

RDAV Rural Emergency Services Position Paper 2009

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12.8.09

Toll from the 2009 Victorian Bush Fires was a sobering reminder of the hazards of rural existence. Rural rates of accident, suicide and many acute illness are all higher than metropolitan and place a continuing and high impost on the rural community. Rural hospitals and General practices are designed to be and are an essential part of response to accident and acute illness. They depend on the training, experience and motivation of their medical, nursing and ancillary staff.

However, there is concern in the community and representative organisations that rural emergency services are attenuating. This has been expressed in the 2006 VFF, CWA and RDAV consensus statement (#) 'Good Health for Rural Communities' and in the 2008 VHA Rural Emergency position statement (#). Major service cutback over many years is continuing and it takes a major crisis, such as Wonthaggi in 2008, for any significant steps to be taken to reverse the trend.

There are distinct signs that politically, the State would be content with a system that relies mainly on transport to larger centres no matter how long that takes, and to accommodate the unlucky who suffer from lack of early 'golden hour' management. It is generally accepted that definitive management of serious acute conditions should start well within this hour. Much management does not lie within the compass of ambulance officers, especially given the fewness of rural 'MICAs'. Moreover, over-reliance on transport results in much unnecessary transport. The less well-off especially are disadvantaged.

This paper sets out arguments for retaining a proper outlying network of small, medium and large hospitals, augmented by bush nursing centres, for definitive training and remuneration of doctors, for a radical look at nursing and midwife supply, and for development of an ambulance service that is much better integrated with, and more contributory to, local services.

The matter is complex and is presented in detail and in the historical context. Victoria is lagging behind other States and needs to improve its planning and implementation strategies. Loss of obstetrics is part of the same process and is detrimental to other services, as it leads to loss of anaesthetics, and theatre facilities.

Australia has for so long been well served by the medical profession that the safety umbrella of emergency medical care tends to be assumed as a given. Purists insist that preventive medicine is more important and it tends to be forgotten that readily available acute and emergency care is an essential structural element of modern society. Without it, the operation of viable community becomes prejudiced.

A handwritten signature in black ink that reads "Mike Maynard".

RDAV President

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Executive Summary

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1. To those without training and experience, Emergency Services bring to mind a few commonly known conditions. In fact, serious disease presentations are infinitely varied, complex and often obscure. As examples, conditions include a plethora of cardio-respiratory, orthopaedic, psychiatric, palliative, geriatric, intercurrent illness, and obstetric complications. Casualty work cannot be summarised by quoting a few simple presentations.
2. There is steady major loss of rural health services and personnel, with growing emphasis on private car and ambulance transport to obtain care. The workforce is under extreme strain.
3. The rural sector is progressively being stripped of urgent medical capability. The process has not been thought through. A line needs to be drawn and re-organisation effected behind it. Unnecessary deaths and disasters are occurring, which require high level commonsense and direction to curtail as far as is humanly possible.
4. Rural combined primary and secondary care cuts across both Commonwealth-funded community and State-funded hospital practice. Simultaneous consideration of both sectors is necessary for balanced and successful planning. Currently the two funding sectors plan and execute in isolation from each other.
5. Victorian rural GPs provide large amounts of acute care from their surgeries, quite comparable to rural hospital AED. The RDAV agrees with VHA that this is unrecognized and unassisted, and includes locations with massive tourist influx and locations without hospitals.

6. Both the Victorian State and the Commonwealth have been avoiding full responsibility for rural acute care in Hospitals without State-funded Emergency Departments. The State-Commonwealth Health Care Agreement needs evolution towards better delineation of responsibilities and clearer aims for appropriate rural services.
7. Much greater attention needs paying to function, inter-relation, and balance of institutional, community (especially GP) and ambulance sectors at the strategic, operational and tactical levels, especially at the first of these.
8. Decisions need to be made in which strategically placed towns are to be targeted for continuation of procedural services, full roster casualty, operating theatre facilities, and obstetrics, so that the necessary workforce can be planned both within the medical community and the administrative process. Political processes need to be set in train to obtain community agreement.
9. The role of small town hospitals in providing acute services needs examination, elucidating and setting into context of the future workforce.
 - a. Will they continue to be an isolated training setting for doctors recruited overseas, or a place for trained Australian graduates?
 - b. Does the network need further scaling back in favour of better resourced medium-sized centres?
10. Towns that have lost hospital beds and resident doctors require efficient Bush Nursing centres providing acute care, preventive health and case assistance, with the excellent training and protocols enjoyed by VAHEC locations extended to other existing and new centres as they occur.
11. The newly formed combined metropolitan and rural 'Ambulance Victoria' needs encouragement and/or direction to progress integration of rural ambulance units with hospital and community services in the form of better communication, team framework and co-location. Emphasis needs to shift from response and transfer times to clinical effectiveness. The local recruitment program must continue.
12. Rural workforce shortages and widespread population create logistical challenges meriting different standards from the metropolitan zone and penumbra. The last 15 years has seen a major push to impose metropolitan standards on the rural sector, often with procrustean results. DHS working groups invariably have majority representation from the non-rural sector.
13. The desperate shortage of nurses and appropriately trained doctors calls for new approaches for rural hospital operation free of unworkable and unnecessary constraints, and a much more affirmative approach.
 - a. The rural Procedural GP workforce, which is the backbone of emergency care, especially the anesthetists, is steadily phasing out because of ageing and non-replacement. Overseas recruitment will not replace this workforce.
 - b. The experienced nursing workforce is in the same situation, and a wide range of initiatives is required to redevelop rural nursing cadres.
14. Remodeling of the medical workforce through training of recognized Rural Generalists along Queensland lines is strongly advocated.
 - a. Rural medicine as a Specialty was endorsed by COAG in 2006.
 - b. The FACRRM is endorsed in Queensland for rural generalist work.

- c. Significant changes to the FARGP (RACGP) are awaited to accommodate needs for combined community and hospital practice.
 - d. Significant entry of Australian graduates to State rural medical workforces is not expected unless suitable industrial packages are in place.
 - e. To validate the workforce as an entity negotiation should occur with the RDAV, (in partnership with ACRRM) as its evolved representative.
15. Systematic inclusion of the rural medical workforce itself in processes of planning, education recruitment and retention is essential for a strong academically sound and effective workforce.
 16. The term 'rural' is a relative term and is no longer used in ABS classification. Victoria is divided into metropolitan, inner and outer regional, and some very small remote areas. Outer Regional Victoria is functionally rural. The Inner Regional area was expanded on 1.7.09 to include the whole middle 2/3 of Victoria, with the substitution of the RRMA system by AGC. This will have far reaching implications for the rural medical workforce in terms of Federal subsidy particularly because fringe metropolitan zones now receive the same incentives as for inner regional. *Many locations in the rezoned area are functionally rural* and depend on GPs for combined community and hospital work. Federal grants supporting rural hospital work have been only a recent innovation and will likely be lost in due course for much of rural Victoria.
 17. Rural Casualty work cannot be simplistically summarized as 'stabilisation and transfer'. Transfer should occur in only a minority of cases. Equity of health provision demands sophisticated algorithms and a well-trained workforce.
 18. Telemedicine is for management of serious complex cases only. It is extremely time and cost intensive, and has only marginal advantage over telephone advice to the well trained doctor. Calls for implementation also ignore workforce implications at the advising end and the sheer scale of rural casualty.
 19. The Health workforce needs recalibrating so that Rural Doctors, Nurses and Ambulance Officers can all perform their proper functions in effective team collaboration.
 20. A dedicated office of rural health is suggested in DHSV with an overview of all rural health processes. Genuinely rural-affirmative policies have to be inserted and embedded into Departmental processes.
 21. Rural health requires depoliticising and reorganizing on a distributive, equal and humanitarian basis.

Specific Recommendations

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1. **Direction.** The State of Victoria needs to stop and reconsider it's direction with rural hospitals. Inaction is resulting in attrition. If an effective rural hospital network is desired then a substantial amount of attention, decision making and ongoing administration is required. (The Federal Government has not indicated any intention to become involved in the immediate future.)

2. **Formal recognition of the combined community and hospital role of GPs.** More definitive interaction with the Commonwealth is required in the management of such a sector.
3. **Recognition of the rural generalist category** is recommended as an option to save attrition of procedural and emergency GPs (on the Queensland model). NB This would also have benefit for the operation of Emergency Departments of State Tertiary hospitals.
4. **A State industrial package for Victorian rural VMOs** is recommended to prevent total loss of the core rural generalist workforce and its replacement by mostly short term overseas trained doctors. (On the lines of NSW, Queensland, and to a lesser extent SA). The RDAV, authorized by the ACCC has such a package fully developed and is encouraging members to use it in negotiations. The aim is openness, clarity as career path, and removal of disparity between locations.
5. **A State-based pathway for rural generalists**, connecting students, registrars and practicing rural doctors, on the lines of Queensland, should be considered as a long term strategy. Victorian rural doctors have been intimately involved in the evolution of this pathway through the ACRRM
6. **The overseas doctor recruitment program** should be better formulated to generate long-stay appropriately trained doctors. This is currently a Federal activity.
7. **Regional Registrar Training Consortia** would be better powered to produce doctors properly orientated to the combined community and hospital sector. In Queensland one has been contracted by DHSQ to train rural generalists and this would have application in Victoria. An affirmative process within the training program is envisaged, much more pronounced than the present simple availability of rural and non-rural streams. This after all was the original stimulus for the creation of the consortia. Potential re-organisation of the consortia, as indicated by the present Federal Administration must take cognizance of this requirement and the State would have to make an approach on this matter.
8. **Recruitment through the relevant Government Agency**, at present the Rural Workforce Agency of Victoria, be reconfigured and separated from regional and fringe metropolitan recruitment to reflect workforce needs of the combined community and hospital sector (including isolated towns without hospitals). Potential reorganization of this agency is noted under the present Federal administration and the State would have to interest itself in the process.
9. **Any reorganization of rural Divisions of General Practice**, as recently indicated by the present Federal Administration, affirmatively include support for the combined community and hospital sector (including isolated towns without hospitals), and the State would have to interest itself in the process.
10. **Parallel affirmative processes to ensure adequate rural nursing and midwifery be instituted.** This includes affirmative pay structures, education for generalist midwives, and free training modules in triage and accident and emergency nursing. (It is recognized that some of the elements for this already exist in rudimentary form.)

11. **The VHIA and the VHA**, in the best interests of their sector, affirmatively support establishment and recognition of the rural (medical) generalist category, together with relevant training processes and a State industrial package.
12. **That parts of the State requiring consolidated primary and secondary health workforce** be regarded as an individual sector, separate from regional areas with tertiary hospitals and community only general practice, which requires a separate workforce policy with which this paper is not concerned.

Section 1. Introduction

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1. Victoria has rural areas of population density high by Australian standards. Medical isolation becomes significant as transport time from place of emergency inception approaches 1 hour.
2. Studies regularly demonstrate that much of this population lives in poverty (#), (#) which is probably increasing because of drought conditions.
3. Operationally, emergency medical management requires a safety net of local services appropriate to the size of population. In 2009 this means
 - a. properly distributed, resourced and flexible ambulance services,
 - b. at the periphery Bush nursing clinics, preferably with visiting doctor services,
 - c. a network of smaller hospitals,
 - d. and medium or large size hospitals with on-site roster of doctors which includes anaesthetists, obstetricians and necessary nursing teams as well as other doctors with emergency skills.
 - e. *Note:* In 1982 there was a state-wide system of fully resourced public and private small hospitals 90 or so of which have since lost major facilities.
4. Strategically, this leads to a requirement for
 - a. careful balancing of ambulance, nursing and medical capability across the state, ensuring equilibrium of community and hospital services,
 - b. developing much greater Commonwealth and State joint planning and input, (given their essentially separate input at this time),
 - c. well-judged measurement and distribution of resources to produce an even spread (endeavoring to redress loss of parity with metropolitan).
5. Whilst some would regard such an approach as utopian, it should be compared to the present situation of necessity to fight for political attention to retain individual services, and the lack of structured State or Federal responsibility for providing rural hospital services.
6. Whenever concern is expressed about loss of emergency services, administrations point to increases in community services. This raises concern that there might no longer be a proper understanding of the two sectors, and a belief that ambulance service = emergency service.
7. The wide extent of fiduciary medical expertise means that maintenance of skills in both urgent and preventive medicine can only be obtained by individuals of exceptional talent, who must be selected on the basis of educational attainment,

trained for the purpose, and properly supported for the period of their working life.

8. Obstetrics is frequently mentioned by us together with urgent and emergency services because these capabilities by and large run together. Loss of obstetrics generally means loss of GP anaesthetists with emergency skills and with them serious loss of local emergency capacity. Childbirth is an acute medical condition however much this is glossed over.
9. This paper looks first at the broad sweep of institutional based services, then progresses to examine the individual sectors of GP services, informal small hospital casualty, funded emergency departments, bush nursing centres and ambulance services.
10. It then examines what in fact comprises urgent medicine, where the doctor fits, what the rural medical workforce comprises, why Australian-trained doctors are not entering the rural workforce, why the State needs to sponsor and nurture this workforce, and how it should do it.
11. If it wishes to preserve services the State will have to be much more proactive. From its reactions to recent Inquiries, it is also quite obvious that the Commonwealth currently has no interest in the matter These Inquiries barely acknowledge the rural combined community and hospital sector and offer no suggestions for safeguarding it, and introduce the very worrying concept that populations up to 12,000 only require primary health centres, not hospitals (no reference to isolation). (NHHRC final report [\(#\)](#), NPHCS discussion paper 20.11.08 [\(#\)](#), Maternity Services Review 25.5.09 [\(#\)](#).

Section 2. Rural Sector Overview by functional region:

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1. General – [2.](#) East Gippsland – [3.](#) Central Gippsland – [4.](#) South Gippsland – [5.](#) Metropolitan Penumbra – [6.](#) North East – [7.](#) North – [8.](#) Central – [9.](#) West – [10.](#) South West – [11.](#) Mallee and North west – [12.](#) Major rural Hospitals

1. General. This section covers all rural areas in the State. State-funded rural hospitals bring services closer to the people. They combine with local HIC funded General Practice and sundry State and Commonwealth funded ancillary medical services to provide acute care, chronic care, elective surgery, midwifery, psychiatry, renal dialysis, palliative care, drug and alcohol abuse care and so on. The State remedies the inequities of rural care to an extent by keeping these hospitals open.

The rural GP provides input to all these processes and has to adapt to changes in them if not wanting to move, acquiring new skills as needed. The attachments [\(#\)](#) give lists of 32 bed closures, the loss of 22 bush nursing hospitals, the survival of 28 hospitals through overseas recruitment, the 30 hospitals sharing afterhours roster despite significant distance from each other, and the closure of 88 maternity units. Listed are also the surviving hospitals, all of which are having trouble with staff complements far in excess of metropolitan hospitals. They also by and large have progressive reduction of urgent capacity, *many not even having XRay*. Details are also given of bush nursing

centres since they are an important link in the chain of urgent care. Brief information is also given about poverty rates and their relation to closure.

The run-down to date has been quite unthinkable and far worse is to come, even if measures are taken. In the absence of social policy, towns fight towns and institutions fight institutions for resources. Formation of health services or 'hub and spoke models' creates pecking orders and expansion of the stronger at the expense of weaker. Rural health expenditure has dropped in ratio to metropolitan and is being used to subsidise hugely more extravagant approaches to health care. What falls to the lot of the average GP, not always helped by part time ancillary staff, is routinely approached by a large team in Melbourne. (#)

2. East Gippsland. Outlying areas have well established efficient bush nursing network. Mallacoota is particularly isolated: GPs there had much trouble providing emergency care, with HIC interference, but have had a smoother time since receiving a resident community ambulance officer. Orbost hospital has been kept going through adroit overseas medical recruitment by the Division of GP, with partial continuance of obstetrics. Both Mallacoota and Lakes Entrance have very large tourist flow. Bairnsdale has a slightly younger GP population as it is a popular place to live, with two very large clinics; it has not progressed its ED need for casualty officers, who could form a pool of potential future rural doctors. Sale Hospital appears to have increasing trouble because of emphasis on specialists rather than GP VMOs, and maintains a patchwork roster in Casualty. Sale has fought a successful battle against yielding services to LRH except for neonatal care. The reasons for the 2004 sacking of the Sale Board, were repudiated by an independent inquiry. GPs also provide hospital based casualty services in Maffra and Heyfield. (#)

3. Central Gippsland. Since the bitterly resented closure of Moe Hospital, Casualty Services have essentially devolved on to LRH Traralgon and Warragul. The area functions as an extended suburb with a metropolitan pattern of emergency services along the Princes Highway and it has lost some rural characteristics. Moe after-hours GP extends to 10 pm only by roster. Rural GPs supply anaesthetics to both hospitals from as far away as Foster, and specialist services tend also to be non-residential. Obstetric cover at LRH has been very weak.

4. South Gippsland does not have the critical mass for a base hospital. It is physically separated from Traralgon and transfers go in to Monash. Closure of Cowes Hospital precipitated the otherwise inevitable upgrading of Wonthaggi to GP sub-regional hospital, with GP-assisted casualty officers. Wonthaggi doctors blamed progressive burn-out to which they had been alerting the hospital for some years. Leongatha and hospitals, which share after-hours services, are at a significant distance from Wonthaggi. The closure of Foster would be a great impost on the local population, the tourist traffic in Wilson's promontory and along the coast to Yarram, which has problems with GP supply. GPs on Phillip Island have reorganised and built a large casualty-friendly surgery with ambulance access but not with 24/24 cover. (#)

5. The Metropolitan penumbra offers an interesting comparison to rural. As the arterial road network develops, so do hospitals tend to reduce services or close. Gisborne Sunbury and Kooweerup closed, Rosebud lost obstetrics, Healesville is 'under review', Kilmore, (regarded erroneously as metropolitan), remains in the firing line, Bacchus Marsh has a run down air, Kyneton is being progressively downgraded. Peripheral hospitals continue to close or cut back services. These functionally rural areas are to be distinguished from outer suburbs that are functionally metropolitan but are described and subsidised as 'rural' by federal politicians for political purposes, placing them in direct competition with areas dependent on the combined community and hospital sector for services.

6. North-East. In 2003 the Clearview report, commissioned by Hume Region, recommended closure of obstetrics and surgical services in hospitals 45 minutes or less from a subregional hospital. The plan made no examination of the mechanisms of existing services the size and needs of communities living beyond such towns, nor the effect that it would have, nor where the manpower and finances to effect the transition would be found. It was successfully resisted. Viable ski fields and mountain recreation areas require local procedural towns. The frequency of air inaccessibility is a huge problem and vastly under-estimated. Later, in 2005, obstetrics and emergency were allowed to lapse at Seymour in a most regrettably casual manner. They were reinstated through immense goodwill on the part of GPs in 2008. It is possible that the loss of services in Beechworth and Euroa can be adequately tolerated, but it is essential that Yarrawonga (much cross-border flow), Benalla, Mt Beauty, Bright, Myrtleford, Mansfield, Alexandra, and Seymour at least survive. Whether they will do so is seriously in doubt with present workforce trends. Walwa is a long way out on a limb and despite extensive publicity lost its inpatient beds. Corryong lost its 4 procedural GPs some years ago when theatre and obstetrics were peremptorily closed and since has managed as the only Victorian rural hospital employing Queensland-style HMOs with right of private practice. (#)

7. North: A number of locations, including Tatura, Murchison, Numurka (obstetrics and AH closed 2005), have been downscaled in favour of Shepparton. Nathalia and Cobram retain limited rural casualty services. Cobram has a lot of cross border flow especially from Tocumwal, and should have been maintained on the same footing as Yarrawonga, (illustrated by the recent maternal death). Kyabram has with difficulty continued full procedural services by a limited number of GPs, who have accommodated extra work from Rochester, the former hospital towns of Rushworth and Tongala, and also from towns nearer to Shepparton because of their reputation for superior skill. Kyabram is running a project to up-skill casualty staff.

