

Where Do We Need GP's Trained For Isolated Practice?

Only in isolated areas.
Urban type or non-procedural GP's are suitable in the capitals, urban fringes (up to 1 hour by road) and in regional centres with 24 hour specialist care and perhaps within 30 minutes of other regional centres.

Training of Isolated Practitioners.

Isolated GP's are not trained for the job they are required to do.
No training program is yet available.

Suggestions for a Program.

Hospital based, specialist controlled training in large provincial hospitals. The trainers need be experienced in provincial practice.
Suitable sites would be Townsville, Ballarat, Geelong and Wollongong.

Training Program Over 4 Years -

with rotation through all areas over the first 2 years followed by 2 elective areas for the next 2 years.

The Areas Needed

are Obstetrics to the level of caesarian section.
Surgery to acceptably open an abdomen, appendectomy, burr-hole craniotomy and closed fracture reduction.
Anaesthetics to intubate successfully under difficult circumstances.
Psychiatry and Behaviour to recognise and refer serious mental illness.
To handle Psychoses when not acute, Drug abuse and Suicide prevention.
Briefer time on Radiology and Radiography.
The elective areas can be any of the above, plus Medicine.

Following Hospital Training

there be a 5 year period where graduates work in isolated practice in association with experienced bush doctors at GP rates.

When successfully completed

a specialist degree, status and income be provided.
The specialist income would only apply while the practitioner practiced in isolated areas where the town population was less than 20,000 people.

While this training may seem arduous and long it is benefiting the needs of the doctor and patient and it is likely to attract young males who prefer the status of specialty.
The status and training would aid relationships with other specialists also.

Where to Seek Suitable People to Train

Urban-reared doctors and their spouses uncommonly put down roots in small and isolated towns.
There is nothing in this scheme to discourage relocation to the country.
Students from isolated areas – here used in a wider way to mean those who reside and have received all their schooling more than 1 hour from a capital city – have an advantage once trained in staying permanently where they are most needed.

Proposal 1.

That 20% of each State's positions in medical schools be reserved for isolated students from that State.
All isolated students be bonded for 5 years of isolated practice whether or not they choose to do the training outlined. Some may choose to work a GP rates.
All isolated students in one state attend the same medical school.
That Isolated Medical Students Clubs be encouraged to support, brief, inform and encourage partnerships with others who like small town life.

That Isolated Students recognise their privilege in entering medical school this way for the purpose of the long-term country practice.
That students from isolated areas may apply to medical schools for general rather than privileged admission.
That 1 or 2 urban students with convincing rural commitment be accepted into the scheme.

Proposal 2.

That all students who complete their secondary studies in an isolated school have special access to medicine, nursing, dentistry, law, education and veterinary science.
That these students compete only with other isolated students for (say 20%) of their state's places in those facilities.

Remove the current disadvantage of professional people remaining in small towns.
It would also create a larger class of new graduates who may choose to spend a life in a small town in their own profession.

The Most Important Points.

1. Adequate and rigorous training as the highest priority. The flow-on into practice can take no less than 4 years after establishment and up to 15 years for the isolated student stream to reach specialist practice. This could be reduced by shortening the undergraduate course, which would mean less education and a higher percentage of training overall.
2. A doctor who feels more comfortable in a small town than in a capital city is likely to stay. Isolated students are more likely to feel this by a large factor.
3. The training needs psychiatry and behaviour in it. Graduates keen on surgery and obstetrics are good objective thinkers yet more of their patients will suffer or die from psychiatric or behavioural disorders.
4. Women are advantaged in behaviour by their nurturing natures. Women may find this training appeals to only a few. It is those few women who are and would be so valuable in country practice.
5. Isolated country practice needs be patient and not doctor orientated. To do what is needed will require a lifetime of long and hard work – like surgery and obstetrics. Patients needs are real! Doctors without desire to serve need not apply!
6. I believe this to be a sound framework to provide more and better isolated practitioners.
7. If this strategy is accepted in principle, the details can be varied without necessarily compromising the end results.

If I were called to attend the Commission to further explain these proposals, I would do my best to attend.

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