Submission to Senate Inquiry on "The Factors Affecting the Supply of Health Services and Medical Professionals in Rural Areas"

Bairnsdale Regional Health Service (BRHS) is a rural health service in eastern Victoria, serving a large geographical area from the township of Bairnsdale to the Victorian-New South Wales border, with a population of approximately 40,000. Medical services in the health service are provided by:

- Over twenty General Practitioner Visiting Medical Officers (Emergency Department patients, General Medical inpatients, Hospital in the Home patients, anaesthetic services, obstetric services and minor surgical services), assisted from time to time by their General Practice Registrars (there are generally two to four of these at any given time);
- One Staff Specialist General Surgeon and one General Surgeon Visiting Medical Officer who provide elective and emergency surgical services, supplemented from time to time by Locum General Surgeons;
- Various Visiting Medical Officers in surgical and medical subspecialties who provide elective and/or consulting services;
- One Staff General Practitioner who provide services in Rehabilitation and Emergency Medicine;
- One Career Medical Officer who provide services in Emergency Medicine;
- Ten Full Time Equivalents (FTEs) of junior medical staff, on rotation from Eastern Health (a tertiary metropolitan health service in Melbourne), consisting of: one FTE of unaccredited Surgical/Emergency Medicine Registrars, one FTE of Hospital Medical Officers (Year 2) and eight FTEs of Interns;
- One 0.5 FTE Director of Medical Services.

Key risks affecting the quality and sustainability of medical services at BRHS include:

- The ageing Visiting Medical Officer workforce, and increasing expectations of work-life balance (across all age groups within the Visiting Medical Officer workforce). This makes after-hours medical cover for the health service increasingly onerous and unpopular, and there is an implicit understanding between this workforce and the health service that cover for Emergency Department patients and General Medical inpatients will decrease or be withdrawn in the coming decade.
- The multiplicity of professional commitments of Visiting Medical Officers (e.g. to multiple health services and/or to private rooms), making engagement of this workforce in vigorous clinical governance activities difficult (e.g. annual performance appraisals, participation in clinical quality improvement and risk management activities).
- The amount of work available for Staff Specialists (i.e. General Surgeons currently and prospectively employed, and General Physicians prospectively employed) is insufficient for enough Staff Specialists to be employed to operate a sustainable on-call roster. For example, BRHS is likely to have enough work to employ two Staff Specialist General Surgeons and two Staff Specialist General Physicians only – however, a one in two roster is generally considered unacceptable by the learned Colleges.

- Our Staff General Practitioner and Career Medical Officer essentially provide rural generalist services. However, at present, Victoria does not have formal training and industrial frameworks for developing and employing rural generalists.
- BRHS is currently fully dependent on Eastern Health to supply junior medical staff. Historically, this has meant that BRHS has little control over the recruitment and allocation of its junior medical staff, resulting in a very junior or 'bottom heavy' establishment despite the limited capacity of the health service to provide formal training and supervision. Moreover, there is very little continuity in workforce as all of these junior medical officers rotate to BRHS for periods of ten to thirteen weeks only.
- For all of the above reasons, and BRHS's geographical isolation, medical recruitment is very difficult and heavily reliant on International Medical Graduate (IMG) candidates at BRHS. However, BRHS has limited capacity to provide on-site supervision for IMGs while they pursue their Fellowships of Australian learned Colleges, as there are few Fellows of these Colleges employed or associated with the health service.
- There is limited medical management capacity in the health service.