8. Central: Discounting Bendigo and Ballarat. It is plain that hospital capability is disappearing. Even the substantial town of Castlemaine has not performed Caesarean section for many years. Creswick and Gisborne lost capability some years back. Daylesford obstetrics has just closed, and loss of anaesthetic skills will reduce emergency capability. Unless Kyneton rebuilds, procedural GP numbers it will also cease to be a useful emergency centre. Departmental reticence about Kilmore reveals

miscalculation in what is a population growth area with over 200 maternity cases, where only a few dedicated Gs have maintained services. It is far better to preserve and support teams than at a later date to reopen after closure with huge expenditure to obtain necessary team capacity. Centres that have lost beds include Lancefield, Heathcote, Maldon and Dunolly.

9. West: All capability is progressively devolving on Horsham, with some on Ballarat. A vast area centred on Nhill, all the way to Murray Bridge, now has little capability. Extensive corporate involvement in the area has not improved after hours and hospital services. In the centre, Stawell and Ararat are increasingly sharing on-call and manpower resources, with neither adequately positioned to serve the whole area. The situation of Marybrough is tenuous and it would be a problem for residents to have to travel to Ballarat for urgent medicine. Outlying towns such as Murtoa, Rupanyip, Willaura, Minyip, Skipton and Beaufort need further conversion to Bush Nurse centres as GP services decline and move further towards visiting status. (#)

10. South-West: There is a real danger that emergency services will devolve onto just Geelong, Warrnambool and Hamilton before very long. Of the coastal towns, Lorne and Apollo Bay are poorly resourced, Port Fairy is close enough to Warrnambool. There are serious concerns about services at Portland, which should have procedural GP services at the same level as Swan Hill, Wonthaggi, Echuca and Bairnsdale etc. Centres such as Winchelsea, Birregurra, Beeac, Lismore, Mortlake, Koit, MacCarthur, and Peshurst have downgraded to Bush Nursing and/or visiting GP. Services from Terang, Timboon and Cobden are in the process of devolving onto Camperdown and it is essential that ongoing support is provided to this centre and its GPs if capability is to be preserved in the long run. Colac has shown signs of fragility for some time. It is a prime example of a centre lacking younger age renewal of procedural GPs. Obstetrics was forcefully removed from Coleraine and remaining GPs in this centre working in tandem with Casterton, have with some self-sacrifice preserved an emergency roster.

11. Mallee and North-West.

South-central Mallee has a collection of small towns with a total population of 12,000+ that are poorly provided. Formerly all having obstetrics, operating theatres and an operant network of procedural GPs, none now have these, except for a handful of informal safe obstetrics in St Arnaud; patients have to travel up to 70 Km for after-hours care depending on which hospital is on call. There is no X-Ray except for in-hours at St Arnaud, the most southerly town. There are ambulance services at St Arnaud, Charlton and Sea Lake only. Birchip, Wycheproof and Boort depend on Charlton. The opportunity to centralise services in Charlton has probably been lost, but as a Bush Nursing Hospital it never had favour. Expectant mothers in this area have had a particularly tough time, with many deliveries en route. Sea Lake was down to one resident Division 1 nurse in 2008.

Swan Hill is a busy sub-regional centre which has been lucky with a large, procedurally oriented, medical group which has thus far succeeded with succession. However the supply of obstetricians and anaesthetists remains tenuous and the unthinkable scenario of loss of resident procedural services remains on the agenda

because of quick burnout if any of the current cadre are lost, which appears a possibility in 2010. Kerang is sustained at a high procedural level by the efforts of a medical couple who have visited India to recruit doctors. During the rail disaster, four waiting fully and portably equipped GP anaesthetists, accustomed to attending emergencies with the local ambulance, a fully prepared hospital, a warmed up theatre, and a visiting very experienced general surgeon, were fully bypassed contrary to State Trauma Guidelines. In the north, Manangatang (Swan Hill 99 Km) and Ouyen, (at one end of a wide expanse of Mallee, Mildura 103 Km), have one doctor each, Robinvale two (Mildura 85 Km). 100 maternity cases are ambulated to Mildura annually from Robinvale. Balranald NSW (Mildura 158 Km) is functionally in this area.

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12. Major Rural hospitals less dependent on GP Visiting Medical Officers.

In 1994 all Inner Regional towns were using GPs extensively in their hospitals. A then expanding rural Australian trained specialist workforce allowed larger centres like Mildura, Bendigo, Ballarat, Shepparton and Wangaratta to dispense with these GPs. It created ill-will, and the doctors were obliged to pursue full time general practice. Well over 100 GP obstetricians were dispensed with in this manner (Pieter Mourik private communication), most recently 2007 in Warrnambool, (total cost >\$10m training in present day terms). Although seemingly isolated this process has had a deleterious effect on the viability of rural medical workforce function.

The short-sightedness of the exercise has now been demonstrated by Tertiary hospitals increasingly needing to fill their obstetric rosters through overseas recruitment. South Africa has an active training program for GP Proceduralists, and many smaller regional procedural centres (both regional and district) have only been able to keep going with GP recruits from there, Horsham and Hamilton being notable examples. These hospitals also continue to rely on GPs to help fill their casualty rosters, and a number have recruited rural GPs to head their EDs at one time or other, emphasising that rural GPs are equal to this task. Larger hospitals, instead of looking for combined specialist and generalist teams, are opting to recruit overseas specialists. Queensland has decided to meet the problem and has started a training stream of specialty generalists with anaesthetic, obstetric, surgical, medical and emergency subspecialist skills, trained through the Fellowship of the Australian College of Rural and Remote Medicine (FACRRM), who will staff regional hospitals.

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Section 3.

Service sectors providing accessible rural sector urgent and emergency care

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A. General Practice: [1.](#) Emergency Cases – [2.](#) Acute conditions – [3.](#) Fee-for-service – [4.](#) GP infrastructure investment – [5.](#) Checks and balances – [6.](#) Towns without hospitals – [7.](#) Hospital towns – [8.](#) Superclinics – [9.](#) HMOs – [10.](#) GP VMOs – [11.](#) Practice Co-location – [12.](#) Rural Medicine – [13.](#) State Awards.

B. Informal Casualty in rural hospitals without State-funded EDs. [1.](#)

Underlying processes – casualty non-recognition – lobby for small hospital closure – attempts paediatric closure – importance of practice – GP time available – [2.](#) **Commonwealth and State**

responsibilities – Hospital Boards – State Health Care Agreements – COAG 19 (2) exemption
3. Small Hospital Casualty – 1. Private patients – 2. Experience and Training – 3. HIC rebates – 4. On-call incentive – 5. After-hours – 6. Hospital Costs – 7. Models – 8. Triage – 9. Nurse role development – 10. Nurse availability

C. Rural and Regional State-funded Emergency Departments (ED) – 1. State Obligations – 2. larger regional – 3. middle-sized hospital – 4. Nurse practitioners – 5. GEM medical training

D. Bush Nursing Clinics. Centres –VAHEC – non-VAHEC – Locations and Poverty – Medical Input

E. Rural Ambulance Services – 1. Amalgamation – 2. Transport – 3. Clinical outcomes – 4. Golden hour - 5. Integration – 5.1 Communication – 5.2 Co-location – 5.3 Team Interaction – 6. Team operation – 7. Obstetrics – 8. Recruitment

3.A General Practice: 1. Emergency Cases – 2. Acute conditions – 3. Fee-for-service – 4. GP infrastructure investment – 5. Checks and balances – 6. Towns without hospitals – 7. Hospital towns – 8. Superclinics – 9. HMOs – 10. GP VMOs – 11. Practice Co-location – 12. Rural Medicine – 13. State Awards. (#)

The contribution of rural community General Practices, and approximately 550 Victorian GPs to emergency medicine, is consistently underestimated and understated in debates at State Level about rural health services. In terms of urgent and emergency medicine, rural GPs deal with an astonishing breadth of medical conditions, many of them from their own surgeries. At the same time they work closely with all ancillary medical and specialist sectors in the promotion of health and management of chronic illness.

3.A.1. Emergency cases are not uncommonly seen in surgeries, and stabilized while awaiting ambulance transfer.

- a. The RDAV 2002 Emergency study (#) found 65% of GPs reported having managed life-threatening conditions presenting in their surgery, 22% having administered treatment for life-threatening conditions, and a higher presentation of acute psychiatric conditions (83% of respondents) than the hospital (76%).
- b. GPs continue to complain about lack of payment for what can be prolonged periods of stabilization and observation in their surgery.
- c. Until there is an ambulance the patient cannot be transferred to the local hospital or away as appropriate.
- d. Some complain of what appear to be unnecessary delays in ambulance attendance once it is known the patient is stable and under observation.
- e. All surgeries tend to have life support equipment including defibrillators, oxygen, intubation and intravenous.
- f. All this particularly applies to ski-fields, tourist towns, and other GP towns without hospitals.

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3.A.2. Less major acute conditions. The size and service level of the contribution of the General Practice sector to lower triage level acute care is generally underestimated and almost certainly well exceeds that of hospitals.

- a. GP provides substantial amounts of early urgent and preemptive care often combined with vital and ever improving preventive care during working hours.
- b. Rural per-person GP attendances average about 5 per annum. It is common for opportunistic preventive and chronic disease management to occur during attendances for lower triage categories of acute illness.
- c. Full time rural GPs have variably 6-10,000 total HIC rebatable patient contacts per year within their practice, extended care units and in the home to which is added their hospital work.
- d. We estimate up to 25% of practice contacts contain triage categories 4 and 5 presentations, which also form around 80% of reported rural ED presentations.
- e. Preservation of full time practice in rural and outer regional areas is therefore vital to prevent overload of transport services but retraction of this sector is occurring.
- f. The longer a GP stays and the more appropriate his initial education, the better the diagnosis and management and the lower the impost on transport.
- g. A lack of GP services is known to increase ED attendances. In a 4 year period at Caboolture 1999-2003, bulk-billing declined from 80% to 50% and ED attendances rose by 49% overall, 174% for non-urgent presentations (P Beattie Premier letter to Senate Select Committee on Medicare 22.12.03) (#).

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3.A.3. Fee-for-service GP represents an extremely cost effective mechanism of providing patient care. Throughput is much higher than for salaried practice. Whereas Government would like to devolve health care away from private GP, there are major cost imposts on publicly funded team care, including much less patient through-put, and increased sickness and Workcover costs in the salaried sector.

3.A.4 In larger towns the total State **infrastructure** commitment by Victorian rural GP might exceed \$100m in present day terms.

- a. This represents savvy recycling of government expenditure in health processes, freeing up public funds for other purposes, with protection of the asset by the working GP.
- b. Investment by GPs is only likely to occur where there is reasonable outlook for on-sale of practice facilities, ie in medium (area population 6,000+) or larger sized towns, either to other medical practice entities or to commercial interests.
- c. Smaller communities are now resigned to providing infrastructure and it can be noted that resident doctors are increasingly not found where hospital beds have been closed, except in Gippsland for lifestyle reasons.
- d. The whole question of financing rural GP was addressed in the 2003 RDAA viable models of rural and remote practice (#), in which the higher costs of such practice and the necessity for concomitant HIC rebates was subject to academic scrutiny in a carefully designed study. (#)

3.A.5. Checks and Balances. Apart from the terms of HIC GP Vocational Recognition, there are a wide variety of inducements, checks, balances, compulsory CPD and accreditation processes designed to keep GPs up-skilled and in the proactive rather than reactive zone of practice.

- a. Australian medical training is more geared to these requirements than that obtained overseas.
- b. The compulsory triennial CPD cycle is operated through the RACGP and the ACRRM. Practices have a rigorous triennial accreditation process.
- c. GPs organize a wide range of CPD through their Divisions, local hospitals, with visiting specialists, on their own initiative, through various programs, and have their own specialist College affiliations.
- d. They attend a number of high intensity emergency courses with extensive pre-reading such as the EMST, ELS, APLS, and ALSO. The REST course was designed by rural doctors with Federal funding and is currently auspiced by RWAV using Victorian rural doctors.
- e. Because of core (long-stay experienced) workforce shrinkage, the number of long-stay rural doctors available for fiduciary processes is palpably reducing, including RWAV, Division and Regional Training Program Boards, Divisional processes, Credentialing, Privileging, hospital committee liaison, mentoring, practice accreditation, political representation, examination processes, departmental liaison and participation in planning exercises. These rather than attendance at usually well-financed conferences are the meat of workforce business.

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3.A.6. In towns without hospitals it is GPs that are providing casualty services, together with infrastructure, equipment and supplies, not the State.

- a. Ski-field and tourist towns are entirely dependent on GPs for their often very substantial health needs. (Falls Creek, Mt Hotham, Mt Buffalo, Mt Buller, BawBaw, Mallacoota, Lakes Entrance, Phillip Island, Gisborne, Woodend and Yarrowonga.)
- b. VHA are concerned about lack of Government support but Victoria and other States have persistently avoided involvement with the tourist sector.
- c. Problems with the tourist sector, mainly on the Victorian and NSW coastline, have surfaced regularly in the medical and popular press since the 1980s. Hard-worked GPs have burnt out, have received poor understanding from Medicare, and have suffered from a generally metropolitan public expecting free care, refusing to pay reasonable private fees.
- d. RDAV representations in the mid 1990s to the Kennett administration for Phillip Island for effective support with Government funding did not find favour, one of the factors leading to the eventual closure of the hospital. PIMG now has its own purpose built centre. Huge pressure was placed on Wonthaggi by the closure.
- e. RDAV support for Mallacoota eventuated in MICA ambulance provision.
- f. Other towns like Woodend and Gisborne provide substantial services. Yarrowonga copes with substantial NSW influx.
- g. Speculative corporate interference at Mt Buller in 2007 caused major damage to the medical service both there and in Mansfield, ending a long term commitment by the Mansfield medical group going back to the 1950s, which now supplies services on a contract basis only.
- h. A 1996 study (#) demonstrated the commitment of and difficulties faced by GPs in these towns.

3.A.7 Hospital towns. Rural General Practices supporting hospitals with theatre and obstetric services have a great onus to maintain a balance of procedural and non-procedural GPs. Australian entry to the workforce has been negligible since the early 1990s. Overseas Recruitment, which has kept these hospitals going, has plunged to a very low level because of 1.7.08 new restrictions placed by the AMC and Medical Boards. Assessment has become very slow, with months taken for preliminary assessment of qualifications.

- a. The current workforce is divided into
 - a. a long stay older experienced group providing procedural services, advanced emergency care, infrastructure and recruitment, and
 - b. a short stay younger overseas-derived non-procedural group who tend to move to the metropolitan penumbra (still area of need) in Victoria or other States once they have full registration.
- b. Australian medical training is more geared to rural requirements than that obtained overseas.
- c. All efforts by RDAA to have absolute priority given to rural have failed, with fringe metropolitan getting equal status in Medicare + prior to the 2001 national election, further reinforced in the 2009 Federal budget, consequently attracting many rurally trained and experienced doctors from rural.
- d. The ineffectiveness of laissez-faire management of rural medical workforce is increasingly recognized by States. Western Australia has long had a policy of short-term recruitment to rural which has had major deleterious effect on rural hospital function. Links to WA (<#>), SA (<#>), NSW (<#>) and Queensland (<#>) programs are provided in the references.

3.A.8. The superclinic debate, on which the VHA has made comment (<#>), has unmasked substantial ignorance as to the operation of GP, both in terms of distribution of proposed clinics and their function.

- a. The Wallan superclinic will be in opposition to present GPs maintaining hospital and emergency services in Kilmore.
- b. The Ballan 'superclinic' will be nothing more than a local Health Service (Population <2000).
- c. Special funding will have to be found. The Ballarat corporate megaclinic has been unable to attract Vocationally Registered doctors because of RRMA 3 level rebates.
- d. A Bendigo superclinic set up some years ago specifically to perform all the desired functions of this program, was a financial failure. The new Bendigo Tristar clinic has been located in an outer section of Bendigo currently classified at RRMA 4.
- e. Whilst the concept of community governance advocated by VHA is laudable it is unlikely to achieve the throughput necessary for community health. Even if GPs working in the clinic are included in Governance, which they are not in Victorian Hospitals, (which has been disastrous for some rural hospitals in our opinion), it is unlikely that these clinics will function in the efficient and innovative manner of group GP.
- f. The fears of the VHA (<#>), concerning a concentration within superclinics on minor acute conditions to the exclusion of health promotion are quite correct

because of shareholder driven emphasis on turnover. Corporates also do not contribute significantly to self-regulation of medical professional processes through involvement of their doctors in the activities of professional bodies.

3.A.9. HMOs. Queensland has a widespread model of **resident Hospital Medical Officers** with rights of private general practice. The problem with this model is it's inability to provide safe working hours because a. the hospital predominates in determining working conditions and b. the State is not prepared to employ necessary numbers in small hospitals. EEC maximum working hours for hospital doctors are now a non-negotiable 49 hours per week and hours beyond this are denied medical indemnity.

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- a. **3.A.10. GP VMOs.** The future best model in rural Victoria is that of the Private GP Medical Group providing **visiting medical services** to the local hospital. These groups have 50 years development of multi-skilled team maintenance capable of supplying the mix of community and hospital work This provides the critical mass of work necessary to employ sufficient numbers of doctors to provide the minimum 1 in 4 on-call period for safe hours, leisure, and necessary travel.
- b. They have built their own 'superclinics' in many locations.
- c. GPs perform best as private sector providers and, as they grow older, as owners of their own business
- d. As the small hospital networks contracts, these groups have an expanding responsibility in maintaining area services in larger towns and the surrounding areas.
- e. They need to be encouraged to expand their numbers when possible and supply visiting services to the increasing number of smaller towns without resident doctors.
- f. However recruitment is extremely difficult in most areas [\(#\)](#)
- g. Rural practices have to be financially very savvy to keep their doctor remuneration in competition with Fringe metropolitan Corporates offering \$1/2m+ inducements with no on-call requirements. Rural doctors are highly sought after.
- h. A further complication is the invasion of rural towns by bulk-billing practices not taking responsibility for on call and not providing procedural doctors, reducing the mix of community work necessary to maintain proceduralists in viable practice.
- i. **Indemnity:** The State ensures that an active program through the VMIA RGPP ensures full coverage for rural doctors in combined community and hospital practice. See attachment [\(#\)](#).
- j. In some locations administrations have quite deliberately decreased GP input by various means, seeking to replace them by Career Medical Officers (CMOs).
 - i. In one location these have operated the General Practice on the Queensland model after the GPs decided to leave town.
 - ii. In another, Hospital operation has been severely curtailed, obstetrics frequently being closed and casualty no doubt compromised at times.

- iii. The State may well have had to find extra funds for these CMOs and this can be a very expensive practice when GP proceduralists are replaced by specialists
- iv. In larger towns it is more than likely that the State views the replacement of GPs by overseas specialists as a method of introducing more specialists into the metropolitan workforce, because they invariably move on to the city once further qualifications and approvals are obtained.
- v. Many towns have been affected. Given that in Victoria there is a good supply of specialists for elective medicine, the expense is highly questionable and the GPs themselves rarely return to procedural practice, a huge waste of manpower and training not to mention the personal cost.
- k. Preventing such events is a difficult exercise given the independence of hospitals, and has been made much more difficult with lack of medical representation on Boards. It is another example of the lack of mechanisms for effective planning and execution of desired service in an age devoted to 'free market' mechanisms.
- l. All this has happened in the face of at times substantial public protest.

