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EDITORIAL

Good health to rural communities?

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In a recent edition of the *Journal for Rural Health*[1], Thomas Ricketts cautioned rural health advocates to avoid being perceived as a special interest group seeking special advantages, but rather be known as advocates of policies that appeal to society's sense of fairness. Australia is known internationally for its sense of 'a fair go', so it may be an apt setting for a test case of Ricketts' assertion.

Earlier this week, five Australian rural health advocacy groups jointly released a collaborative policy document, a 10-point plan that aims to provide strategies towards better health in rural communities[2]. One test of fairness is whether there is good evidence to support the proposals. Examining the 10-point plan on the basis of this criterion may also be a useful way of determining the relevance of a Journal, such as *Rural and Remote Health*, to such policy development.

The first strategy advocates for small rural hospitals to become *centres of quality health care and training* and for policy makers to consider their impact on health outcomes and community sustainability, not just the financial bottom line. Walters et al.[3] and Rosenthal et al.[4] have shown how small rural hospitals can become centres of excellence in medical education in Australia, and Doekson and Schott[5] have demonstrated how the health sector provided nearly 20% of the non-farm employment in a group of typical small rural counties in the USA.

The second strategy emphasises a strategic approach to support procedural rural medicine. This strategy's emphasis on the importance of appropriate training is supported by Levitt's[6] comprehensive review of the literature on maintenance of procedural competency.

The third strategy emphasises enhanced linkages between visiting medical specialist services and high quality local practitioners. This was a key finding from Rankin's rural consumer focus groups[7] and Greenwood and Cheers'[8] study of female practitioners and can be seen as a cost-effective solution in communities that cannot be expected to provide the high level of infrastructure that Katekar[9] identified as necessary to support resident specialist services.

The fourth strategy called for higher payments for rural doctors reflecting the increased complexity of medical services in this context. Recent Australian research strongly

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supports the notion that rural medical work is more complex than that undertaken by urban peers[10] and Ryan-Nicholls'[11] work shows historically how lack of adequate funding has incapacitated rural health services in Canada.

The fifth and sixth strategies call for greater support for collaboration with rural nurses and Aboriginal Health workers in primary health care teams. Brown's[12] study of falls in rural communities has shown the value of a collaborative multi-disciplinary approach to preventative medicine and Shephard's[13] work with an Indigenous community has shown the effectiveness of an Aboriginal Health Worker led approach to detection and management of renal disease. Battye and McTaggert's work would suggest that extension to collaboration with other allied health disciplines should also be effective[14].

The seventh strategy suggests the creation of a locally managed recruitment fund to purchase practice facilities and suitable housing to attract doctors and their families. Veitch and Crossland[15] have shown the importance of a sense of financial, social and professional security in retaining doctors in rural Australia, and Couper's[16] observations of the South African recruitment environment are strongly supportive of the need for adequate accommodation for rural doctors and their families.

The eighth strategy emphasises the need for improved access to broadband services in rural communities, a strategy supported by Peterkin's[17] work in Scotland and currently being advanced in Canada[18].

The next strategy is for greater incentives, especially through bonded scholarships, to encourage medical students to choose rural medicine. Dunbabin and Levitt's[19] international review, and Alkan et al's[20] report from Kyrgyzystan, outline evidence of the influence of undergraduate initiatives on career choice, whilst Wilkinson[21] has cautioned that there are still considerable gaps in the evidence base in relation to workforce policy and student initiatives. There will be great interest in following the students enrolled in such bonded schemes.

Finally, the tenth strategy moves to support the place of overseas trained doctors in the Australian health system through appropriate mentorship and supervision. This journal has highlighted the ethical dilemma[22] of recruiting overseas trained doctors to work in wealthy countries, but given the reality of such doctors forming the overwhelming majority of recruits to Australian rural practice over the last 5 years, it seems only right to give them a 'fair go' and support them through the professional, bureaucratic and cultural challenges[23] that they face.

Readers from outside Australia must remember that this most recent collaborative policy statement is made in the context of over a decade of substantial rural health policy developments, so these strategies are not intended to be seen as the first priorities for a *de novo* rural health policy. Some may also see them as inappropriate, or unachievable for their country. International debate on the priorities in rural health policy can only be collectively helpful, and *Rural and Remote Health* welcome such contributions and the debate they raise.

Collectively these ten steps do, however, demonstrate the principle that integration is a key to workforce policy. Integration across the disciplines and between generalists and specialists; integration across the varying needs at the different life-stages of medical practice; integration of education, clinical service and career choice incentives; the persuasiveness of an integrated approach from lobby groups to policy development; and a recognition of the integral link between the social, cultural and economic resources of rural communities and their success in recruiting and retaining a high quality health workforce.

This brief overview of these ten strategies also demonstrates the need for high quality research to underpin rural health policy development. Rural and Remote Health salutes the authors of the sited articles. Their work enlightens our understanding of this particular initiative, and reaffirms the Journal's commitment to providing an easily accessible, peer-reviewed international evidence base for rural and remote health. Whilst the need for better evidence remains,

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for both practice[24] and policy[21], it is reassuring to find that the body of published work is providing a quiet but useful voice of reason to support the fanfare of rhetoric that is required to move political systems to give rural communities a fair go. May this Australian experience be a catalyst for similar action around the world.

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