To date, BRHS has managed some of these risks through the following strategies:

- The development of a five-year Junior Medical Workforce Plan. This aims to achieve a larger and more balanced junior medical workforce at BRHS, through a combination of negotiating with metropolitan health services, and internal recruitment. This would in turn be an intermediate step towards relieving General Practitioner Visiting Medical Officers of some of their obligations to the health service, as well as making the health service more attractive for Staff Specialists. It is also thought to have the advantages of diversifying BRHS's reliance from one metropolitan health service, and rotational junior medical staff, only. Another inclusion in the Junior Medical Workforce Plan is an expansion in the medical management capacity of the health service, through the employment of a 0.5 FTE Medical Workforce Manager.
- The recruitment of Staff Specialists. One IMG Staff Specialist General Surgeon commenced work at the health service in June 2011, and another potential Staff Specialist General Surgeon is undergoing IMG assessment by the Royal Australasian College of Surgeons. Supervision is arranged through a combination of on-site and off-site activities. A 0.6 FTE Staff Specialist General Physician role has been created in conjunction with a 0.4 FTE role for the same at Central Gippsland Health Service, however the role remains vacant after over two years.
- Developments of the medical clinical governance framework of the health service, such as participation in the Limited Adverse Occurrence Screening Program associated with the General Practice Alliance – South Gippsland.
- The occasional use of Locum General Surgeons, which eases the on-call burden on the Staff Specialist General Surgeon and the General Surgeon Visiting Medical Officer who provide emergency surgical cover for the health service. Nevertheless, the health service has gone on 'surgical bypass' to Central Gippsland Health Service on several occasions in the past two years.

- Partnering with the local General Practice training network, local clinical school and other health services in the region to develop a model and funding submission to the pilot Victorian Rural Generalist Program, and to cooperate in junior medical workforce recruitment and training through the Gippsland Medical Workforce Partnership.

However, there remains a need to increase and improve coordination of support for the recruitment, retention and development of the medical workforce at BRHS. Examples include:

- Various grants exist to support the recruitment of senior medical staff and IMGs to rural health services, funded by the Victorian Department of Health. However, these one-off grants are unlikely to be effective for the retention of these doctors in rural health services.
- One of the key ongoing grants that had been supplied by the Victorian Department of Health to support senior medical staff – reimbursements to public hospitals for paying Continuing Medical Education entitlements to the tune of over $20,000 per year per FTE – was terminated in 2010/11 and replaced by a much less generous grant (of up to $2,000 per year per FTE) in 2011/12. It is important that rural health services in particular are incentivised to support Continuing Medical Education, given the geographical and professional isolation that rural senior medical officers experience, and the fact that many of them are IMGs undertaking supervised practice in Australia.
- There are no grants at present to support health services to transition from Visiting Medical Officer services to Staff Specialist services – when they have reached the threshold size to make this transition.
- There is little support for rural health services to employ locums to maintain continuity of services and support senior medical staff retention. An exception is the SOLS subsidies for obstetricians and gynaecologists accessed through the Royal Australian and New Zealand College of Obstetricians and Gynaecologists.
- There is a multiplicity of grants to support the recruitment and training of junior medical staff, from: the Commonwealth, State governments and learned Colleges. However, these are generally targeted at very junior staff (Interns and Hospital Medical Officers Year 2) or accredited training Registrars. Rural health services are often more reliant, or need to be more reliant, on mid-level junior medical staff, such as unaccredited Registrars, senior Hospital Medical Officers and Career Medical Officers. These positions tend to be less supported, and this has been a barrier to the implementation of the BRHS Junior Medical Workforce Plan.
- Aside from fixed term project funding, there is relatively little support for metropolitan and larger regional health services to partner with smaller regional health services to support medical workforce recruitment, retention and development in the latter.
- Medical management and clinical governance is heavily guided by government policy (e.g. credentialing) and regulations (e.g. medical registration). However, there is limited support for the development of capability and capacity in medical management and clinical governance (an exception is funding for the Limited Adverse Occurrence Screening Program provided to Divisions of General Practice), and for clinician engagement (hence implementation of government policies can lead to clinician disenfranchisement, such as claims of ‘just additional paperwork’).

It would therefore seem that a higher quality and more sustainable medical workforce in rural health services require additional and more coordinated investments across levels of government, with leadership sought from the industry and from clinicians. While fixed term grants are often less risky for funders, and the introduction of a national efficient price for health services would tend to favour the rolling up of specific purpose grants into casemix funding, incentivising sustained change may actually be more effectively achieved through the provision of recurrent, specific purpose grants.

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