3.A.11. Practice Co-location of the community GP building with the hospital or at least close association on the same street is an important facet for effectiveness of visiting services. The GP also has to have a house with close access to answer emergencies. Problems inevitably arise when the GP is not living close at hand. It has been a problem when the GP wants to live further away for life-style reasons and maintain practice.

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3.A.11. Without preservation of the GP VMO model the State will be forced into centralizing acute services into a few locations with employed specialist and generalist practitioners.

- a. This would place a much greater onus on what would be a clinically under-supported bush nursing and ambulance network.
- b. Centralisation has tacit support in the DHS but cannot be voiced for political reasons. Attempts to close even small locations like Manangatang have attracted furious opposition. Such locations now have very limited services.
- c. The creation of small health services has bypassed opposition and facilitated cutback, but the lack of case-mix viability in these reduced locations has, as well as making them more expensive per patient contact to run, led to a scope of practice unattractive to the kind of enterprising would-be-Generalists now moving to Queensland.

3.A.12. Rural medicine was recognized by COAG in 2006 as a specialty, ending 15 years of opposition to the concept. The breadth and depth of rural general practice, already a specialty like all GP under Commonwealth legislation, has led to its industrial recognition as a distinct specialty in Queensland hospitals (#). If Victoria wishes to preserve its rural hospital network, it needs to catch up with this development and decide how to train, recruit, employ and keep its own Rural Generalists.

3.A.13. State-based salary packages and awards for rural GP VMOs have been emerging in other States on the lines of the 1987 NSW industrial court settlement for rural doctors. Victoria has been opposed to this. RDAV believes it to be essential for future recruitment and retention and has matched it to generalist training. The ACCC has authorised the RDAA and hence it's constituents to negotiate with the State on behalf of rural doctors.

[\(#\)](#)

3. B. Informal Casualty in rural hospitals without State-funded EDs. [1. Underlying processes](#) – casualty non-recognition – lobby for small hospital closure – attempts paediatric closure – importance of practice – GP time available – [2. Commonwealth and State responsibilities](#) – Hospital Boards – State Health Care Agreements – COAG 19 (2) exemption [3. Small Hospital Casualty](#) – [1. Private patients](#) – [2. Experience and Training](#) – [3. HIC rebates](#) – [4. On-call incentive](#) – [5. After-hours](#) – [6. Hospital Costs](#) – [7. Models](#) – [8. Triage](#) – [9. Nurse role development](#) – [10. Nurse availability](#)

[\(#\)](#)

3.B.1. Underlying processes

- a. Most Victorian rural hospitals have casualty areas which are not recognized as emergency departments.
- b. A list of relevant Victorian hospitals is appended [\(#\)](#).
- c. A very strong lobby exists for the closure of such hospitals throughout Australia. 'Consumer sentiment' is cited as the main reason. Fleets of helicopters are envisioned, transferring all acute medicine to tertiary hospitals. Describing administrators closing down small rural hospitals as 'responsible', and displaying complete ignorance of rural distances, travel times, and realities of air transport, the well-known Prof Stephen Leeder (University of Sydney), talking on SBS in 2007, likened small rural hospitals to outdated corner-shops, stating that only helicopters, as in a war, could provide golden hour response, about which we make further comment. We can hardly overstate the patent absurdity, unworkability and ineffectiveness of such opinions, which nonetheless unfortunately have had a strong propensity to contaminate bureaucratic processes, particularly in NSW.
- d. In 1992 the RDAV fought off attempts by the Government, backed by certain paediatricians, to ban paediatric admissions to all but tertiary hospitals. The same process was repeated in NSW in 1996 and 2008. It completely ignores the necessity to monitor undifferentiated and early illness, and the treatment of outlying dwellers for relatively straight-forward conditions such as pneumonia, croup, asthma, bronchiolitis and gastroenteritis. It exemplifies the poor understanding that there can be of the nature of GP and Casualty presentation of illnesses, and ignores the actual frequency of missed diagnosis even in the most illustrious of institutions such as the Royal Children's Hospital.
- e. An especially important concept is that medical and allied-medical personnel have to be actively engaged in practical medicine to be good at it. The idea, so often promulgated, that rural medicine can be operated just by means of theoretical knowledge, workshops, computer generated telemedicine and video-conferencing is simplistic, naïve, quasi-utopian, often media-generated and substantially illusory.

- f. It is not commonly appreciated how much hospitals and agencies responsible for community practice are in competition for the time of GPs. The Commonwealth has made community practice much more attractive to GPs through Extended Care item numbers, which improved practice viability but have a major onus of paper work. The State is busily establishing community programs which also require substantial GP support and time commitment, also which have to be organized within the EPC framework to be paid for.
- g. A huge onus of paperwork and communication is therefore subtracting from time available for study and professional development, and it is edging general practice towards substantially deskilled 'case management' as opposed to direct medical care. The actual benefit to patients in terms of health management is to be seriously questioned. Accountability does not necessarily = good health care, and there is a balance to be struck. Above all, Rural doctors need to be actively maintaining skills and up-to-date knowledge over a vast area of medicine. (#)

3.B.2. Commonwealth and State Responsibilities

- a. On each occasion since 2004 that RDAV has raised the matter of provision of rural casualty services in hospitals without funded EDs, with the Department or previous Minister, the answer, whether by letter or in meetings, was that 'Rural Casualty is a Commonwealth responsibility and that the State is not responsible for it.'
- b. The ambiguous status of rural casualty in Victoria is made more complex by the legal independence of Victorian hospitals
 - i. Control by the State over its hospitals extends only to appointment of the Boards and supply of budgets.
 - ii. This creates difficulties in Victoria but it has also prevented the kind of wholesale closure patterns seen in other States because Boards have been able to resist closure and cutbacks.
 - iii. The Government has used a strategy of weakening hospital boards by the removal of doctors and local business persons, using the excuse that they could potentially benefit from their position. (Schoolteachers remain on School Boards.)
 - iv. The mandate and funding of rural hospitals has been to provide inpatient services and not casualty services.
- c. State perceived obligations are derived from the 2003-8 Healthcare agreement (HCA) www.health.vic.gov.au/agreement/index.htm, which commits the State (Part 2 7a) to a 'range of services.....no less than was available on 1.7.98'.
 - i. In actual fact there have been numerous rural closures during that time, shown in lists appended (#).
 - ii. With respect to urgent care, Victoria has in effect maintained only a commitment to established funded Emergency Departments, ignoring Casualty areas of rural hospitals, even though they constitute EDs under the HCA, and to avoid the obligation (HCA P2 6c and P6 39) to treat free all patients presenting at public hospitals in 'all geographical locations'.
 - iii. NSW in contrast has respected this obligation, which gives doctors in Yarrowonga problems in dealing with week-ender patients from Corowa

expecting free treatment who refuse to pay bills. All rural casualty patients throughout NSW are treated free and since 1987 there has been a State fee schedule for attending doctors (#).

- iv. In April 2007, COAG gave approval for States to apply for an exemption from section 19 (2) of the Health Insurance act of 1972 which, on signing of written agreements between the State and Commonwealth, would allow casualty in locations serving populations of 7,000 or less to use HIC item numbers and reimburse doctors for services retaining monies which, it is stipulated, must be used for local health service purposes.
 - i. The MOU for the 19 (2) exemption expires on 30.6.10 by which time all the individual location agreements must be signed. The arrangements however are hopelessly complex and constitute a bureaucratic nightmare. There has been no known movement on the issue in Victoria. An impression is gained that the Commonwealth did not want to officially saddle itself with the responsibility. Complex arrangements have been negotiated between RDAQ and the Queensland Government.
 - ii. The agreements also require multiple signatories, including doctors themselves. Why would a doctor want to sign and give away part of his earnings to the hospital? At present in any case doctors can privately bill as they do in their rooms and the patient must pay a surcharge. Most rural doctors do this routinely because standard HIC rebates have fallen so far behind inflation.
 - iii. Additionally under the HCA (P6 40.), patients ('normally.....rural') have the right to request non-admitted services privately from their GP.
 - iv. Victoria remains in limbo. In response to an inquiry about lack of HIC arrangements for doctors responding to a serious emergency in teams of 2 or more as they would in any ED, Minister Pike replied on 27.4.07 "as you are aware, this is a Commonwealth matter". (See also 3.B.3.3 below) This position was restated in writing by DHS on 14.5.07.

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3.B.3. Role of VMOs in small rural Hospital Casualty – 1. a. Private patients – 2. b. Experience and Training – 3. c. HIC rebates – 4. d. On-call incentive – 5. e. After-hours – 6. f. Hospital Costs – 7. g. Models – 8. h. Triage – 9. i. Nurse role development – 10. j. Nurse availability

- a. **Private Patient Status.** In these hospitals, because 'casualty' is not officially part of the hospital, GPs undertake responsibility for providing Casualty services, not as VMOs but as Community Doctors seeing patients on a private basis in hospital premises, paid through Federal HIC rebates. (#)

- b. **Skill of the Doctor.** Diagnosis and treatment are dependent on the experience of the doctor. Doctors not trained for the sector take some years longer to get up to speed and any doctor finds that skills expand enormously in the first 5 years, if assiduous study is maintained, fixing many more patients and referring far fewer away.
 - a. Overseas doctors are required to study for the FRACGP, taking up to 5 years to pass it. This is a community GP exam, not designed to include hospital medicine.
 - b. The FACRRM has been adopted in Queensland. It was specifically designed by rural doctors throughout Australia for combined community and hospital medicine. (#)
- c. **HIC Rebates.** The HIC refuses to pay more than one Medicare rebate per casualty no matter how many doctors are involved or how life-threatening the emergency was. This includes treatment at a transfer destination. The primary attenders are refused any rebate at all if the transfer destination is quick to submit billing to HIC. (#)
- d. **On-call incentive.** The State provides an incentive for Doctors to make themselves available to see casualty patients (on a privately billed basis) at their local hospital. The arrangement is designated the “Rural enhancement package” and was supplied as a block grant to each involved hospital (#).
 - a. The package was proposed by the RDAV and negotiated by its President through the AMA in 1999, commencing in 2000 at \$22,000, indexed on an annual basis, reaching \$26,601, The allowance was not always made available or notified to doctors in relevant hospitals.
 - b. The package was withdrawn for the 4 group B hospitals involved, leaving on-call incentives as a matter for individual negotiation in these locations.
 - c. Following a 2006 election commitment by both major parties, the amount was increased to \$150 per week-day, \$200 per week-end day and \$250 per public holiday. Stricter conditions, including payment for registered days on call only, and week-end rates, were applied. This was accepted by the RDAV. The new rate was set at the level then received by doctors in South Australia
 - d. The package has almost certainly been effective in improving retention but needs review and indexing.
 - e. It is stressed that the package is an availability allowance and does not constitute an obligation to see every patient presenting at the hospital either immediately or later. Only proper shift payments would cover that contingency. (#)
- e. **After-hours.** Most rural GPs have had periods when they received forceful demands from hospitals at all hours, to attend immediately for outpatient attendances of all triage categories, irrespective of GP responsibilities to their community practice.

- a. Scarcity of doctors has tended to result in evolution of more reasonable attitudes.
 - b. GPs have to be, or become, quite thick-skinned to survive such periods.
 - c. The RDAV insists that measures to ensure safe working hours and to respect the status of rural generalists must be developed well in excess of present levels. 1 in 3 on-call is barely necessary.
 - d. GPs must have discretion to assess triage reports by phone and issue instructions as to temporary treatment and time for the patient to be seen.
 - e. Good team operation and a reasonable attitude by the administration has been noted to result in better cooperation and better outcomes, also the converse.
 - f. The Rural Enhancement Package (above) is designed to produce an incentive to reasonable availability and is not a payment for attendance, being far below accepted payment for hospital on call.
 - g. The carefully designed, Commonwealth funded, West Vic Telephone triage system, also operant in Central Highlands, had a well documented enormous drop in after-hours call-outs, illustrating amongst other things the pressure that GPs had been under prior (See 8. 'Triage' below). (#)
- f. **Hospital Costs.** Whilst subsidizing on-call, the State has not made specific provision for other aspects of casualty care including nursing support, equipment and consumables.
- a. To cover costs, Hospitals for decades attempted to levy, or required from GPs, fees for seeing all casualties in the hospital casualty area. This practice died but slowly and still exists in several locations.
 - b. Communities have generally raised funds to supply equipment
 - c. Health Services have had to fund casualty support from their inpatient resources.
 - d. The State is deflecting Casualty costs, ostensibly provided under the Health Care Agreement, firstly to the Commonwealth and secondly to the Public if doctors choose to charge higher rates. (#)
- g. **Rural Casualty Models.** Hospitals tend to come under pressure from Communities to 'provide a casualty service'. It is seen as a short-cut to getting medical services, bypassing the GP surgery. Sometimes hospitals give the impression that the GP is at their disposal to give this service. They are reluctant to admit the true state of affairs.
- a. Financially the Hospital benefits from only seeing genuine emergencies of higher triage level, unless they feel there is a chance of gaining ED funding.
 - b. The patient best interests are served if, for lower triage categories of acute medicine, he or she is given the benefit of the kind of combined acute and preventive medical intervention they are likely to obtain from a vocationally recognized GP in the GP surgery.

- c. Approximately 80% of all rural ED attendances are Category 4 and 5, of which a very substantial % would be classed as non-urgent if triaged by an experienced clinician and appropriately diverted to a general practice.
 - d. Rural GPs do casualty work for challenge and out of a vocational sense of duty. It is not done primarily for the money except on shift in Regional Hospitals, where the pay is reasonably handsome.
 - e. Demographic changes and cheap housing have resulted in an influx of non-rural residents, an increase in drug and alcohol use, and more irregular hours of attendance.
 - f. Much attention therefore needs to be paid to good triage and prioritization in order to conserve resources and maintain community cooperation.
 - g. This makes better sense than rural casualty departments with the same onus as EDs to see patients at any time with no charge. (#)
- h. **Triage.** Because so many people do present to hospitals hoping to get quick services, triage of patients has become a significant issue.
- a. Australian Triage scale categories of desired time to management are as follows: 1. Immediate, 2. 10 mins, 3. 30 mins, 4. 60 mins, 5. 120 mins, (6. Non-urgent).
 - b. Quite obviously the hospital has a responsibility to triage patients, to sort out those that can be deferred to the GP clinic, to treat those that need only minor assistance, and to arrange for the GP to come to the hospital either immediately or at a time warranted by the patient's condition, or at a later time. Hospitals are increasingly prepared to perform this function.
 - c. When and whether the GP answers a call is based on clinical information received from the triaging nurse so that it is important that the nurse has the ability to assemble necessary information before ringing the doctor so that he or she can make an informed judgment. By and large this is similar information to that assembled when expressing concerns about inpatients and debating whether a visit to the ward is necessary. However, indemnity-conscious hospitals attempt to transfer liability and risk to doctors by insisting on attendance.
 - d. A development in the last few years has been an insistence that because nurses do not have a licence 'to prescribe', then they should not make decisions to give medicines of any variety nor take telephone directions from a doctor to do so. Hospitals started refusing to accept phone orders from GPs in the outpatient setting, even when the GP was on call from another hospital, and even in a simple matter like prescribing aspirin for a headache. It became necessary for the Department to conduct a study and to look at necessary legislative changes to allow this to happen. Questions arose as to whether this would be a matter of prescribing, dispensing or supplying. At the time of writing the further status of this situation has not been ascertained, as changes to the legislation are required.
 - e. Very effective telephone triage systems, staffed by Div 1 Nurses, are operating in the West Vic (#) and Central Highlands Division, based on an

American Model, (Briggs J K Telephone triage protocols for Nurses pub. Lippincourt), financed by the Commonwealth. These have cut call-outs by 60% and 'made life tolerable', as many have put it, even as others have said, to keep them from retiring as yet. Delivery of the service was found to be favorable in a study by De Witt et al in one location (#).

- f. The currently operating State telephone triage system is believed to increase casualty attendance, and hence call-outs, because it has not been specifically designed to avoid unnecessary call-outs. (#)

i. Developing the role of nurses.

- a. A logical way of improving the situation would be to introduce education across the board for nurses working in rural hospitals, to improve their triage skills and to create team-work between GPs and hospital nurses.
- b. Hospitals have rosters. Nurses in small hospitals generally have ward duties in addition to other activities like casualty. The bulk of ward work is accomplished by staff on the morning shift, leaving some capacity for casualty in the after hour period. The importance of all nurses on the roster to acquire triage capability does not seem to have been appreciated.
 - i. Many nurses already have a variety of skills which can be utilized and also give a better sense of fulfillment.
 - ii. Whilst Departmental thinking has been in the direction of **Nurse Practitioners**, there is considerable doubt about the desire of the majority of nurses to achieve independent NP status.
 - iii. An example is the large number of USA NPs who have opted to transfer into **Physician Assistant** training schemes. Despite opposition in Australia this category is by far the most sensible approach to shortages of rural doctors and has become a major category in the US, attracting also army and civilian paramedics.
 - iv. We suspect most nurses would prefer to practice on the basis of their education, which includes a considerable quantity of diluted medical training, with knowledge of basic medical science and medical conditions admirably suited for developing casualty skills on the job.
- c. The DHS has funded a few projects in rural casualties which have focused on individual nurses rather than across-the board education. These include Nurse practitioners in Kyabram and Seymour, the former through the 'Better Skills Best Care' program. <http://www.health.vic.gov.au/workforce/skills.htm>. Nothing further has been done to our knowledge. This is consistent with the State's position that it does not hold responsibility for rural AE. (#)

j. Availability of nursing staff.

