ECHUCA REGIONAL HEALTH

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13 December 2011

Senator Bridget McKenzie
Senator for Victoria
PO Box 2047
Delivery Centre, Bendigo, Vic 3554

Dear Senator McKenzie

Re: **Central Loddon Mallee Medical Workforce Group submission** to Fairer Outcomes for Regional and Rural Victorian Communities Regarding Supply of Health Services and Medical Professionals in Rural Areas

Thank you for your letter of 10 November enquiring about health services in small regional communities.

This submission is made on behalf of the Central Loddon Mallee Medical Workforce partnership which includes six hospitals in northern Victoria - Echuca Regional Health, Swan Hill District Health, Kerang District Health, Cohuna District Health, Kyabram and District Health Service and Rochester and Elmore District Health, and the Murray Plains Division of General Practice, working in conjunction with Bendigo Healthcare Group.

This year, supported by the Victorian Department of Health Loddon Mallee region, a Research Officer was employed to examine medical workforce issues for the partnership. I enclose a copy of the report of Phase I of the project. This document details the particular concerns of the executive/s of each service with regard to sustainable medical staffing and a profile of current medical staffing in March 2011.

During the course of this project, several themes have emerged, all of which have ramifications for rural and regional health services. It has been helpful to have had funding for a Research Officer to undertake investigations and coordinate discussion and planning among members.

Broadly the identified issues are:

Maternity Services
Smaller centres in the Loddon Mallee region are losing population and larger centres are increasing. Greater Bendigo's growth 2004-2009 was 8.5%; Echuca/ Moama 10-12%. Swan Hill Rural City 4%.

The number of births across the region has not changed significantly between 2008/9 and 2010/11 (73 less births in rural/regional hospitals and 50 more at Bendigo Health in a total of 1851 regional births in 2010/11).

A small number of Obstetric and Gynaecology Specialists visit rural hospitals, but few provide obstetric services. Medical obstetric services in these rural hospitals are provided by GP Obstetricians.

During 2011 medical obstetric services closed at Kyabram (replaced by a low-risk midwife model of care with transfers to Goulburn Valley Health at Shepparton if required) and the same will occur at Deniliquin Hospital early in 2012 with higher risk mothers referred to Echuca or Goulburn Valley Health in Shepparton. Expensive locum services are currently required to maintain obstetric services at Swan Hill, and the future of obstetric services at both Kerang and Cohuna is dependent upon a very small number of GPs.

Echuca has an adequate supply of GP Obstetricians (and other GP Proceduralists). However, the percentage of ERH General Practitioners over 45 years (75%) is, greater than the national average (63%), so sustainability of this service in the longer term is an issue. No babies are delivered at Rochester and Elmore District Health.

As a result of the closure of medical obstetric services, mothers from Hay NSW in the north may find they have to travel extensive distances (up to 300km) to Echuca or Goulburn Valley Health to have their babies.

Medical Specialists

All rural health services in the partnership identified shortages of specialist medical staff. Most hospitals rely on visiting specialists. Post-surgical continuity of care is more difficult to provide with only visiting specialists. Echuca Regional Health has been without a resident general surgeon for nine years. Locum surgeon services have been required in the interim.

Some specialist regional services are based in Bendigo. Patients receive acute care in Bendigo with follow up in rural hospitals. (eg. mental health, cancer services). Cancer outcomes for non-metropolitan populations are significantly poorer than for metropolitan populations and further assistance and support has been sought from Bendigo Health for rural centres.

Evolution of General Practice

The partnership welcomes the introduction of the Loddon-Mallee-Murray Medicare Local scheduled to commence operations based in Bendigo in January 2012. The introduction of this new service should improve access to Medicare Local services in the environs of Bendigo. We await further information regarding new regional services.

Another factor impacting on regional hospitals recently is the growth in corporate General Practices. During 2011the region has seen bulk-billing Tri Star clinics open in Bendigo, Swan Hill and Kyabram. Rural patients are pleased to have a bulk-billing option. Where corporate clinics are now operating there has been a small reduction in weekend emergency department presentations, but this reduction has been smaller than anticipated. Doctors in the corporate-style practices typically do not apply for hospital credentialing and do not participate in after-hours hospital emergency rosters. This has the effect of reducing the bread-and-butter work in the established GP clinics and concentrating the more demanding emergency and after-hours workload on a smaller number of doctors.

