Let's have more equity and justice in rural health services provision

Maureen Gleeson

As we are all well aware there have been great changes in health care delivery over the past two decades. The scientific advances that have made all of this possible command headlines in our national newspapers almost daily. So too has been the rate of change in the publication *Australian Health Review*. I want to offer my warm congratulations to the Editorial Committee who, over the years, have brought AHR to the stage it is at today — a quality professional journal.

While so much that is great has happened in our hospitals over the last quarter of a century we need to be honest and admit not everything has been optimal. And we must be honest, too, in admitting there have been some quite remarkable 'power plays' within some of our finest health facilities and bureaucracies. Patients losing out to politics has so often been the result of these unpraiseworthy antics. Does it have to stay this way? Or can we move on to a better way of behaving and distributing scarce resources?

Many years of my professional life were spent within busy teaching hospitals where we did our part in consuming the lion's share of the scarce resources. The last five years in consulting practice have seen me working a substantial amount of my time in rural Australia. This has been a very rewarding personal, as well as professional, experience for me. It has also been an eye-opening one — my city-blinkered view has been challenged in a variety of ways.

The total lack of equity in the distribution of resources to the rural sector of health care is something I consider should horrify and dismay all of us. The large regional cities struggle to provide even basic health services. As well as appalling transport systems which make accessing health services a nightmare for many (usually those who need the services the most), the demography, the special needs and additional expenses (eg, ambulance costs) are so often ignored in the planning, development and funding of new health services. This can be made perfectly clear by a brief look at beginning and end of life services and cancer services — but one could examine any services and find the same situation.

Recently, in rural NSW, I spoke with a woman hospitalised while awaiting the arrival of twins. There were sound clinical reasons for her hospitalisation. She had already been assessed by ten (yes, ten), 'fly in, fly out' obstetricians during this hospitalisation! And she had two weeks to go before her planned caesarean section. She had no idea who would be performing this procedure. I suspect the hospital did not know either! So much for 'continuity of care', 'world best practice' and all those other catch cries that we hold seminars about. Recently, in a Northern Victorian country town, I noticed a letter in the local newspaper that was headed "Rural obstetrics is dead and rural obstetricians aren't far behind!" New training models to ensure availability of rural obstetricians for the years ahead are clearly needed. The School of Rural Health, University of New South Wales, Wagga Wagga/Albury Campus is attempting (with support from both Commonwealth and State governments) to address this matter and to develop and pilot new training models. Some say this is too little too late — I like to think their cynicism is ill-founded. Full marks to the Riverina community in driving this needed initiative that should improve obstetric services for rural Australia in the future.

End of life care for country people in many parts of Australia is no better than beginning of

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life care. Palliative care is a relatively new subspecialty that can offer so much for symptom and pain control when curative models of treatment are no longer appropriate, but is not of world standard in all parts of Australia. The local multidisciplinary team is sometimes supported by the 'fly in, fly out' model of specialist palliative care physican support. However, this model only seems to work satisfactorily when it is linked to a metropolitan palliative care unit that can supply a 24-hour on-call service for provision of advice to the local rural practitioners. Some rural centres have managed to arrange such service provision. Many have not. But, even when such arrangements do exist to support the weekly visit of the specialist palliative care physican, the model is not an ideal one. If the city-based palliative care unit becomes short staffed, guess who goes short, or misses out altogether!

There are also the ongoing problems of the cost of air fares, ground transport, etc. for the visiting specialist. All of this means that even when the 'fly in, fly out' model of care to regional cities is supplied by an experienced, skilled palliative care physican the model is a suboptimal one. Country people want to, indeed have a right to, die at or close to home. They have the right to the same quality of palliative care as city people. Believe me, currently they do not all receive it.

Now to look at cancer care services. The University of Sydney research published recently has shown that the further away from the metropolitan area patients with bowel, liver or lung cancer lived the higher the risk they would die within five years of their diagnosis. The *Sydney Morning Herald* put it well with a page-three headline "Poor treatment puts cancer at its most deadly in country areas". Access to 'add on' treatments creates enormous difficulties for country patients (and their families). One large regional centre in NSW recently took these matters into its own hands. With concerted community efforts several million dollars were raised. It now has a world class cancer care service, including a radiotherapy centre. While the health planners within the bureaucracy were not too festive about these developments the local people are delighted with the outcome!

And finally, a word about attitudes. I see a need for significant attitudinal change on the part of a number of city clinicians. It seems to me that there is a belief, sometimes expressed overtly, but more often covertly, that rural practitioner equals 'inferior'. In many instances this could not be further from the truth. There are some enormously talented country clinicians who, for a variety of reasons, choose regional or rural practice. There are, too, many talented, experienced health service managers and executives in regional and rural cities. They need more recognition of their expertise and significantly more resources, both human and economic, than they currently receive to provide the health services their catchment populations have a right to. We all say that we believe health care is a right, not a privilege, in this country. Country people must smile (or maybe grimace with anger) when they hear such notions expressed. For many it is just not their experience.

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