- a. The crisis with nursing staff is possibly approaching that of doctors. One small hospital was down to one Div 1 nurse recently, so that agencies are

- in use extensively and all means are used to find staff, including scholarship training programs.
- b. Obviously midwives are the most affected and rosters are extremely tight in many hospitals.
 - c. This has the potential to render much of what we are saying here obsolete.
 - d. The age distribution of experienced staff is much the same as rural GPs. The younger ones tend to move on. Fewer are marrying into the community because of the closure of the rural schools..
 - e. We have just started to see the results of an overseas recruitment process through the Area of Need regional sponsored migration scheme.
 - i. Many of the new faces have families back home that they will be able to bring here after achieving and completing their 3rd year of training and obtaining registration.
 - ii. It costs them about \$20,000 all told, including employment consultant fees, a substantial amount for less developed country residents.
 - iii. There are some indications that they prefer larger locations and seek to move to them after arrival. Hopefully they will at least merge into some of the larger regional communities and stay long enough to take on greater responsibilities.
 - f. Appropriate rural standards are as badly needed as ever. A critical look at the rural situation by the Nurses Board and the Australian Nurses Federation is in order.
 - i. Further substitution of simple and non-nursing duties is urgently required.
 - ii. Div 2 nurses need to take on Div 1 functions as well as having every facilitation to up-skilling towards Div 1.
 - iii. AINs need development and establishment as a category to free up as far as possibly Div 1 and 2s.
 - iv. The problem of outpatient nurse-initiated dispensing needs to be solved.
 - g. Long-stay nurses acquire the ability to triage and manage patients but their number is decreasing
 - h. The overall numbers of Nurses in the State has risen from 72 to 81 thousand since 1995, ¼ of them Division 2, though 75% EFT figures give a more realistic total of 54 to 61 thousand. (DHS 'Nurses in Victoria' 2004 and current Nurses Board Figures.)
 - i. What is the availability of nurses to rural? Probably much less. Nurse to patient ratio has increased, allowing much greater numbers of separations. The working week is limited to 38 hours. Melbourne has become a more attractive location **but you wonder if the diminution in rurally located nurse training schools has not been a principal factor in decline of availability.** (#)

3. C. Rural and Regional State-funded Emergency Departments (ED) – 1. State Obligations – 2. larger regional – 3. middle-sized hospital – 4. Nurse practitioners – 5. GEM medical training (#)

1. **State Obligations.** As discussed in 3.B.2 above, the State signs an obligation to provide free casualty services in funded emergency departments under the Commonwealth and State Health Care Agreement.
2. **Larger Regional Hospitals**, (classed by the State as rural and by the Commonwealth as regional), staff their EDs with a mixture of interns and casualty officers supervised by the occasional fellow of ACEM and by non-FACEMs who are often rural doctors, a number with FACRRM. The supply of FACEMs has been sufficiently scant for a number of rural doctors to be recruited to head regional EDs.
 - a. The problem with EDs is that they attract a great deal of routine GP and this GP is not administered by doctors trained in preventive health and chronic disease management. Hence social classes taking advantage of the free service tend to have chronic health needs that never get addressed.
 - b. Lack of effective management in EDs increases the number of patient contacts required to fix a problem.
 - c. Untrained and inexperienced staff provide a quality of management which often engenders patient issues requiring management attention. Proper 24-hour systems of supervision are essential. (#)
3. There are 6 **middle sized hospitals**, namely Bairnsdale, Hamilton, Horsham, Swan Hill, Echuca, and lately Wonthaggi, with funded EDs.
 - a. The streaming of rural casualty towards hospitals with funded EDs because of service closure has placed often massive impost on the reduced number of willing and able rural GPs available.
 - b. Some of these hospitals use GPs to supervise, train and assist junior casualty officers, who are generally IMGs working to obtain full Australian Registration. As many have been medically unemployed, sometimes for up to a decade, very close assistance supervision and mentoring is required for the initial years.
 - c. Once they pass their AMC examinations, some of these IMGs are able to progress into supervised rural GP or GP training.
 - d. Some of these hospitals are employing a full time senior casualty officer. Our advice is to encourage on-call GPs to exercise a major supervisory and teaching role so that assistance and mentoring is given to these on every shift, on the Swan Hill model, improving level of care. Not only does this provide better training but it maintains skill, capacity and interest in the local GP workforce. Increasingly, rural GPs are involved in teaching activities of some sort.
 - e. Good nurses are invaluable, carry a great deal of the work in the hospitals formerly done by doctors, play a strong part in team management, while

mentoring and assisting inexperienced overseas recruits. The ones that stay enjoy the challenge, responsibility and team ambience.

- i. Such nurses are required in quantity and the best way to attract and retain them is with a sympathetic and supportive working atmosphere.
- ii. Unsupportive administrations tend to lose nurses rapidly.
- iii. These points are more important practically speaking than formal career pathways.
- iv. The number of educational opportunities for casualty and hospital nurses has multiplied considerably but deserves review.
- v. In particular we see education in basic assessment and diagnosis algorithms as hugely fruitful for casualty operation. (#)

4. **Nurse Practitioners.** The College of Emergency Nursing of Australia offers dedicated training towards a nurse practitioner model of emergency nurse and no doubt there is a place for this category in large Metropolitan Hospitals and some Regional Hospitals. This is not a workforce solution for smaller rural EDs and non-ED rural hospitals especially. They are strong advocates for the New Zealand Nurse Practitioner model, which of course has to be assessed in the light of NZ No-fault Compensation legislation. There are many advanced modules for nurses working in Casualty Departments and it is our view and that of the sector in general that it is best to aim for generic rural nurses in smaller hospitals rather than nurse specialists, (including midwives with a wider hospital role at times).

(#)

5. **Queensland GEM medical training.** A State commitment to FACRRM generalist training (which includes a variety of sub-specialisations including emergency, along the lines adopted by Queensland, would seem an extremely prudent route to bolstering both the rural medical workforce and the functioning of rural and regional EDs.

- a. After examining the possibility of sponsoring the training of emergency physicians through the Australian College of Emergency Medicine (ACEM), Queensland decided, in consultation with that College, and with a promise of help from them, to train doctors for the FACRRM.
- b. **GEM** (Generalist Emergency Medicine) training will comprise 3 years' generalist experience followed by one year in emergency medicine. There will be up to 55 graduates annually.
www.health.qld.gov.au/orh/ruralgeneralist/geninfo.asp
- c. They will be employed as SMOs in the Generalist category.
- d. They will have the training to deal effectively with triage categories 1-5 and to arrange appropriate GP follow up. They will have an excellent basis for teaching junior casualty staff, for running smaller EDs, and for progressing to the FACEM, which many will undoubtedly do.
- e. GEM training will improve critical mass of the whole FACRRM rural generalist training program.
- f. The model can be expected to extend to other States providing the economic down-turn does not hit too hard.

- g. The importance of the VMO model has been covered in [3.A.10](#) above [\(#\)](#)

3.D. Bush Nursing Clinics [\(#\)](#) – Centres –VAHEC – non-VAHEC – Locations and Poverty – Medical Input [\(#\)](#) [\(#\)](#)

- a. BNCs are an essential part of preventive and acute care rural services in smaller locations. Effective training, assistance and help renders nurses able to treat many lower triage scale conditions effectively and on occasion to give potentially lifesaving treatment.
- b. A number of locations belonged to the Victorian Bush Nursing Association, which merged, after the closure of most of its many hospitals in the 1990s, with the Aged Care Association to form the Victorian Aged Health and Extended Care association, **VAHEC**. These locations have a coordinated structure, a pay scale, and proper training processes in association with ambulance training, using a curriculum developed at the Centre for Rural Health.
- c. Other BNCs as listed are part of area health services, either historically or as a result of small hospital closure.
 - a. Essentially any hospital that does not have a locally resident doctor is a Bush Nursing agency and we include them on our list.
 - b. These non-VAHEC locations tend to be poorly supported, often restricted from providing acute care, and do not have suitable training or ongoing professional development.
- d. An over-arching system is required to provide rural uniformity.
 - a. As VHA points out, poor areas have fewer facilities. Hospital closure is associated with worst Jesuit study poverty percentiles [\(#\)](#).
 - b. A number of closed locations have lost doctors [\(#\)](#).
 - c. There is no systematic policy for developing BNCs where they are needed, either de novo or to replace closed hospitals.
 - d. Training, conditions and protocols should be consistent for the sector.
- e. Medical input is highly desirable, with visiting medical services, and ongoing interaction with visiting doctors during working hours.
 - a. Email is commonly used, with photographs.
 - b. Telemedicine can be expected to come into use once broadband facilities are improved, should this occur but this is primarily for acute medical situations and is not a time effective method for supervision.
 - c. Such interaction enhances care, allows learning to proceed, and avoids common mistakes.
 - d. We advise that most nurses are much more comfortable with this model than with totally independent nurse practice
 - e. We support an advisory rather than supervisory role for visiting doctors
 - f. Patients commonly use the neighbouring practice and the availability of patient files with suitable measures for confidentiality greatly enhances care.

3.E. Rural Ambulance Services – 1. Amalgamation – 2. Transport – 3. Clinical outcomes – 4. Golden hour - 5. Integration – 5.1 Communication – 5.2 Co-location – 5.3 Team Interaction – 6. Team operation – 7. Obstetrics – 8. Recruitment. (#)

3.E.1. Amalgamation of Metropolitan and Rural Ambulance Services

- a. The rural (now combined State rural and metropolitan) ambulance service has been moving steadily towards the metropolitan model of an independent service with full responsibility for pre-hospital emergency care. Such separation of service is coming to be seen in the US and UK as counterproductive and in our view is particularly so in rural areas.
- b. Regional ambulance authorities, including all of rural Victoria except for Alexandra district, were amalgamated in 1999 following a 1997 report by the Auditor-General questioning viability, administrative arrangements and planning. In 2002 the Auditor General observed that many problems still remained. As a result of 2004 questions raised by the Public Accounts and Estimates Committee, funding was provided for computerisation of dispatch and clinical information systems, and upgrading of the mobile radio network. A suggestion to study amalgamation of RAV with MAS and the still independent Alexandra ambulance service was not progressed. In 2004 the Ambulance Services Act 1986 was amended to give the Minister and Department much greater powers over the RAV, cementing the Minister in direct authority over the RAV Board.
- c. The 2006 DHS 'Review of the governance and effectiveness of RAV' P16 [www.ssa.vic.gov.au/CA2571410025903D/WebObj/RACFinal/\\$File/RACFinal.pdf](http://www.ssa.vic.gov.au/CA2571410025903D/WebObj/RACFinal/$File/RACFinal.pdf) , made some welcome comments about the need for longer term strategic overview, recommending consideration of the 'USA EMS Agenda for the future study' which envisioned "EMS..... will be community-based health management that is integrated with the overall health care system" www.nhtsa.dot.gov/people/injury/ems/agenda/ and cited UK developments along these lines. We are aware that in the US paramedics are moving on as Primary Physician Assistants with major clinical roles. It noted a report by the Council of (Australian) Ambulance Authorities that found " conventional models of pre-hospital care would be unlikely to meet the future emergency and health demands in small rural communities in an appropriate manner." It was anticipated that demographic changes with ageing, increased chronic disease (which create many acute needs) would seriously affect response times and challenge financial viability. The review P17 also made note of the problems that RAV has had with isolation from other services and welcomed initiatives by RAV to attend hospital forums.
- d. On 1.7.08 Ambulance Victoria was created, RAV was amalgamated with MAS and the last remaining local volunteer ambulance service in Alexandra was also closed down. The budgetary announcement came pretty much out of the blue, because merger had previously been specifically rejected, but in retrospect it

can be seen that the previous administrative and legislative evolution, combined with public and press reaction to perceived problems in RAV made it an inevitability. Other States had long taken the same track.

- e. The DHS consultation paper “The future of ambulance service delivery in Victoria”, setting out the changes, which was released at the time of the 2008 budget, is not currently available. The VHA (#) made 4 points in relation to this document, to which we add comment.
 - a. *VHA supports the establishment of a state-wide ambulance service for Victoria* (Reasons for support without reservation were not given)
 - b. *VHA recommends that the Government investigates the role that Ambulance Victoria can play in delivering health services from a population health and prevention approach. This may include amending Section 15 of the Ambulance Services Act 1986.* (RDAV has reservations about this and believes that the major focus of ambulance services should remain on acute care.)
 - c. *VHA recommends that the board appointed to govern a merged ambulance service into the future comprise a minority representation from the existing three services and be chaired by a person independent of the existing three ambulance services. The processes behind these appointments should be transparent and robust and should occur in the short-term.* (This is obviously necessary and 5 of the 9 appointed in June are non-Metropolitan.)
 - d. *That the principle of co-locating ambulance stations with health services be supported and extended at a state-wide level; building on resource efficiencies already apparent.* (This would be only a first step in overcoming the gap between ambulance and other health services.)
- f. High profile cases had resulted in response times becoming a political issue. The change to the service was justified by the Premier on this ground. This has detracted from the real issue, which is timely and effective treatment. In fact the decision to amalgamate was made late in the day and probably related more to publicised problems within RAV. In particular the 2005 “Government response to recommendations contained in the 58th report of the public accounts and estimates committee on Victorian rural ambulance services” (#) indicated Government satisfaction and support for the service. It specifically rejected (recommendation 20) a feasibility study to investigate amalgamation, in particular noting “the current structure enables the ambulance services to develop models of service delivery that provide high quality ambulance services tailored to meet the particular needs of the diverse communities that they serve”.
- g. Apart from a few minor experiments, the Rural Ambulance service in Victoria has not yet begun a systematic process of integration at the local level. We can hardly not be concerned that the effect of amalgamation into the metropolitan model might defer such a process for many years if not permanently.
- h. There would be many other fears about the results of an amalgamation and the general feeling is that rural will end up as second best. In particular, career pathways in the combined service will inevitably become skewed towards metropolitan service.

- i. The public good should be paramount and the amalgamation should never have taken place, particularly as advice had been against it.

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3.E.2 Rural Ambulance Transport.

- a. The rural (now combined State rural and metropolitan) ambulance service has been moving steadily towards the metropolitan model of an independent service with full responsibility for pre-hospital emergency care. This separation of service is coming to be seen in the US and UK as counterproductive and in our view is particularly so in rural areas.
- b. **Victorian Population.** Perhaps 600,000 persons live in towns that have a significant transport time to tertiary care, but have local facilities, often of a sophisticated nature, that have significant capability to improve the prognosis of sick and injured patients through early intervention. (A figure of 1.1m - 1.4m population is generally cited for rural Victoria but this includes large population aggregations in towns with tertiary hospitals and short transfer times in which a metropolitan Ambulance model is applicable.)
- c. **Transfer times** are extremely protracted. Even one hour delivery is often not possible and combined with response and initial management, this is more like 2-3. (Johnson 1991, quoted O'Meara (#), judged ideal response time to be 4 minutes for application of basic life support, 8 minutes for Advanced LS and < 30 minutes to a fully functioning medical facility, an impossible rural ideal except where there is a town with a functioning hospital.)
- d. **Air transport** is frequently not feasible because of weather conditions.
 - a. Ski fields in particular depend heavily on local doctors because of frequent weather closures to local fixed wing landing fields but wind and cloud preclude flying in all areas of the State.
 - b. Particularly in mountains, helicopter pilots have a low threshold to refusal to fly, and there have been instances reported to us of refusal even in good weather conditions to fly to Falls Creek for major trauma. Time and again rural GPs have born the brunt of care with local AOs in these locations.
 - c. Kerang was closed by weather to air transport only one week after the 2008 Rail disaster.
 - d. Swan Hill experiences delays up to 36 hours, one case involving a neonate with bilateral pneumothorax.
 - e. Helicopters also crash from time to time and the more they are used the more crashes there will be.
 - f. Even road transfer confers a significant effect on mortality. This has been computed at a 1% absolute increase for every 10 Km travelled. (# sample distances in Victoria). *Emergency Medicine Journal* 2007;24:665-668
<http://emj.bmj.com/cgi/content/abstract/24/9/665>
 - g. Transfer algorithms need to be constructed against worst-case scenario. Farmers do not succeed by assuming best weather conditions.

(#)

3.E.3 Clinical outcomes.

Documents quoted above indicate that the main priority in administrative development of rural ambulance services has been towards cost efficiency, corporate governance and efficacy of retrieval rather than towards clinical outcome.

- a. Clinical perspective has been guided by whole State considerations of what protocols can be applied for the particular mix of volunteers, paramedics and MICA officers who have trained in the clinical environment of retrieval and transport.
- b. Clinical treatment protocols have been evolved within the service, assisted through a committee by emergency physicians with responsibility for advising on pre-hospital care in the metropolitan sector where transfer times are short.
- c. Medical presentations include **a.** non-urgent, **b.** hidden serious, **c.** semi-urgent, and **d.** urgent requiring immediate management to prevent long term morbidity or mortality.
- d. Strategic direction across the rural sector is required to optimise management. Strategy involves provision and education of workforce, and directed interaction of workforce segments.
- e. Since 1982 strategically determined distribution of services has also been dominated by political considerations rather than humanitarian provision of effective services for all areas. Neither State nor Commonwealth accept responsibility for rural casualty services, of which ambulance is a part.
- f. The ambulance sector has been considerably expanded at great expense and is seen as a replacement for the perceived declining (but seriously neglected) medical and hospital sector. As such it has started to claim a role not only in medical response but in medical prevention, for which it has received support from VHA.
- g. Optimum clinical outcomes will not be achieved unless the combined rural GP, hospital and ambulance sector is well developed and harmoniously coordinated.
- h. Without achieving optimal outcomes ambulance personnel are more likely to experience burnout.
- i. Clinical efficiency is not achieved by creating competing sectors such as medical, ambulance and nurse practitioner, such as we have been seeing. Team integration offers much greater economy and cross fertilisation
- j. Simply expanding the service in preference to other sectors will not achieve the desired end, will worsen outcomes, and will also balloon ambulance requirements because of unnecessary transfers, even though many AOs exercise their discretion not to transfer and provide first aid and advice.

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3.E.4. Golden Hour Response.

This term itself does not appear to be in parlance outside of the medical sector.

- a. In Victoria, and probably elsewhere, events to date have not allowed serious consideration as to what is the best model of care in the first 4 hours or so when clinical events occur in more isolated localities that have existing medical services. First or 'golden hour' criteria have not been factored in to the construction of protocols or inter-sectoral cooperation, and there has been very

little attempt to evolve coordinated response based on available services in each local zone.

- b. Recent advances in adult retrieval, with the creation of Adult Retrieval Victoria (ARV), added to the already excellent services provided by NETS and PETS mean that every doctor has access to instant expert assistance, increasingly well-versed in communication, while actually managing the emergency. This should progressively enhance quality of emergency care provided.
- c. However the ARV service, now located at Essendon, must not serve as a magnet for cases more suitably managed at a local or regional level. It is a resource to be used sparingly.
- d. Reserve amongst experienced ambulance officers about utilising the local hospital can be understood when the incumbent doctor is not well know to them. This underlines necessity for team cooperation and opportunities for AOs to learn and experience what is often the considerable experience and expertise of the rural doctor.
- e. The service must be held accountable to State Trauma Committee guidelines (#) for triage, so often ignored. (see also 4.4.e below #). ((#))

3.E.5. Team Integration.

The VHA and the RDAV appear to have some consensus that the best interests of rural patients would be served not by a totally independent and separately operating transport organisation but by a service that is closely integrated and co-located at the local level, so that **a.** optimal treatment is given by all suitable clinicians to hand and **b.** unnecessary transfers do not take place. (O'Meara (#) explores and discusses at length the need for integration of local services rooted in the particular community, collocated and integrated with local medical and hospital services and sharing the same systems of continuing education, which is not served by a centrally directed monolithic organisation with 'reactive' planning mechanisms. A "rural...one system model....unlikely... to be effective" (P72)

The principal parameters of Team Integration are:

1. Close Communication
2. Co-location
3. Team interaction with other medical, nursing and allied health staff

1. Communications. During retrieval, Paramedics are not able to communicate with their retrieval destination, nor evolve management in communication with clinicians either at an advisory service or at the retrieval destination.

- a. Communications systems have been upgraded but they operate only within the ambulance organisation itself.
 - i. A result of amalgamation appears to have been a directive that there will be no notification of retrieval destinations by ambulance control.
 - ii. Excess radio traffic was cited as the reason.

- iii. A computerised email dispatch notice to retrieval destination would be relatively simple to organise.
 - b. Mobile phone coverage is now uniform except where there is no line of sight, so that mountainous areas can be a problem.
 - i. Ambulance officers are increasingly using their own mobile phones unofficially.
 - ii. No objection has been raised to this.
 - iii. It has the potential to greatly enhance performance and outcomes.
 - iv. Good AOs contact their local hospital to ascertain doctor availability so they can plan direction of transport.
 - c. Ability to discuss clinical issues and problems is an obvious necessity.
 - i. Headset communication would enable communication while administering care.
 - ii. However hands-free facility on mobile phones is also an option and is being used by AOs on their own initiative.
 - iii. Some AOs prefer to get advice within the organisation and like to locate a MICA if they have a clinical problem, and some store numbers on their phones to do this in an emergency.

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2. Co-location.