Hospital executives are concerned that this will ultimately reduce the medical workforce needed to keep hospitals operating, and are consequently looking at alternative models such as hospital-run GP clinics. Several hospitals in the region are considering this option. Many established GP doctors in the region are in the 50 – 60+ year age bracket, and are looking to reduce workload.

Transferring to a hospital-run clinic has some attractions for these doctors. Newly graduated doctors are reportedly more attracted to GP positions which offer walk-in, walk-out flexibility and are less keen to buy in to established practices.

Changing face of rural medical workforce

Concern has been expressed at a medical professional level about the fact that International Medical Graduates who are prepared to work in areas designated as area of need or area of workforce shortage, can, with no experience of the Australian health system, take up positions being required to pass only a basic PESCI clinical assessment. Clinical supervision requirements for such doctors are also minimal. Nevertheless, with rigorous recruitment processes in place, having a better supply of IMG doctors available has meant that rural hospitals have been able to secure more senior HMO staffing, which improves scope to provide better JMO supervision.

Junior Doctor training

Since the significant increase in intakes into medical training, metropolitan hospitals are reportedly struggling to ensure that they have sufficient supervisors to provide appropriate clinical training. For rural hospitals, the positive impact has been that a small number of additional junior doctors have been sent on rotation. Supervision for junior doctors after-hours is typically provided via GP VMOs on-call which is less than ideal. The better alternative is supervision provided by full time on-site staff.

Clinical Leadership

A Victorian Government review is currently being undertaken of the role of Directors of Medical Services for rural and regional centres. Hospitals have been surveyed and responses suggest that most rural hospitals have only a part-time visiting Director of Medical Services whose focus is on medical credentialing of doctors and providing medical advice. Rural hospitals typically utilise Visiting Medical Officers who are external contractors and only junior doctors are salaried. With only part-time senior medical oversight, scope for developing organisation-wide clinical governance and leadership is limited.

Australian Standard Geographical Classification – Remoteness Area Classification

In a program specifically designed to provide incentives for the medical workforce to come and stay smaller rural communities, offering the same level of support to doctors prepared to work on the metropolitan fringe as in Campaspe Shire disadvantages the latter. Kyabram and District Health Service, Rochester & Elmore District Health and Echuca Regional Health are in Campaspe Shire which is classified as Inner Regional (RA2) despite being two or more hours drive from Melbourne and one and a half hours from Bendigo. (Kyabram district patients do have access to regional hospital facilities at Goulburn Valley Health which are within half an hour's drive.)

The RA2 classification is appropriate for outer metropolitan zones which have their own level of disadvantage, but does not have the desired effect for more remote services such as those in Campaspe Shire.

Under the three GP Rural Incentive Grants support to recruit/relocate to a RA2 region requires longer qualifying periods and provides much smaller incentives than in RA3. General Practices in Campaspe Shire with older doctors seeking to attract new doctors into the practice receive minimal financial assistance to secure the longevity of their services.

Assistance through the Medical Specialist Outreach Assistance Program is not available in RA2. Specialists prepared to provide visiting services to Echuca Regional Health are therefore not eligible for MSOAP support.

The other towns in the Central Loddon Mallee partnership are classified as Outer Regional (RA3). Some MSOAP funding is available for RA3 areas and this helps with retaining visiting specialists.

Swan Hill District Health is the most remote hospital in the partnership being 2.25 – 2.45 hours by road from the nearest Regional Hospital in Bendigo. The consequence is that Swan Hill must have reliable medical services for example maternity services. For a mother and baby in trouble, the time to the regional centre may be life critical. Securing locums to ensure adequate medical cover can be very expensive.

Wish list

Into the future, we would expect and hope that the increased number of local medical graduates should help to encourage Australian doctors to take up practice in rural and regional areas. We would expect and hope that larger regional centres will provide networked clinical services to ensure that smaller hospitals can provide local care for their rural populations with lower complexity clinical services.

We would also expect and hope to see better coordinated care across the continuum with a strong focus on prevention, early intervention, primary care and secondary care as well as rural hospitals continuing to offer procedural services.

Efforts to break down professional barriers to teamwork and encourage work practice reform should go hand in hand with big picture funding and structural changes at a state and federal level to remove disincentives to optimal care.

We appreciate the opportunity to present our views to the hearings.

Yours sincerely

Michael Delahunty
Chief Executive, Echuca Regional Health
On behalf of the Central Loddon Mallee Medical Workforce Group