- a. The actual location of rural ambulance services is difficult to ascertain. There are no lists and the only source found is a difficult-to decipher map in the 2006 DHS Review. Most of the State has either professional or community ambulance services in towns with hospitals, except for the 22 towns with CERTs, which replaced volunteer teams, (unacknowledged in their demise). The most poorly serviced area is the Southern Mallee, which relies on a single professional service in Charlton for Boort, Wycheproof, Birchip and Donald.
- b. Traditionally ambulance stations have been located away from hospitals in these towns. We would like to see a list reviewing progress if any to the long cherished and frequently discussed ideal of co-location.
- c. In supporting the 2008 move to amalgamate RAV and MAS, the VHA also advised: "That the principle of co-locating ambulance stations with health services be supported and extended at a state-wide level, building on resource. efficiencies already apparent". (VHA response to DHS Consultation paper.
- d. Gratifyingly, the new station at Timboon will be co-located with the health service, which has recently lost procedural medical capability, and in need of team development therefore.

3. Team interaction with other medical, nursing and allied health staff

- a. In 2006 VHA also recommended the creation of a template for the development of closer relationships between Health Services and RAV.

- b. Co-location of services creates the potential for use of AO downtime within the Primary service, and availability for acute response within the hospital. There have been successful experiments in Omeo (Health service) and Mallacoota (GP service).
- c. We are not just looking at Small Hospitals but at services co-operating with bush nursing clinics, and the better integration not only of professional but of community ambulance services, as well as CERTS with local institutions.
- d. There are or were 29 Community Ambulance stations which 'need to be integrated into a local urgent care system that has the support of a broad coalition of stakeholders such as medical practitioners, nurses, emergency service workers, local government and a local hospital'. (O'Meara JEPHC 2003).
- e. The Centre for Rural Health in Moe, closely associated with RDAV in its formative years, made early moves to combine ambulance and rural nurse training. An associate professorship was created, a curriculum devised, and consensus reached on the use of medications. The combined training has improved supply of trained nurses to VAHEC Bush Nursing Centres (D2 above).
- f. It has to be noted that here are very few MICA officers in outer regional areas. The cost effectiveness might be an issue but MICAs have been noted in Balranald NSW.

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3.E.6. Team operation.

The separateness of ambulance services has long been commented on. Many rural doctors have experience of being bypassed by local services, just as many rural AOs have been unhappy with the attitude of doctors to them. Ways of encouraging team development have to be found.

- a. A number of other factors have contributed to the separateness of ambulance services. These include growth and evolution of the service, degeneration of the small rural hospital network, diminishing number of Australian trained doctors, and frequent changes of local doctors.
- b. The very extensive programs for rurally located medical school education include contact with ambulance services. Australian trained doctors are currently being trained to inter-relate with other sectors in a way not formerly included in medical education.
- c. Although ambulance officers could and should be, when they are not out on calls, involved with work in the local health facility, their primary function is to be available, which means that, like the GP, they might have to leave what they are doing to answer call.
- d. Suggestions that AOs might be involved in preventive care as a primary function run counter to this necessity. However call-outs in small stations might be as low as 10 a month and better use needs to be made of time.
- e. Once an ambulance is called out it is not available. The public might advisably make a decision to use their own transport to the nearest health facility. The Ambulance service must be able to make practical decisions based on sound knowledge of local situations.

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3.E.7. Obstetrics.

Despite trends to home delivery and claims for safety childbirth is an episode of medical danger during which catastrophic events often occur without warning. Due to unopposed, progressive and inexorable closure of rural maternity units, ambulances are increasingly transporting mothers in labour. Births frequently occur on the way. One mother, delivering in a small non-maternity hospital en route, was told by the AO that it was “his 4th such delivery in 10 days” (personal communication from the mother). Childbirth courses are available to AOs (as they are to small hospitals without obstetrics). The experience of transporting a newborn baby with breathing difficulties can be quite frightening to an ambulance officer. This is set to increase if action is not taken to stabilise rural maternity services. AOs also have to live with the adverse outcomes of such incidents, which are quite definitely occurring, but regrettably not being studied or compiled.

3.E.8. Recruitment.

Policies in RAV and the combined service are not conducive to future staffing of small rural stations.

- a. Recruitment was formerly of mature individuals. Many older local persons were successfully trained as AOs and have proved to be durable and long stay local personnel.
- b. The policy of recruiting school leavers mostly from larger and metropolitan centres means a class of AO who is less likely to want to live in a small town.
- c. There is a small sign of a reversion to former recruitment methods. This is reasonably urgent given ageing of the peripheral workforce.

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Section 4. The nature and desirability of effective urgent and emergency medical interventions

1. Effective interventions – 2. Hospital load – 3. Necessity for regular practice – 4. ‘Golden Hour’ response – 5. 1999 RDAV Study – 6. 2002 RDAV Study – 7. Retrieval of patients requiring tertiary care – 8. Establishment of appropriate services – 9. The primary and secondary health care dynamic

(#)

1. **Effective interventions** prevent immediate mortality and long term morbidity. The earlier the intervention, the better the prognosis, the less the total medical care including hospitalisation. A well-versed rural doctor is familiar with perhaps several thousand different presentations
 - a. Early serious illness is often undifferentiated and tends to need full undergraduate and postgraduate medical training and experience to diagnose accurately.
 - b. The differential diagnosis of pain presentations needs great medical skill. Chest pain in particular is very common, with only a small but significant proportion cardiac.

- c. There are a plethora of orthopaedic conditions requiring accurate diagnosis and appropriate early management to prevent long-term morbidity.
 - d. Medical Treatment protocols are only effective if correct diagnosis is made.
 - e. For any medical situation there is usually a variety of possible approaches, together with opposing viewpoints that the experienced health professional is aware of, has assessed and prioritized, and a number of levels of intervention which can be applied according to the skill, experience, application, and immediate resources of the operator.
2. **Hospital load** at local, regional and tertiary level can be greatly reduced by a viable well-trained, experienced, rural GP sector managing chronic disease and risk factors effectively, intercepting acute illness, and making accurate triage assessment of acute presentations. (#)
3. **Necessity for regular practice.** Rural GPs have to be in regular practice to provide effective emergency medicine. It is not a matter of consulting the protocol when a dangerously compromised patient presents. GP anaesthetist members of the team also need weekly lists to maintain their airway and emergency anaesthetic skills. It is simply not satisfactory, and more than that dangerous, to routinely bypass local services and then expect them to step in when ambulance is not available. (#)
4. **‘ Golden Hour’ response** in serious illness and injury, makes a huge difference. See also 3.E.4 (#)
- a. Every 10 Km travelled adds 1 % to Mortality (#)
 - b. State trauma committee guidelines (2008) currently direct patients to local hospitals where transport time is in excess of 30 minutes.
 - c. ‘Scoop and run’ retrieval, although the preferred method of ambulance services at present, is incrementally inferior to local stabilization when travel time is in excess of 1/2 hour.
 - d. The long-delayed coronial inquest into the Kerang rail disaster will hopefully examine the problem in relation to the complete bypass of local services that occurred, and what effect this might have had on outcomes.
 - e. Current State Trauma Committee (STC) guidelines (#) state that for all (listed) trauma (you should): “triage to highest level of trauma services within 30 minutes”. Such centres are listed and include many rural hospitals. Anecdotes indicate that the guidelines have been ignored quite regularly throughout the State, even for tertiary hospitals such as Bendigo. Whilst this lessens the burden and responsibility of the rural hospital and doctor, it is not usually in the best interest of the patient.
 - f. Such trauma guidelines can be equally applied to Medical conditions, especially Myocardial infarct, which demands thrombolysis within one hour failing arrival at a cardiac catheter lab in that time.

- g. However, the list of STC approved suitable stabilization centres will have to be revised where small hospitals are no longer able to provide such services. Any system evolved must include robust mechanisms for use of local capacity.
- h. The recent death of a woman in Cobram from bleeding ectopic pregnancy, a condition formerly dealt with surgically by rural doctors in most rural hospitals, yet to be elucidated by the Coroner, provides a clear cut example. However there are many more avoidable deaths that occur as a result of delayed management, as the UK study showed, and there is absolutely no point in denying this fact.
- i. Supply of ambulances will always be limited in relation to peak demand. Once an ambulance is dispatched it is not available for other work. Hence the need for interaction outside the ambulance service, and also flexible response.
- j. As mentioned above (3.E.4.), the term 'golden hour' is not overtly in parlance' outside of medical circles. It is an uncomfortable reminder that rural ambulance response is often not within the first 45 minutes.
- k. For optimum outcomes therefore, we recommend facing up to reality, and advocate better communications, more medical input to management, more medical involvement at the local level and above all maintenance of an effective medical workforce with capacity for acute and emergency care. (#)

5. **1999 RDAV Study.** In 1999, in reaction to the closures and cutbacks that were then in full swing, RDAV looked at the Minimum Acute Care requirements for rural towns (#) and noted as examples a then recent AIHW report citing up to double death rates for serious injury more than metropolitan, and burns admissions at 7 times.
- a. At the time rural hospital acute day expenditure was 50% that of Metro, there were 50% the number of vocationally trained GPs per head of population, and 67% fewer consultations per head of population in rural areas (90% in remote).
 - b. A 1996 study (#), through the auspices of the Centre for Rural Health, of 'towns without hospitals' had demonstrated that such towns had a greater incidence of emergencies presenting at the surgery, were more likely to carry emergency equipment, but not surprisingly often lacked confidence to deal with every emergency that might occur.
 - c. The views of RDAV have not changed. Communities still want a medical presence, a bush nurse if they can't have a doctor. They know full well from experience the things that are likely to happen.
 - d. Sadly many of the recommendations of the paper, to have a well-prepared operating theatre for example, are now a thing of the past in most rural towns. The 88 towns that have lost obstetrics now mostly no longer have operating theatres, and are often not open to casualties.
 - e. Quite a number do not now even have X-Ray, and far too many difficulties have been placed in the way of rural practitioners willing to take simple

limb, chest and skull X-Rays, such an incredibly useful tool, despite the availability of solid state technology. (#)

6. **2002 RDAV Study.** In 2002 RDAV conducted a study of rural emergency requirements, funded by RWAV (#). 263 of 729 doctors responded from 93 of 136 communities surveyed. 90% were working in group practices.
- a. The survey covered emergency, medical, trauma and psychiatric skills, training requirements, perceptions of nursing and paramedic skill levels, patient transport issues, communications, protocols and procedures (including debriefing), medical indemnity and a medical equipment inventory.
 - b. 74.3% of respondents considered themselves as having participated in golden hour management. 36.5% of these did not carry procedural insurance and were therefore reliant on 'emergency' provision in their policies. This is less concerning for holders of VMIA insurance (#). (Note: there are a number of GPs in towns without hospitals who are ineligible to hold this insurance. Only Phillip Island doctors currently hold this insurance through special dispensation.)
 - c. 78.3% of respondents said that they are able to recruit another GP in serious emergencies. There is of course no system of remuneration for such GPs.
 - d. Conclusions emphasized were: Development of a comprehensive debriefing protocol for all rural health workers. Improved coverage in the mobile phone network. Standardizing and benchmarking of essential medical equipment and pharmaceuticals. Better funding for emergency skills training. Upgrading of both air and road ambulance services.
 - e. Of these, the mobile phone solution was desired by the whole sector and was vigorously prosecuted successfully by National rural politicians, but full exploitation of the facility has yet to be developed.
 - f. The need for emergency training was solved by RDAA and ACRRM together negotiating with DoHA and establishing an adequate grants process which resulted in an explosion of self-funding emergency courses. Only the traditional courses (EMST, ELS, APLS, ALSO) have major pre-reading requirements. The study confirmed that such courses improve confidence in management. (NB these grants may be lost through the 2009 RRMA review).
 - g. In terms of team cooperation it was noticeable that GPs had most confidence in their practice teams to respond to an emergency, and much less in the hospital, although most GPs had a high regard for a proportion of hospital nurses. This suggests that good team building has potential. The regard of GPs for ambulance staff showed good potential for team building there. There was not significant awareness of skill levels in SES and other ancillary response workers, and a low level of teaching involvement.
 - h. In general there was little awareness of the role that GPs should play in Displan, although most would assume that their role would be to provide

emergency stabilization and treatment in their hospitals. This is a further reflection of the growth in emergency planning away from GPs, the former mainstay, and a presage of the bypassing of local hospital services in the Kerang rail disaster.

- i. Of great interest is the 65% GPs reporting management of life threatening conditions presenting in their surgeries, 22% severe, with 83% reporting presentation of acute psychiatric conditions, against 76% in the hospital. Experience of threat or injury by patients to doctors was 28% of individuals in the surgery and 44% in the hospital. (#)

7. Retrieval of patients requiring tertiary care.

- a. Adult retrieval, through the creation of ARV, has been recently reorganised, with more immediate and interactive advisory services, which, added to the already excellent services provided by PERS/NETS and PETS mean that every doctor has access to expert assistance, through a manned switchboard, increasingly well-versed in communication, while managing emergencies.
- b. This not only greatly enhances care but also decreases unnecessary transfer.
- c. At present, ambulance care during transfer is autonomous, being left to involved officers. Care during retrieval organized by one of the major services is conducted by selected highly skilled ambulance service personnel and presumably has access to medical advice during transfer.
- d. The further amalgamation of PETS with PERS/NETS will enhance the efficiency of this service although expert advice will still be needed from specialists in the specialty appropriate to the case.
- e. ARV has recently translocated to Essendon, a move long desired, to better facilitate transfer. Direct helicopter transfer to all tertiary hospitals remains an ideal in some cases.
- f. ARV was overloaded on Black Saturday but no doubt will develop contingency plans to adapt to disaster situations in the future. (#)

8. Establishment of appropriate services

- a. Rural Victoria has moved in 30 years from a situation in which every sick person was first seen by a doctor to one in which increasingly no doctor at all will be available within an effective length of time. However, the strain on doctors with the former system became intolerable with changes in rural society, especially to an ageing workforce.
- b. During that time, training for rural medical practice has increased from 6 to 10 years including the intern year, making rural generalists into highly effective doctors. By comparison basic ambulance and nursing training are for 3 and 4 years with considerable disparity in VCE entry levels.
- c. Workforce considerations now mean that triage by nurses and ambulance officers has become increasingly the norm for patients not presenting at general practices. Even within these practices nurse, nurse practitioner and physician assistant triage is likely to become commonplace in the

future, both in rural and metropolitan practice, as it has already done in the UK and US.

- d. It is to be hoped that Ambulance officers will become increasingly involved in triage at a local level, working as part of a team with nurses, and using the same triage protocols such as those in use in West Vic and Central Highlands.
- e. Equally it is hoped that appropriately trained doctors will fit naturally into the local team situation, dealing with situations appropriate to their expertise and offsetting unnecessary transfers. (#)

9. The primary and secondary health care dynamic

- a. Preventive and primary level medicine is currently receiving great emphasis, but a reading of 2009 reports from the National Health and Hospital and the National Primary Care review processes reveals that the rural combined community and hospital sector is not receiving due consideration.
- b. It appears not to have been realized that the doctors responsible for delivering community medical and preventive care are also responsible for acute medical conditions.
- c. Such thinking pervades the planning process and need for rural acute services appears to have been lost sight of. The ABS has also been allowed to enter the debate and make proposals for rural medical access independently of any consideration of medical outcomes.
- d. The problem for Victoria is to determine a level of accessibility which provides optimal outcomes with minimum allocation of resources.
- e. RDAV considers that levels of accessibility have already become unacceptable and are going to worsen considerably with further loss of services and no further basic improvement to peripheral road network.
- f. The Commonwealth is moving away from assisting rural and to concentration on primary care. Rural combined community and hospital work may well be a problem the State has to solve by itself.
- g. Politics is paramount unfortunately in determining many of these matters and leaving it to the political wind will result in only greater disparity for the rural populace. (#)

Section 5. Workforce supply: [1.](#) Historical perspective – [2.](#) Rural medical life cycle – [3.](#) Supply from Australian Medical Schools – [4.](#) Feminisation of the workforce – [5.](#) The battle for recognition of rural generalist medicine. – [6.](#) Commonwealth Initiatives - [7.](#) Victorian State Policy – [8.](#) Geographical provision of provider numbers

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5.1 Historical Perspective: Many Australian trained doctors went to the UK in the post-war decades and obtained training in obstetrics and anaesthetics, then returned to rural Australia.

- a. In the early 1980s the workforce shortage, caused by cutbacks in medical training, was just beginning and locations were starting to apply for sponsored medical immigration.
- b. A significant contribution to loss of rural doctors was the 'rationalisation' of rural hospitals that started to get into swing in the mid-80s. The RDAV 1999 study (#) cited 3 studies showing "that paramount amongst the reason for doctors leaving rural practice were the lack of ability to solve professional problems, most notably overwork, forced deskilling (through closure of hospital facilities), and professional isolation".
- c. There were already quite a few overseas trained doctors in Victoria who had graduated to rural through work in mission hospitals and less developed countries, or in the UK armed forces.
- d. Rural Victorian practices started to recruit from wherever they could get candidates. Those in more attractive mountainous and coastal locations, more in the east of the State, were able to find some Australian graduates. Others took to using overseas recruitment agencies, or even going to the UK to find doctors.
- e. Creation of divisions of General Practice, and activity by rural doctors' Associations in the 1990s led to the creation of State Workforce Agencies designed to improve workforce supply. Their main activity has transpired to be in overseas recruitment.
- f. Smaller locations were increasingly forced to use the resources of their hospital to find candidates. Once the RWAV was operational, with proper funding, the development of the internet, and their own immigration consultants, this became the main source of supply for small locations, but has proved to be less effective for larger procedural locations. It wasn't long before the State also started to look to them for assistance with recruitment to Regional towns and from 2001 to fringe-metropolitan areas (recently described as 'rural' by the Rudd Government).
- g. Other activities have resided primarily with the rural Divisions of General Practice. Within these too there has been a tension where large towns are also being serviced in which the combined community and hospital sector is not active. (#)

5.2 Rural medical life cycle

- a. For 20 years or more, during a period of intense expansion of metropolitan medical specialties, Australian entry into the rural medical workforce has dropped away to a negligible level. Studies have suggested rates of 4% or less.
- b. Doctors train in their 20s, settle down in the 30's, become teachers in their 40s, mentors in their 50s, and retire or cut to part time, non-procedural and less on-call after 55.
- c. Our very thorough 2006 age cohorts for rural GP proceduralists (#) show few doctors in the 20s or 30s, rapid fall-off in the 40-45 group, with the whole cohort moving into the 50-60s. It suggests that the major reduction in entry occurred in the 1990s rather than the 1980s. This data is being updated at present and shows further significant fall-off.

- d. This is quite untenable and means the whole sector is in danger of collapse. (Further review will be posted soon in 2009 on the RDAV website.)
- e. There never has been a fully formalised training program for rural GPs in Australia. Australian doctors for the most part went overseas for procedural experience on their own initiative. The regionalized GP training program, which supplanted the RACGP training program, although it occurred in response to the rural problem, has remained a generic GP training program and has failed to generate significant numbers of rural doctors.
- f. 20-30% of rural doctors are now from overseas but in some areas of Victoria like the Mallee this figure is over 80%. RWAV extrapolated figures for the rural medical workforce as a whole are much the same as those of RDAV for proceduralists, meaning that OTD/IMGs are in a similar age range and looking to establish their families in the best position for the future, which is rarely the bush. In particular they like to locate to metro for year 9 schooling.
- g. Rural medical work is vocational in nature. This has been taken advantage of in the past but rural GPs no longer tolerate exploitation. We argue that there will always be adequate numbers of doctors with sufficient potential available from Australian medical schools providing there are: proper education, guaranteed scope of practice, recognition, support, and industrial conditions adequate to ensure prosperity commensurate with metropolitan counterparts after the expense of childrens' boarding school education has been met.
- h. There has not been systematic fostering of a purpose-built rural medical workforce, A stereotype has developed, unfortunately close enough to actuality, encouraged by extensive media coverage, of a sector desperate to take any doctor willing to work there for however long. This is, although a natural consequence of the situation, self-defeating because it encourages no long-term commitment.
- i. Older doctors watch with dismay as standards slip and vital elements of services are lost.
- j. In recent years the social process of settling doctors from both Australia and overseas in with their families has been pivotal in the survival of some major locations. Experience suggests that long-stay can mostly be effected only with the involvement of other doctors in a group practice situation, rather than by bureaucratic constructs.
- k. RDAs have always advocated measures which encourage education, support, industrial conditions and family support all conducive to a sense of workforce identity along the lines of one of the medical specialties. This is what will give long term viability to the sector. All agencies funded by government have to be subservient to this ideal. (#)

5.2 Supply from Australian medical schools.

- a. If we are to secure a sustained supply of adequately trained rural doctors then appropriate incentive has to be created for medical students to move forward into a rural career. The alternative of operating rural as an interim period of experience on the way to other formal careers tends to result in provision of a lower level of care and hence second rate health services for rural residents. The issue cannot be safely side-stepped.
- b. It must be stressed that virtually any doctor graduating through Australian Medical Schools is capable of specialisation, and that the rewards for specialists in terms of income, simplicity of practice, and working conditions, are very great. The expansion of metropolitan-based specialties has been unbridled and not subject to fiscal policy.
- c. Medical school students studying at rural locations score consistently higher than their metropolitan counterparts (Flinders University figures reported Worley et al), which has been attributed to quality of rural GP teaching.
- d. However General Practice as a whole continues to be regarded as inferior and GPs to be a lesser being than a specialist, whereas in actual terms the complexity, breadth and challenge of GP, even more so rural GP, is equal to any specialty.
- e. Young doctors have generally done rural rotations during training where they observe that rural doctors are obliged both to diagnose and manage complex, difficult and often obscure conditions. Many become concerned about the difficulty, inconvenience, challenge to health, and medico-legal implications of this kind of work.
- f. How many or them continue to see it as a potentially rewarding challenge, and take up a career, depends on a number of intervening factors, whether they continue to work in a regional setting, how influenced they are by specialists they work under, whether they acquire a spouse accepting of rural, and whether to them it seems they will be advantaged or disadvantaged by becoming a rural doctor. These factors play a part up to the end of their regional training, 8-9 years after starting.
- g. The various rural scholarship schemes ensure rural experience but many with rural scholarships seek to refund these once qualified, and data is lacking as to their effectiveness. There is a general feeling that scholarship bonding is not contributory. Significantly, scholar entry to the **Queensland rural generalist pathway** is very strong (Denis Lennox DHSQ personal communication)
- h. **Affirmative Medical School intake.** RDAV has previously supported modifications to medical school intake processes, with entry standards based not only on academic achievement but also all round character, as well as affirmatively equal numbers of male and female entrants. Rural schooling attracts a 'loading' for rural applicants.
- i. Of the Regions in Victoria only Gippsland is beginning to develop the necessary coordination between rural medical school, regional GP registrar training program and procedural training and is now turning out GP obstetricians at least on a regular basis. This is fertile ground for

generalist pathway training. Significantly the area is the only one that was able to establish an independent GP training program in the early 1990s.

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5.3 Feminisation of the workforce. Working medical mothers also face real difficulty in making full commitment, so that most rural on-call and procedural work continues to be done by male GPs. Medical school intakes based on school-leaving achievement have female intakes of well over 50%, rising to 80% in some instances. The availability of male Australian graduates to the rural sector has shrunk considerably. In 2003 ARRWAG figures showed increasing female preponderance with decreasing age and a majority of 55% in the (very small) 25-29 age group.

5.4 The battle for recognition of rural generalist medicine.

- a. Disappointing support for rural from mainstream medicine has involved much more than just a matter of 'looking down' on rural doctors and rural medicine as a career. There has been surprising indifference amongst Medical Colleges and regulatory bodies to rural need for doctors and services.
- b. The creation of the ACRRM occurred as a result of a vote in the RACGP council against rural medical fellowship training, and with the departure of so many senior rural doctors from the RACGP nationwide, the impetus for training for the combined primary and secondary sector was lost within the RACGP. The RACGP, after renaming it's 'Faculty of Rural Medicine' to 'Rural Faculty', only decided, 10 years later, to accept the concept of rural medicine and commit itself to fellowship training during events that followed the 2006 COAG decision to recognize Rural Medicine as an entity. However it has limited itself to upgrading its rural primary care Diploma to a Fellowship with, to our knowledge, no change in curriculum as yet.
- c. Political indifference to the rural situation was evident already in 1996 when, at the height of rural medical shortages, before overseas recruitment had become properly organized, National Minister Wooldridge 'warned overseas doctors..... they had little chance of registration because there were already more doctors than we can cope with.....he felt..... 'no obligation to the 450 doctors still turning up each year.....we have got enough doctors.' (Australian Financial Review, Monday, 8 July 1996 quoted <http://www.rirdc.gov.au/reports/GLC/00-159sum.html>).
- d. In many ways the rural sector was subject to excessive restraint of metropolitan origin. The same paper by the then Rural Industries Research and Development Corporation questioned the over-regulation of supply and supervision of the rural sector including, specifically the medical and nursing sectors, based on a study of the Victorian rural health sector.
- e. The GP/specialist algorithm of patient management breaks down with distance but remains an article of faith with the specialist professions, who view with trepidation the training of subspecialists, and by their

Colleges and College Chapters, who since the 1990s have been trying to control GP activities relating to their sector, to expand their own workforces, and in the case of some to sequester as much activity as possible from General Practice to improve income streams for their increased numbers.

- f. Anaesthetists were particularly intrusive in the 1990s and were criticized in a Government inquiry (Lochtenberg) for this, but have latterly been much more supportive thanks to adroit liaison within their Society, which works closely with RDAV.
- g. Note: Colleges have political wings termed 'societies' along the lines of AMA and RDA's. Following COAG recognition of Rural Medicine as a Specialty:
 - a. DoHA recognized the FACRRM as a portal to Vocational Recognition
 - b. AMC gave it provision recognition which was to be completed in 2010 but is now we understand to be completed in the near future in 2009
 - c. Queensland Medical Board has given it recognition for State Registration as a medical degree.
 - d. The ACEM has undertaken to support GEM training in Queensland to the FACRRM endpoint

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5.6 Commonwealth initiatives have been confined to working within the algorithm of separate approaches to community and hospital medicine, not addressing the separateness of State and Federal domains. They have included rural attachments, rural scholarships and bonding, creation of rural medical schools and decentralizing GP training to regional foci, but as yet we see or hear no evidence that this has created traction in terms of increased entry and retention.

- a. Regrettably it has undone much of this good work by increasingly treating fringe metropolitan and large regional towns as identical to rural, as in the May 2009 budget, but also under the Coalition in Medicare +. These areas do have medical workforce shortages but for **GP community-only practice**. Rural GPs have been placed in the invidious situation of arduously training many Overseas-derived doctors only to see so many of them move on to the Metropolitan penumbra, 20-30 from the Mallee area alone.
- b. The 1.7.09 Australian Bureau of Statistics reclassification (ASGC) of rural Australia has down-graded large areas of Australia into 'inner-regional', generally within a radius of 100 Km from a tertiary hospital, with the implication that they should now travel for medical care. This has classified the entire middle 2/3 of Victoria as 'Inner Regional'. Classification of each Victorian Rural Hospital is appended [\(#\)](#). Refer mainly to the AGSC column
- c. Major 2008-9 studies, namely the National Health and Hospital Reform Commission, the National Primary Health Care Strategy, and the National Maternity Services Review, completely failed to address the problem of **combined community and hospital care**, and where, as in the first of

these, the problem of rural was considered, there seemed to be only an attempt to address very remote areas.

- d. DoHA in particular has never addressed the divide between State and Commonwealth responsibilities to the **combined community and hospital sector**, and in all processes has insisted that the sector comply with requirements of the metropolitan sector, placing great onus upon it.
- e. The recent appointment of a Minister responsible for regional affairs potentially offers only an ambassadorial approach to the problem since only COAG has the authority to change matters. (#)

5.7 Victorian State policy has been to try to live with the workforce reality rather than to influence it. The result has been a process of attrition of services

- a. Other States have started to question this approach and Queensland has decided to act otherwise. State programs in NSW (#) and SA (#) have been successful in attracting rural doctors. However it is the assiduous planning and cultivation of young doctors that has led to the success of the new **Rural Generalist Pathway in Queensland (#)**, which recognizes and rewards rural medicine as a specialty, with a proper industrial structure and an entry pathway for overseas doctors to obtain full medical registration and Australian residence. Victoria is only in the earliest stages of assessing this process.
- b. Victorian rural hospitals are offering fewer and fewer services, to the extent that patient outcomes are seriously compromised and travel requirements continuously increase. Appropriately qualified and experienced doctors are essential to these services. The 1.7.09 reclassification of rurality basically means that the Commonwealth has started to opt out of assistance to most of rural Victoria, whatever the rhetoric.
- c. The State therefore has to decide whether or not it will provide rural hospital services and at what distance from the populace. If in this respect it is felt that the pendulum of supply has swung too far in the wrong direction, affirmative action will only be achieved by a lobbying process.
- d. Some consolidation of services will have to occur. RDAV holds that hospital services based on strong community located groups of rural generalist doctors offers the best hope for the future survival of rural hospital services outside of major centres able to sustain full tertiary specialist teams.
- e. In medium-sized centres, a combination of Specialist and Generalist services is the best option, as recommended by the 2007 Victorian Ministerial Inquiry in to Public Hospital Workforce (#).

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5.5 Geographical provision of provider numbers to enforce parity of distribution of doctors, and which would have to be matched to control of specialist numbers to be effective, has often been raised and discussed, especially by rural Politicians. However it offends clause 51 XX11A of the Australian Constitution, which proscribes 'medical and dental conscription'.

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Section 6. Supply of overseas trained doctors. 1. Historical perspective – 2. Required qualifications and workforce needs compared – 3. Recruitment and retention – 4. The future need for a better supervised more targeted recruitment program (#)

It has to be realized that the dependence of rural on overseas-derived doctors (OTD/IMGs) is now absolute and may always remain so. The supply of Australian doctors willing to undergo a rural career is totally inadequate to maintain both community and small hospital services. Without them there would be widespread closure. However this supply is not guaranteed, and the availability of established rural generalists to train them on arrival is steadily diminishing.

6.1. Historical perspective

- a. In 1986 NSW was the first State to recruit wholesale from overseas to its casualty departments. Prior to that, entry to Australia was by sponsorship to locations that had not been able to attract candidates after 6 months' advertising. Overseas recruitment rose rapidly in the ensuing years.
- b. The shortage of rural doctors, foreseen by Monash Centre of Rural Health studies (Strasser et al), accelerated rapidly in the 90s. In Victoria the Rural workforce agency RWAV, funded by the Commonwealth and partly by the State, with a specific mandate to recruit and place GPs, was given a mandate to solve the problem.
- c. Nationally it was ordained that the FRACGP, a community-only practice examination, would be the required qualification for full registration as a prerequisite for permanent residence in Australia. (#)

6.2. Required qualifications and workforce needs compared

- a. Unfortunately the question of procedural and emergency capability in rural Victorian practice was never addressed. This might be explained by the fact that since taking over VRDCU, (the Victorian Rural Divisions' Coordinating Unit, a fully rural-led GP organisation), the RWAV under its constitution has had minority combined-practice rural GP input into its Governance, and has been primarily a Federally funded organization with obligations to Primary Care only. Because of the pressing need for doctors in locations, placements have not routinely been made on the basis of procedural skills and experience, but only on evidence of good general medical capacity.
- b. The FRACGP is a community examination and is not intended to train doctors for hospital practice. It is also a very hard examination for OTDs/IMGs to pass, often placing them under substantial stress. Many of them have been in unsupervised locations out of touch with fellow rural doctors in the region, except where GPs volunteered their services. It took some time, and some hard lobbying in Canberra, for Divisions to find funding for and develop educational programs for them. This also meant that they were not able to focus on the many emergency skills, required for rural practice, which fall outside of the curriculum of the FRACGP.

- c. All this contributed to a sense of impermanence and not belonging to the rural sector, greatly augmented by ethnic separation, which led to most of them moving, often interstate, to the metropolitan penumbra of Melbourne, Sydney and Perth especially, as soon as their registration and immigration status allowed it.
- d. Many OTD/IMGs have had extensive overseas hospital experience especially in obstetrics and anaesthetics and this gives them procedural know-how, which translates into good emergency skills. Sadly, very many of these graduates also have moved into the metropolitan penumbra. The few that have remained have been pivotal in keeping locations like Swan Hill and Hamilton open. (#)

6.3. Recruitment and retention

- a. RDAV disputes those who allege that OTD/IMG retention has been satisfactory in rural and suggest that figures are skewed by those in large regional towns. In the rural combined community and hospital sector, retention has been poor. Very few indeed have stayed on in the Mallee region, and substantial financial inducement is required for them to do so, which has to be found through efficient general practice initiatives utilizing new descriptors.
- b. Additionally, recruitment has now become very much more difficult. On 1.7.08 MPBV brought in a new system of approval, meaning essentially that unless acceptable community (not hospital) practice qualifications are obtained in other UK or Commonwealth countries conducting them, (AMC Competent Authority pathway), candidates will be required to sit and obtain the first part of the AMC examination overseas before coming here in addition to the English language test set at a high standard (AMC Standard pathway).
- c. Preliminary processing for the new system by the RACGP is taking up to 6 months. Our present assessment of the system is that it will deliver few doctors of good general skill and will inhibit many of good procedural skill from trying to come to Australia.
- d. The situation remains, after 22 years from the NSW dispute, that there is no provision or system for targeting and recruiting potential procedural generalists. The FACRRM remains unrecognised by Medical Boards as a portal to full registration so that it is not a fruitful pathway for OTD/IMGs to take, undermining their rural commitment from the outset. We have to wait for AMC approval in 2010 for this, followed by lengthy State Board deliberations and then a 5 year lead-in time to effectiveness.
- e. There are of course large numbers of doctors trained overseas who are finding their way into Australia through family ties. For the most part they lack experience necessary for rural entry, though there should be a commitment to educating them further.
- f. Overseas recruitment does of course have its critics and a commitment to minimise this source for moral reasons does exist in the 2002 World Rural Health Congress '**Melbourne Manifesto**', (#) to which Australian delegates were signatory. Resentment exists as much in New Zealand as it does in

underdeveloped countries because of the flow of especially more able doctors into larger developed countries such as Australia.

- g. The success of corporates in diverting a significant amount of recruitment directly to their own practices deserves mention. Overseas doctors obviously value the umbrella of a corporate organization and the commitment to settling in and education, also accepting lower pay rates.
 - a. However it must be noted that corporates are less likely to provide hospital services.
 - b. The presence in towns of corporates removes critical mass from community practice and jeopardizes the operation of those practices providing Visiting Medical Services to the local hospital.
 - c. Corporates have provided community-only practice in all but a couple of instances, including the ill-advised taking over of the Phillip Island Hospital accident area as a practice (which resulted in the only example known to us of extensive use of helicopters).
- h. The structure of the Rural Workforce Agency of Victoria as a community-governed organisation might therefore militate against its success as a recruitment agency if it is not seen by potential recruits as a sympathetic organisation in the way that corporates are. Certainly it has not by and large been regarded by recruiting rural group practices as a primary source of recruitment.
- i. Divisions are heavily involved in recruitment but have limitations in their ability to deliver, with very variable effectiveness in their interaction with RWAV, For this reason most rural group practices conduct their own separate overseas recruitment programs, utilizing every means at their disposal with informal networking, direct advertising, use of overseas recruitment agencies, even sending members overseas themselves to interview. (#)

6.4. The future need for a better, well- supervised more targeted recruitment program

- a. The new much more restrictive registration requirements (6.3.b) seem to have seriously curtailed overseas recruitment. This almost certainly signals acceleration of rural rundown if candidates of the caliber required, traditionally a much rarer commodity, cannot be found for smaller locations especially.
- b. Agencies are increasingly going abroad looking for doctors. Tasmania has an active program in the UK to groom potential candidates, as there has been overproduction of doctors combined with disaffection for the National Health system. Only a trickle of doctors is coming and very few of these will have procedural capability.
- c. The Victorian Government has recently made statements about recruitment from the UK. It has not been made clear where these doctors are expected to work but the mandate of the State administration is to employ hospital doctors. It may be that this program in fact will be targeted at large hospital junior staff as it has been in all States. Such doctors have been commonplace since 1986. Such doctors are technically, and usually in practice, under supervision and therefore do not require qualifications for independent practice.

- d. Unless they have training recognized under the AMC Competent Authority pathway, OTD/IMGs in rural practice have to be supervised. As temporarily registered doctors and not vocationally registered they are not registered for independent practice. Except where placed in group practice this supervision has been minimal, another reason why they tend not to acquire skills to deal locally with more complex medical conditions and are happy in due course to move on to less demanding community-only practice.
- e. Rural medical practice demands an extremely wide range of skills but there is flow on in skill acquisition from dealing with one to another quite unrelated condition. Having advice and help at the time of an emergency greatly enhances this process. It's taken for granted in large hospitals but is progressively being forgotten in rural, particularly now that informal networks amongst small rural hospitals are lost as long term doctors retire.
- f. OTD/IMGs can be just as good as Australian-trained doctors if settled in and bedded down sensitively with maximum assistance, a process that takes several years. Doctors practicing anaesthetics, obstetrics and advanced emergency medicine in particular need close support from experienced colleagues.
- g. At present OTD/IMGs with temporary residence only are allowed to practice with temporary registration. They are able to send their children to school but have no access to Medicare or child allowance. They also have to make full re-application for their Visas every two years, a costly and often onerous process.
 - a. When they pass the FRACGP they receive full registration, can apply for permanent residence and, two years later, citizenship.
 - b. If they have certain overseas community GP qualifications, they may be required to practice for 5 years only.
 - c. If they do not have these qualifications then they are required to practice for 10 years under section 19AB of the Health Insurance Act (*10 year moratorium*)
 - d. There have been questions about the usefulness of this and there is prejudice against the constraint that it engenders. A recent 2009 RDAA poll of rural doctors found substantial opposition to the concept. This led the organization to publicly state opposition to continuance of the system.
- h. However, discontinuation of the moratorium may lead to closure, certainly to shorter stay with a concomitant drop in standards. RDAA opposition does however highlight the absurdity in this day and age of needing basically conscripted labour to provide rural medical services.
- i. A probably increasing number of OTD/IMGs are entering Australia with marriage visas. This gives them permanent residence. However they tend to be younger and have much less experience than those applying from outside the country. It is highly premature to consider them as a potential replacement for the current cohort sourced from direct recruitment.
- j. **In summary** it is observed that the overseas recruitment program is not tasked to recruit for the combined community and hospital sector, with a mismatch of skills assessment and workforce need, and an examination pathway that leads to mainstream community-only general practice. It continues to provide a temporary fix only for the Victorian rural hospital sector which, with the fall off in

recruitment due to 2008 AMC requirements, may be about to face a major crisis. (#)

Attachments

(#)

- [1. Locations with full acute bed closure, since 1983, \(35\)](#)
- [2. Survival of Rural Bush Nursing Hospitals \(BNH\) listed in 1983: \(30\)](#)
- [3. Towns classed in 2000 as providing after-hours care but currently having non-resident doctors: \(11\)](#)
- [4. Hospitals reduced to HS or Aged care without beds: \(19\)](#)
- [5. Hospitals saved by recruitment of doctors from overseas: \(28\)](#)
- [6. Towns sharing cooperative after hours, week-end on call arrangements: \(30\)](#)
- [7. Obstetric Units closed since 1983: \(88\)](#)
- [8. Obstetric Units closed since 1997: \(37\)](#)
- [9. Obstetric locations still open: \(42\)](#)
- [10. Procedural Anaesthetic and Obstetric rural GP Workforce and Age Statistics '04 –'09](#)
- [11. Existing Rural Victorian Hospitals in functional Groups](#)
- [12. Existing Hospital Network](#)
- [13. 2007 Listed On-call Rural VMO 'Enhancement Package' locations \(89\)](#)
- [14. Larger hospitals without Rural enhancement Packages: 16](#)
- [15. Details of Victorian rural GP VMO locations](#)
- [16. Bush Nursing Centres with no resident doctor](#)
- [17. Victorians living in poverty by electorate. Age Newspaper 24.5.05](#)
- [18. First \(worst\) quintiles of Victorian poverty by postcode. Jesuit studies 2003](#)
- [19. Australian Life Expectancy at birth by Region 1997 – 2000 \(AIHW\)](#)
- [20. Relationship between distance to hospital and patient mortality in emergencies](#)
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- [22. RDAA 2007 Statement Emergency in Rural Australia: Recommendations](#)
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- [24. Victorian Rural GP VMO locations and Rurality Indices as at 28.1.09](#)
- [25. Medical Indemnity/Insurance for Victorian rural doctors.](#)

1. Locations with full acute bed closure, since 1983, (35)

(#)

At least 22 now with no resident doctor.

Avoca, Anglesea, Beeac, Beulah, Birregurra, Chiltern, Clunes, Cobden, Dunolly, Eildon, Gisborne, Kooweerup, Koroit, Lismore, Lake Bolac, Lancefield, MacArthur, Maldon, Mirboo, Mortlake, Murchison, Murrayville, Natimuk, Neerim, Nyah, Pyramid Hill, Redcliffes, Rushworth, Rutherglen, Tongala, Trentham, Warley, Wedderburn, Yarra Junction, Yackandandah.

2. Survival of Rural Bush Nursing Hospitals (BNH) listed in 1983: (30)

(#)

Still with beds: 8.

Birchip, Charlton, Euroa, Heyfield, Hopetoun, Rainbow, Sea Lake, Yackandandah

Beds closed: 22

Anglesea, Avoca, Chiltern, Cobden, Gisborne, Lancefield, Merino, Mirboo, Murchison, Murrayville, Nagambie, Natimuk) Neerim, Nyah, Pyramid Hill, Tongala, Toora, Trentham, Walwa, Warley, Wedderburn, Yarra Junction.

NB: All had obstetrics, none do now. Annual Victorian BNH Obstetric morbidity statistics were consistently at world's best. State support ceased in 1986, resumed in 1994 in a small way, and subsumed the network from 1997 onwards.

3. Towns classed in 2000 as providing after-hours care but currently having non-resident doctors: (11) (#)

(11) Murtoa, Willaura, Skipton, Rainbow, Chiltern, Heywood, Kooweerup, Lismore, Mortlake, Birregurra, Beac. (This list varies. Some locations still have beds but only intermittent cover)

4. Hospitals reduced to HS or Aged care without beds: (19) (#)

Koroit, Lismore, Minyip, Maldon, Murtoa, Nyah, Pyramid Hill, Rupanyip, ? Rushworth-Waranga, Tallangatta, Tatura, Walwa, Wedderburn, Winchelsea, Yackandandah

5. Hospitals saved by recruitment of doctors from overseas: (28) (#)

Ballan, Beaufort, Birchip, Boort, Charlton. Cobram. Donald, Edenhope, Heathcote, Hopetoun, Jeparit, Kaniva, Manangatang, Nagambie, Neerim, Nhill, Orbost, Ouyen, Peshurst, Portland, Robinvale, Rochester, Sea Lake, St Arnaud, Warracknabeal, Wedderburn, Wycheproof, Yarram.

6. Towns sharing cooperative after hours and week-end on call arrangements: (30) (#)

Mt Beauty and Bright

Yea and Alexander

Stawell and Ararat (all services)

Wycheproof, Charlton and Birchip

St Arnaud and Donald

Minyip and Rupanyip,

Foster and Wonthaggi (for Caesarean)

Leongatha and Korumburra (intermittent all services)

Terang, Camperdown and Timboon (Obstetrics)

Nhill and Kaniva

Rainbow and Jeparit

Hopetoun and Warracknabeal

Sea Lake often on bypass to Swan Hill.

Ouyen often on bypass to Mildura

Orbost on regular bypass to Bairnsdale for Obstetrics

Beechworth bypasses to Wangaratta

NB A number of larger locations use rural procedural generalists to fill shifts.

7. Obstetric Units closed since 1983: (88) (#)

Alexander, Apollo Bay, Avoca, Ballan, Beechworth, Beulah, Beac, Birchip. Birregurra, Boort, Casterton, Charlton, Clunes, Cobram, Coleraine, Corryong, Cowes, Creswick, Dimboola, Donald, Dunolly, Eildon, Edenhope, Elmore, Euroa, Gisborne Heyfield, Heywood, Hopetoun, Inglewood, Jeparit, Kaniva, Kooweerup, Koroit, Korumburra, Lancefield, Lismore, Lorne, MacCarthur, Maffra, Maldon, Manangatang, Minyip, Mirboo Nth, Moe, Mortlake, Murchison, Murrayville, Murtoa, Nagambie, Nathalia, Natimuk, Neerim South, Nhill, Numurkah, Nyah West, Omeo, Orbost, Ouyen, Peshurst, Port Fairy, Pyramid Hill, Rainbow, Redcliffes, Robinvale, Rochester, Rupanyip, Sea Lake, Seymour, Skipton, Sunbury, Talangatta, Tatura, Terang, Timboon, Tongala, Trentham, Walwa, Warley, Warracknabeal, Wycheproof, Wedderburn, Willaura, Yackandandah, Yarra junction, Yarram, Yea.

8. Obstetric Units closed since 1997: (37) (#)

Alexander, Beechworth, Birchip, Boort, Casterton, Charlton, Cobram, Coleraine, Corryong, Cowes, Creswick, Dimboola, Donald, Edenhope, Hopetoun, Korumburra, Lorne, Maffra, Maldon, Nathalia, Nhill, Numurka, Omeo, Ouyen, Peshurst, Port Fairy, Rosebud, Rupanyip, Seymour, Talangatta, Tatura, Terang, Timboon, Warracknabeal, Wycheproof, Yarram, Yea.

9. Obstetric locations still open: (42) (#)

- **Small 5:** Bright, Castlemaine, Daylesford, Healesville, Mt Beauty, St Arnaud
- **Medium: 22:** Ararat, Benalla, Camperdown, Castlemaine, Cohuna, Colac, Foster, Kerang, Kilmore, Kyabram, Kyneton, Leongatha, Mansfield, Seymour (just reopened), Maryborough, Myrtleford, Orbost (intermittently operational), Portland, Stawell, Wonthaggi, Yarrawonga.
- **Larger Centre: 9:** Bacchus Marsh, Bairnsdale, Echuca, Hamilton, Horsham, Kilmore, Sale, Swan Hill, Warragul.
- **Regional/Subregional: 8:** Ballarat, Bendigo, Mildura, Shepparton, Traralgon, Wangaratta, Warrnambool, Wodonga.

Comment on Obstetrics: Services require both Obstetricians and Anaesthetists on full roster. Intermittent closure of centres, going on bypass, shared rosters between centres all compromise patient safety. The median age of GP Obstetricians is now 50 but there are very few under 40. Substantial retirement occurs after 50 and the workforce will be terminally depleted within 10 years without a major training and retention exercise paralleled by a similar process for midwives, who share the same age profile. This means that most of the small and medium maternity centres, and possibly some of the larger, will close, leaving quite a bleak landscape, and adding to rural morbidity. For large centres the supply of obstetricians is meagre and rural specialist obstetricians are in very short supply. (#)

10. Procedural Anaesthetic and Obstetric rural GP Workforce and Age Statistics 2004 - 2009 (#)

The RDAV triennial survey lists every rural GP Anaesthetist and Obstetrician in the State (#)

Notes 2009: The big changes are a drop in dual proceduralists, drop in under 45's, and jump in over 55s. Retirement has not occurred at the expected rate. The actual figures conceal mal-distribution between locations and a number of quite marginal locations. The crucial factor emerging is whether enough entrants will be obtained and whether enough proceduralists will remain to mentor entrants into full and independent practice.

GP Proceduralist Obstetricians and Anaesthetists 2004 – 2009*

	Anaesthetists			Obstetricians		
	'04	'06	'09	'04	'06	'09
Under 45y	45	28	19	64	45	25
Over 55y	23	21	33	26	28	39
Total	118	106	99	167	155	132

(Dual 2006: 61, 2009: 45 – Actual total manpower 2006: 190 and 2009: 176)

Actual GP proceduralists in Rural Victoria 2006 (allowing for dual) by age and sex.

Age	25-29	30-34	35-39	40-44	45-49	50-54	55-59	60-70	Total	Grand Total
M/F	0/2	5/4	11/3	29/5	40/8	44/4	24/1	11/0	163/27	190

Actual GP proceduralists in Rural Victoria 2009 (allowing for dual) by age and sex.

Age	25-29	30-34	35-39	40-44	45-49	50-54	55-59	60-70	Total	Grand Total
M/F	0/0	1/2	8/5	8/5	40/4	42/7	28/2	24/0	151/25	176

GP Obstetricians in Rural Victoria 2006 by Age and Sex

Age	25-29	30-34	35-39	40-44	45-49	50-54	55-59	60-70	Total	Grand Total
M/F	0/2	3/3	7/3	20/3	36/6	37/3	17/1	11/0	131/21	152

GP Obstetricians in Rural Victoria 2009 by Age and Sex

Age	25-29	30-34	35-39	40-44	45-49	50-54	55-59	60-70	Total	Grand Total
M/F	0/0	1/1	4/4	10/5	30/3	30/5	20/3	16/0	111/21	132

GP Obstetricians in Rural Victoria 2004 and 2009 compared to show attrition

Age	25-29	30-34	35-39	40-44	45-49	50-54	55-59	60-70	Total
04/09	2/2	8/2	15/8	39/15	42/33	35/35	17/23	9/16	167/132

GP Anaesthetists in Rural Victoria 2006 by Age and Sex

Age	25-29	30-34	35-39	40-44	45-49	50-54	55-59	60-70	Total	Grand Total
M/F	0/0	2/0	8/1	16/1	22/4	30/1	12/1	8/0	98/8	106

GP Anaesthetists in Rural Victoria 2009 by Age and Sex

Age	25-29	30-34	35-39	40-44	45-49	50-54	55-59	60-70	Total	Grand Total
M/F	0/0	1/0	5/1	11/1	20/1	23/3	19/1	13/0	92/7	99

GP Anaesthetists in Rural Victoria 2004 and 2009 Compared to show attrition

Age	25-29	30-34	35-39	40-44	45-49	50-54	55-59	60-70	Total
04/06	0/0	4/1	19/6	22/12	25/21	25/26	17/20	6/13	118/99

11. Existing Rural Victorian Hospitals in functional Groups (* Still have Obstetrics) Some related NSW locations are added in brackets. TWOH means practises in locations that often have to exercise hospital function in the community. (#)

East Gippsland: Bairnsdale*, Orbost*, Omeo, TWOH Mallacoota, Lakes Entrance

Central Gippsland: Base Traralgon*, Sale*, Yarram, Maffra, Heyfield, Neerim, Warragul*

South Gippsland: Wonthaggi*, Leongatha*, Korumburra, Foster* TWOH Phillip Island

North East Vic: (Albury) Base Wodonga*, Mt Beauty*, Corryong, Walwa, Tallangatta (Corowa)

Central North East: Base Wangaratta*, Bright*, Myrtleford*, Beechworth, Yackandandah, Yarrawonga*, Benalla*, Euroa

North Metropolitan Penumbra: Seymour, Kilmore*, Alexandra, Yea, Mansfield*, Healesville*

Central North: Base Shepparton*, Kyabram*, Numurka, Nathalia, Cobram, Nagambie, Rushworth, (Tocumwal)

Central Northwest: Echuca*, Rochester, Cohuna*, (Barham)

Bendigo and surrounds: Base Bendigo*, Castlemaine*, Inglewood, Heathcote

Central Mallee: Charlton, Wycheproof, Birchip, Boort, Donald, St Arnaud

Western Metropolitan Penumbra: Kyneton*, Bacchus Marsh* TWOH Woodend, Gisborne

Ballarat and surrounds: Base Ballarat*, Daylesford*, Creswick, Ballan, Beaufort, Skipton

Bellarine: Base Geelong*, Winchelsea, Colac*

Corangemite: Camperdown*, Terang, Timboon

Great Ocean Road: Apollo Bay, Lorne

Mid Otway: Base Warrnambool*, Port Fairy

West Otway: Sub-Regional Hamilton*, Coleraine, Casterton, Penshurst, Portland*, Heywood

West Wimmera, Sub-Regional Horsham*, Murtoa, Rupanyip, Dimboola, Nhill, Kaniva, Natimuk, Edenhope, Warracknabeal, Jeparit, Rainbow, Hopetoun

East Wimmera: Stawell*, Ararat*, Willaura, Maryborough*, Dunolly

Mid- Northern Mallee: Swan Hill*, Kerang*, Manangatang

Northern Mallee: Mildura*, Robinvale, Ouyen, (Wentworth, Balranald)

NB: TWOH towns without hospitals having GP practices significantly contributing to acute Health Care

12. Existing hospital Network

(#)

Apart from 7 Base hospitals, there are 94 hospitals with < 500-550 local GPs who are mostly VMOs. (No reliable statistics available). 11 have additional specialists who in sub-base hospitals work with GP VMOs. 35 have Obstetrics, 51 no obstetrics. 46 have no theatre or anaesthetics or GP anaesthetists to provide emergency airway management. A number of these towns do not have ambulance services either. Most smaller hospitals are staffed by Overseas doctors who in the main are a transient workforce awaiting the opportunity to practice in or near to a metropolitan zone. Many end up in Perth and Sydney. A considerable number have worked as proceduralists in South Africa but only a proportion are practising their skills in larger locations that need them and are currently absolutely dependent on their recruitment for continuation of obstetrics and other major hospital functions.

Regional Base with full specialist roster: Wodonga (Albury) (7)

Wangaratta (shaky obstetrics), Shepparton, Bendigo (concerned about obstetrics), Geelong (regarded as rural by State), Ballarat, Warrnambool (shaky obstetrics).

Sub-Regional: specialist roster complemented by VMOs (4):

Hamilton, Horsham. Sale, Warragul.

Procedural GP VMO hospital with obstetrics and active theatre (35):

Major: Bacchus Marsh, Bairnsdale, Echuca, Kilmore, Swan Hill, **Large:** Benalla, Colac, Kilmore, Kyabram Wonthaggi, **Medium:** Ararat, Camperdown, Castlemaine, Cohuna, Foster, Kerang, Kyneton, Leongatha, Mansfield, Seymour (Just reopened), Maryborough, Myrtleford, Orbost (intermittent), Portland, Stawell, Terang, Timboon (? operational), Yarrawonga. **Small:** Bright, Castlemaine, Mt Beauty, Orbost (intermittent), St Arnaud, Terang. (Closed '08 Daylesford and Timboon).

Hospitals with small degrees of theatre activity (5)

Corryong, Korumburra, Lorne, ? Maffra, Port Fairy.

Non-procedural GP VMO hospital locations. (46):

Alexandra, Apollo Bay, Ballan, Beaufort, Beechworth, Birchip, Boort, Casterton, Charlton, Cobram. Cohuna, Coleraine, Corryong, Creswick, Dimboola, Donald, Edenhope, Euroa, Heathcote, Heyfield, Heywood, (Hopetoun), Inglewood, Jeparit, Kaniva, Manangatang, Nagambie, Nathalia, Neerim, Nhill, Omeo, Ouyen, Peshurst, (Rainbow) Robinvale, Rochester, Sea Lake, Skipton, St Arnaud, Warracknabeal, Wedderburn, (Willaura), Wycheproof, Yackandanda, Yarram, Yea. (in brackets =no resident doctor).

Note: These hospitals have mostly had major bed cuts with closure of obstetrics and theatre. Most of them operate shared on-call rosters with neighbouring towns. Having lost the viable mix of services they are not cost-effective in terms of inpatient care. Doctors are often pressured to transfer rather than offer potentially life-saving treatment such as thrombolysis. Many if not most will lose inpatient beds unless there is in principal agreement to continue local inpatient management of acute geriatric conditions and palliative care. An alternative is to manage more conditions in local extended care units. There will however be problems keeping resident doctors in such locations as already happened (see below).

(#)

13. 2007 Listed On-call Rural VMO 'Enhancement Package' locations (89), (* No Beds 9)

Alexandra DH, Apollo Bay, Ararat, Bacchus Marsh, Birchip, Ballan DHC , Beaufort, Beechworth HS, Benalla Dand MH, Boort DH, Bright,, Camperdown, Casterton, Castlemaine, Charlton, Cobden DHS*, Cobram DH , Cohuna DH, Colac Area HS, Coleraine, Corryong, Creswick DH, Daylesford DH, Dimboola DH, Donald, Dunolly*, Edenhope and DH, Euroa H, Foster, Healesville, Hopetoun, Heathcote, Heyfield H, Heywood RH, Inglewood DandHS, Jeparit,

Kaniva, Kerang DH, Kilmore and DH, Kooweerup RHS*, Korumburra, Kyabram and DHS, Kyneton DHS, Leongatha MH, Lorne CH, Maffra, Maldon H?*, Manangatang and DH, Mansfield DH, Maryborough, Mt Beauty, Myrtleford, Nagambie H, Nathalia DH, Neerim D Soldiers Memorial H, Nhill, Numurka DandHS, Omeo DH, Orbost RH, Ouyen, Peshurst DandMH, Port Fairy H, Portland DH, Rainbow, Robinvale DHS, Rochester and Elmore DHS, Rupanyip*, Rushworth (Waranga)*, Sale, Sea Lake DandH, Seymour DMH, Skipton (GP non-resident), Stawell RH, St Arnaud, Tallangatta HS, Tatura*, Terang and Mortlake, Timboon and District HS, Walwa*, Warley H, Warracknabeal, Warragul, Winchelsea?*, Willaura (no doctor), Wonthaggi, Yackandandah BNH, Yarram and DHS, Yarrowonga DHS, Yea and DHS.

Under the Rural Enhancement Package the State provides an on call allowance for Group C to E locations which has just risen from \$3 per hour to \$7 approximately, or a per diem of \$150 per week-day, \$200 for week-ends and \$250 for public holidays, for 24 hour periods on call, very far below that paid in Base hospital casualties for 8 hour shifts, or to specialists for being on call. The total of \$63,401 is the same for every location regardless of size. It does not cover attendances but only availability.

14. Larger hospitals without Rural enhancement Packages: 16 (#)
Mainly VMO GP: Bairnsdale, Echuca, Swan Hill, Wonthaggi
Mixed GP/Specialist: Horsham, Hamilton, Sale, Traralgon, Warragul, Wodonga
Predominantly Specialist: Ballarat, Bendigo, Shepparton, Wangaratta, Wodonga, Warrnambool

15. Details of Victorian rural GP VMO locations These have been subsumed into table 24.
 'Victorian Rural GP VMO location Rurality Indices as at 28.1.09' (#).

16. Bush Nursing Centres with no resident doctor, (many branch surgery): (33) (#)
 Balmoral, Beeac*, Beulah, Buchan, Cann Valley, Chiltern, Dartmoor, Eildon, Elmhurst, Gelantipy, Dargo, Dingee, Harrow, Lake Bolac, Lockington, Mallacoota, Merino, McCarthur, Murrayville*, Patchewollock, Pyramid Hill*, Quambatook, Swifts Creek, Trentham*, Underbool, Violet town, Woomelang. Role of nurses not ascertained in: Yackandandah, Maldon, Lismore, Mortlake, Birregurra, Tatura. *hospital closed since 1983.

17. Victorians living in poverty by electorate. Age Newspaper 24.5.05 (#)
 • 11.1% or more: All rural Victoria and Gellibrand except below
 • 9.6 - 11%: Calwell, Lalor, Gorton, Maribynong, Melbourne, Wills, Batman, Scullin
 • 7.6 - 9.5%: McEwan*, Corangemite*, Hotham, Bruce, Issacs, Dunkley (*Rural)
 • 5.1 – 7.5%: Casey, LaTrobe, Jagajaga, Menzies, Deakin, Chisolm, Aston, Holt, Ports.
 • 5% or less: Kooyong, Higgins, Goldstein

NB. Henderson half average poverty line = 1/2 average equivalent disposable household income for a standard household.

18. First (worst) quintiles of Victorian poverty by postcode. Jesuit studies 2003 (#)
 3242 Birregurra**, 3322 Cressey; 3324 Lismore**, 3333 Meredith; 3360 Linton; 3370 Clunes**, 3371 Talbot (Clunes hospital); 3412 Goroke; 3424 Jeparit*; 3475 Bealiba; 3448 Elphinstone; 3462 Newstead; 3467 Avoca**, 3472 Bet Bet; 3518 Wedderburn**, 3523 Heathcote*; 3563 Lockington; 3580 Koondrook (Barham hospital*); 3594 Nyah (Nyah West Hospital); 3595 Nyah West**, 3612 Rushworth; 3821 Neerim*; 3833 Noojee; 3887 Nowa Nowa; 3889 Cape Conran. **Hospital closed; *Loss of Hospital Services.

19. Australian Life Expectancy at birth by Region 1997 – 2000 (AIHW) (#)

	Major City	Inner Regional	Outer Regional	Remote	Very Remote	
M / F	76 / 81	75 / 80.5	74 / 79.5		73 / 78.5	68.5 / 73.5

Note: blanket statistics such as Life expectancy are a very crude measure of health, seriously mask discrepancies with groups, and do not register physical incapacity.

20. Relationship between distance to hospital and patient mortality in emergencies:

Increased journey distance to hospital (by ambulance in the UK in distances up to 58 Km) appears to be associated with increased risk of mortality. Data suggest that a 10-km increase in straight-line distance is associated with around a 1% absolute increase in mortality. *Emergency Medicine Journal* 2007;24:665-668 <http://emj.bmj.com/cgi/content/abstract/24/9/665>

21. Some sample distances in Victoria:

(#)

• Mallacoota to Orbost	147
• Orbost to Bairnsdale	90
• Bairnsdale to Traralgon	132
• Wonthaggi to CBD	118
• Mansfield to CBD	210
• Seymour to CBD	90
• Colac to Geelong	74
• Camperdown to Warrnambool	69
• Portland to Hamilton	86
• Nhill to Horsham	74
• Ararat to Ballarat	92
• Wycheproof to Bendigo	128
• Birchip to Horsham	123
• Hopetoun to Horsham	121

(#)

22. RDAA 2007 Statement Emergency in Rural Australia: (#) Recommendations

Recommendation 1: Quarantined funding for on-site multidisciplinary training and cross-placements for all rural emergency care teams should underpin mandatory professional development appropriate to the setting.

Recommendation 2: A Rural Health Obligation based on minimum standards of access and services, including emergency care, should be developed with and for rural communities.

Recommendation 3: Jurisdictions should develop integrated emergency service networks based on local health care provision complemented when necessary by coordinated regional and metropolitan retrieval systems.

Recommendation 4: An integrated rural emergency skills curriculum designed for segmented local team delivery should be developed by ACCRM, RACGP, ACEM and the nursing and allied health colleges.

Recommendation 5: The MBS Items relevant to rural emergency care should be adjusted to reflect the real costs of this care and best practice in providing it.

Recommendation 6: Governments and key stakeholder organizations should develop a national framework for emergency management systems, including basic training, infrastructure, communications and equipment, that allows for flexible application at a jurisdictional and regional level.

(#)

23. VHA Emergency service position statement recommendations (#)

1. The VHA recommends the development of a comprehensive plan to address the on-call crisis being experienced across rural Victoria by improving community access to appropriate primary health care services. This must include dedicated funding and structures to facilitate the systematic use of telemedicine to support clinicians in rural health services.

2. The VHA recommends that a strategic review of emergency services provision in Victoria be undertaken. This review must address the issues impacting service sustainability including:

- Access and proximity to other emergency services and after-hours medical services

- Demand issues experienced in high population growth areas and weekend/holiday destinations
- Costs borne by health services into the provision of urgent and emergency services

The VHA proposes that "a funding initiative similar to the state-wide Maternity Initiative be developed, providing grants to health services to support them in developing local service delivery solutions."

3. The VHA recommends that industry agreement be sought and systems implemented for data collection systems for all emergency, urgent and primary care centres across Victoria to ensure a consistent approach for presentations

4. The VHA recommends a plan for rural emergency service provision that:

- Addresses significant workforce issues facing rural Victoria to assist services to recruit and retain a sustainable workforce
- Addresses the issues associated with the maintenance of "currency of practice" requirements for nursing staff, including funding and articulation of strategies for maintaining clinical practice

5. That DHS partners Ambulance Victoria and Rural Health Services to investigate the role ambulance services can play in service provision (#)

24. Victorian Rural GP VMO locations and Rurality Indices as at 28.1.09

The RRMA – Remote, Rural and Metropolitan Area Classification – has been terminated on 1.7.09. What has taken its place is not entirely clear at the time of writing, The table below contains the various systems in use and was compiled from the following sources:

Health workforce Queensland website search facility for RRMA and GPARIA

<http://www.healthworkforce.com.au/>

http://www.healthworkforce.com.au/main_rrma.asp?NodeID=27679

http://www.healthworkforce.com.au/main_GPARIA_search.asp

DoHA 'Advice on Districts of workforce shortage for GPs'

http://www9.health.gov.au/otdw/dws_database/cf/index.cfm

ASGC – Australian Standard Geographical Classification with added ARIA – Accessibility Remoteness Index Australia (As favoured by ABS over the old RRMA – Remote Rural Metropolitan Area classification for use in determining federal grants to rural GPs). Cut offs: Metro <0.2, Inner Regional (IR) <2.4, Outer Regional (OR) 2.5 <5.92, more = remote (R), 15 = very remote (VR).

GPARIA Category Definitions: (Used for rural retention grants)

* Category A – (Least remote category under the GPARIA index. Rural Retention Payments are generated up to \$5,000 upon qualifying (6 years or 24 active quarters) and each year following 4 more active quarters. An "Active Quarter" is when Medicare billing is equal to or greater than \$4,000 per quarter to a maximum of \$20,000 per quarter.)

* Category B – (Rural Retention Payments are generated up to \$10,000 upon qualifying (5 years or 20 active quarters) and each year following 4 more active quarters. An "Active Quarter" is when Medicare billing is equal to or greater than \$4,000 per quarter to a maximum of \$20,000 per quarter.)

* Category C – (Rural Retention Payments are generated up to \$15,000 upon qualifying (3 years or 12 active quarters) and each year following 4 more active quarters. An "Active Quarter" is when Medicare billing is equal to or greater than \$4,000 per quarter to a maximum of \$20,000 per quarter.)

* Category D – (Rural Retention Payments are generated up to \$20,000 upon qualifying (2 years or 8 active quarters) and each year following 4 more active quarters. An "Active Quarter" is when Medicare billing is equal to or greater than \$4,000 per quarter to a maximum of \$20,000 per quarter.)

* Category E – (Most remote category under the GPARIA index. Rural Retention Payments are generated up to \$25,000 upon qualifying (1 year or 4 active quarters) and each year following 4 more active quarters. An "Active Quarter" is when Medicare billing is equal to or greater than \$4,000 per quarter to a maximum of \$20,000 per quarter.)

Details of Victorian rural GP VMO locations and Rurality.

VMO hospital towns	Total GP	So-lo	Grp	Com-ment	Pro-ced-ural	ASGC + ARIA	ARIA	RR MA	GP ARIA	ZO NE	DWS 29/1/09
Alexandra	3		2			2.32	3.85	3	B	IR	Y
Apollo Bay	4		2			2.13	2.29	5	B	IR	Y
Ararat	9		1		Obs	1.47	1.51	5	B	IR	Y
Bacchus M	13		2		Obs	0.27	0.49	5	N/E	IR	N
Bairnsdale	22	1	2		Obs	2.43	2.46	4	B	IR	N
Ballan	2		1	Super Cl		0.73	0.84	5	A	IR	Y
Beaufort	1	1				1.28	1.41	5	B	IR	Y
Beechworth	6		1			1.37	1.47	5	A	IR	Y
Benalla	16		2		Obs	1.31	1.33	5	A	IR	N
Birchip	1	1				4.87	3.86	5	C	OR	N
Boort	1	1				3.72	2.87	5	C	OR	Y
Bright	3		1		Obs	2.45	2.54	5	B	IR	N
Camperdown	8		2		Obs	1.85	1.86	5	A	IR	N
Casterton	5		1			3.09	3.04	5	B	OR	Y
Castlemaine	15		4		Obs	0.6	0.71	5	N/E	IR	N
Charlton	1	1				2.87	2.98	5	C	OR	N
Cobram	10		2			1.93	2.25	5	B	IR	N
Cohuna	4		1		Obs	2.6	2.62	5	B	OR	Y
Colac	13		2		Obs	1.11	1.2	4	C?	IR	Y
Coleraine	5		1			2.76	2.73	5	C	OR	Y
Corryong	3		1		The	3.05	3.16	5	C	OR	Y
Creswick	4		1			0.54	0.89	5	C	IR	Y
Daylesford	8		2		Obs	1.04	1.15	5	C	IR	N
Dimboola	2		1			3.74	3.69	5	C	OR	N
Donald	1		1			3.19	3.19	5	C	OR	N
Echuca	19		2		Obs	1.27	1.34	4	A	IR	Y
Edenhope	3		1			5.28	3.97	5	A	OR	Y
Euroa	5		1			1.7	1.75	5	A	IR	Y
Foster	6	1	2		Obs	1.98	2.28	5	C	IR	N
Hamilton	11		1		Obs	2.59	2.32	5	C	OR	Y
Healesville	4		1		Obs	0.25	0.83	5	A	IR	Y
Heathcote	2	1				1.1	1.28	5	A	IR	Y
Heyfield	2		1			1.62	1.93	5	A	IR	Y
Heywood	2	2				2.73	2.68	5	A	OR	Y
Hopetoun	1	1				6.06	4.57	5	C	R	Y
Horsham	11		3		Obs	2.88	2.83	4	C	OR	N
Inglewood	1		1			4.69	3.46	5	B	OR	Y
Jeparit	1		1			5.28	4.43	5	C	OR	N
Kaniva	1		1			5.69	4.57	7	C	R	Y
Kerang	7		2		Obs	2.74	2.75	5	C	OR	Y
Kilmore	8	1	2		Obs	0.87	1.21	5	N/E	IR	N
Korrumburra	8		1		The	1.27	1.61	5	A	IR	N

Kyabram	10	1	1		Obs	1.02	1.11	5	C?	IR	Y
Kyneton	4	1	1		Obs	1.13	1.22	5	N/E	IR	N
Leongatha	11+		1		Obs	1.48	1.78	5	A	IR	Y
Lorne	1	1				1.35	1.62	5	A	IR	Y
Maffra	7		2			1.72	2.01	5	A	IR	N
Manangatang	1	1				5.21	3.97	5	C	OR	Y
Mansfield	9		2		Obs	2.45	2.55	5	A	?	N
Maryborough	6		2		Obs	1.01	1.66	4	A	IR	N
Mt Beauty	5	1	1		Obs	2.44	2.53	5	A	?	N
Myrtleford	6		1		Obs	1.74	1.88	5	B	IR	N
Nagambie	1	1				1.3	1.38	5	A	IR	Y
Nathalia	3		1			1.78	1.81	5	B	IR	N
Neerim	2		1			1.53	1.51	5	A	IR	N
Nhill	3		1			4.45	4.25	5	C	OR	N
Numurkah	7		2			1.67	1.71	5	A	IR	N
Omeo	4		1			5.15	3.76	5	C	OR	Y
Orbost	2		1		Obs	4.13	4.17	7	C	OR	Y
Ouyen	1	1				4.06	4.03	4	C	OR	Y
Penshurst	1	1				2.73	2.14	5	B	OR	Y
Phillip Island	5		1			1.75	2.02	5	A	IR	N
Port Fairy	5		1			1.93	2.03	5	A	IR	N
Portland	13	1	3		Obs	2.62	2.61	4	B	OR	Y
Rainbow				visit		6.37	4.88	5	C	R	N?
Robinvale	3	2				4.07	3.96	5	C	OR	N
Rochester	2	1				1.33	1.41	5	A	IR	Y
Rupanyup	1					3.99	3.06	5	B	OR	Y
Rushworth	1	1				1.89	1.36	5	B	IR	Y
Sale	25		4		Obs	1.53	1.76	4	A	IR	Y
Sea Lake	2		1			5.42	3.9	5	C	OR	N
Seymour	11	1	2		Obs	1.02	1.2	5	A	IR	N
Skipton	1	1		? new		2.09	1.52	5	B	IR	?
St Arnaud	2		1		Obs	2.51	2.52	5	B	OR	Y
Stawell	9		2		Obs	1.92	1.94	5	B	IR	Y
Swan Hill	10		1		Obs	2.95	2.91	5	B	OR	Y
Tallangatta	2		1			2.18	1.55	5	B	OR	Y
Terang	4		1		Obs	1.82	1.83	5	A	IR	N
Timboon	2		1			2.41	1.96	5	A	IR	Y
Traralgon	17	2	2		Obs	0.81	1.07	4	N/E	IR	N
Walwa	1		1			3.72	NaN	5	C	OR	Y
Warburton	5		2		?	0.54	1.25	5	N/E	IR	TBA
Warracknabea l	1	1	2			3.7	3.67	5	C	OR	Y
Warragul	28	3	3		Obs	0.81	1.12	5	N/E	IR	N
Willaura				Visit		2.96	2.19	5	B	OR	Y
Winchelsea	1	1				0.91	1.11	5	N/E	IR	Y
Wodonga	Inade quate Info		>2	12 GPO	Tert	0.66	0.72	3	N/E	IR	Y

Wonthaggi	17		2		Obs	1.1	1.43	5	A	IR	N
Wycheproof	1	1				3.79	3.25	5	C	OR	N
Yarram	2	2				2.04	2.29	5	B	IR	Y
Yarrawonga	11		2		Obs	1.49	2.04	5	B	IR	N
Yea	4		2			2.03	1.75	5	B	IR	Y
					Obstetric s 37						

locations = 93 525 37 103

25. Medical Indemnity/Insurance for Victorian rural doctors. (#)

The Victorian Managed Insurance Agency operates a dedicated indemnity package for doctors working in the Victorian rural combined community and hospital sector, the Rural General Practice Program. One town now without a hospital but dealing with emergencies, namely Cowes, is currently covered by the package. The package arose out of an obstetric indemnity crisis in 1996 when the bulk of the GP Obstetrician workforce was seriously contemplating withdrawing their services because of cost reasons. Since then RDAV has liaised closely with the VMIA to continually evolve and fine-tune the package so that it covers and adapts to the full range of rural GP activities, including Emergency, Obstetrics, Anaesthetics, Inpatient work, work that crosses over from the hospital to the practice (especially obstetrics), medical and other student teaching, full practice operation, interactions with visiting specialists, and interaction with the plethora of community health services with in town and in other hospitals, bush nursing centres and so forth. The package is structured to remove all obstruction for doctors to both transfer into and retire from the rural sector, and to assist other rural doctors in all States by performing locums. 'Good Samaritan' medicine is fully covered, including disasters like the Kerang Rail disaster. More details of the package may be found off the home page of the website at <http://www.rdav.com.au/medicalIndemnity.html>. The program is overseen by the DHS. This program has probably by itself slowed down the decline in the rural GP workforce. There are other packages available through various MDOs such as MIPS and Avant and others Interstate. These mirror the RGPP but since details are confidential it is not known whether they fully match the comprehensive range offered by the RGPP. A number of isolated rural GPs in towns without hospitals are debarred from the program except for Phillip Island (on a provisional basis). Despite it's RRMA 5 classification, doctors working in Healesville Hospital are also debarred under DHSV instruction. (#)

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Acronyms

[\(#\)](#)

ACEM	Australian College of Emergency Medicine
ACRRM	Australian College of Rural and Remote Medicine
AIHW	Australian Institute of Health and Welfare
AMA	Australian Medical Association
AMC	Australian Medical Council
ABS	Australian Bureau of Statistics
ALSO	Advanced Life Support Obstetrics
AO	Ambulance Officer
APLS	Advanced Paediatric Life Support
ASGC	Australian Standard Geographical Classification
AED	Accident and Emergency Department
ARIA	Area Remoteness Index Australia (also GP-ARIA)
ARRWAG	Australian Rural and Remote Workforce Agency Group
ARV	Adult Retrieval Victoria
AV	Ambulance Victoria
BNC	Bush Nursing Centre
CERT	Community Emergency Response Team
COAG	Council of Australian Governments
CWA	Country Women's Association
DHSV	Department of Human Services Victoria
DHSQ	Department of Health Queensland
ED	Emergency Department
EMST	Emergency Management of Severe Trauma
EEC	European Economic Community
EPC	Extended Primary Care
ALS	Advanced Life Support
ELS	Emergency Life Support course
EMS	Emergency Management Services
FACEM	Fellow of Australian College of Emergency Medicine
FACRRM	Fellow of the College of Rural and Remote Medicine
FARGP	Fellowship of Australian Rural General Practice
GEM	Generalist Emergency Medicine
GP	General Practice
RGPP (VMIA)	Rural General Practice Program (VMIA)
HCA	Health Care Agreement (State/Commonwealth)
IMG	International Medical Graduate
LRH	Latrobe Regional Hospital
MAS	Metropolitan Ambulance Services (since merged)
MICA	Mobile Intensive Care Ambulance
NETS	Newborn emergency transport services
NP	Nurse Practitioner
OTD	Overseas Trained Doctor
PERS	Paediatric emergency retrieval service
PETS	Perinatal emergency transfer service
RACGP	Royal Australian College of General Practitioners
RAV	Rural Ambulance Victoria (since merged)
RDAV	Rural Doctors' Association Victoria
RDAA	Rural Doctors' Association Australia
REST	Rural Emergency Skills Training
RRMA	Remote Rural Metropolitan Area
RWAV	Rural Workforce Agency Victoria
SES	State Emergency Services
VAHEC	Victorian Aged Health and Extended Care association
VCE	Victorian Certificate of Education
VFF	Victorian Farmers' Federation
VHA	Victorian Hospitals Association
VHIA	Victorian Hospitals Industrial Association
VMIA	Victorian Managed Insurance Agency
VMO	Visiting Medical Officer
VRDCU	Victorian Rural Divisions Coordinating Unit