Good Health for Victorian Rural Communities

A consensus statement of the

Country Women's Association of Victoria
Rural Doctors Association of Victoria
Victorian Farmers Federation

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The above organisations call for full political commitment to upgraded systematic provision of emergency, acute and community medical services to outer regional and rural areas of Victoria, in particular:

- obstetric, emergency and urgent services within one hour's drive from all homes in rural Victoria
- emergency transfer structure set at a national standard
- proper and adequate rural input into statewide provision of medical services
- due consideration for high poverty rates in rural areas, in particular to minimise travel to all forms of care
- strategies to provide more rural doctors and nurses in the short, medium and long term
- expanded genuine and effective State and Commonwealth collaboration with proper sharing of responsibilities for rural medical issues.

Why?

The farming economy needs good health support, for the workers and families both of farmers and sundry support industries. Poor medical service leads to young and old people leaving rural towns and to reduced attractiveness for both professional and agricultural workers.

Urgent medical care is particularly important at crucial times of the farming cycle. Decreasing rural population inevitably leads to reduced output in all industries, both primary and support. Victoria's primary production is a major component of State output and hence export income. Victoria currently leads other States in farming indices but, notwithstanding some natural population shift that is occurring, there are real concerns about the effects of rural rundown on core farming population and agricultural output. Medicare underspend on rural areas is $25 per head less than the $193 spent on the metropolitan and regional population.

Loss of urgent care network: Two decades ago farming communities were all well served by a small hospital network which provided effective urgent, emergency and obstetric care. Doctors undertook their own training, very often overseas. Despite repeated acknowledgement of the safety and effectiveness of care provided, particularly for obstetrics, virtually the entire network is in the process of disappearing. 85 rural obstetric units have closed, with more expected to close this year. Rural health care increasingly requires transport to distant locations. Most small locations have lost some or all principal services but the crisis is now spreading to medium sized towns, whose hospitals are found increasingly on standby, and on current manpower projections have no guarantee of an adequate range of hospital services in 5 years' time.

Medical manpower provision is increasingly worrisome: Rural medical services depend on a supply of doctors competent as sub-specialists in a wide variety of disciplines, particularly with skills in emergency care, anaesthetics, obstetrics and surgery. The skills and availability of rural doctors determine the presence, absence and nature of hospital services. Rural doctors retire and move on, but for 15 years have not been progressively replaced by doctors with training in these skills. The average age of rural GP proceduralists (those who undertake anaesthetic, obstetric and surgical work) is over 50. Most retire after 55.

Although Commonwealth heads of State have recently recognised rural medicine as "a distinct Generality", there remains no overt recognition, no proper training, only 10 procedural training places for the State, and no transparent and dedicated system of remuneration. Why choose a rural career when softer options are as well-remunerated? Certainly few GP registrars in the Regional Training Programs are currently prepared to undergo dedicated rural training. An increasing number of significantly sized rural population clusters now have no resident doctor.

Dependence on transport: Access to rural medical services is increasingly dependent on medium to long distance transport, with particular reliance on private transport. This may suit well-resourced individuals and families, but poverty rates rise from below 5% in the CBD to above 11% for Victoria outside the greater metropolitan area. Poverty figures are not available for rural as opposed to regional, but experience and studies suggest that rates of over 20% are not uncommon. These families do not have access to unlimited time, transport and accommodation in referral centres. Total cost per kilometre is well over 60c for private transport. Medical conditions require flexible, often immediate transport. Sickness becomes an element of the poverty cycle. A single illness at a bad time can spell ruin for the farmer. Rural ambulance services are overstretched but there seems to be an assumption that they can be expanded to cover any increased need generated by loss of local services. This is simply not true.

Political commitment is sought for the following:

Obstetric, emergency and urgent services within one hour's drive from all homes in rural Victoria: It is universally accepted that travel to urgent medical care in excess of a ½ hour *from onset* substantially increases risk of complications in trauma, medical conditions and obstetric labour. The previous network of facilities allowed such access, but economic rationalisation in rural areas has put it out of reach. In default, it is suggested that the level of one hour access should be maintained for the future as an absolute standard. Much will have to be done to ensure this. Specific measures include:

- major State-based workforce commitment to obtain and retain doctors and nurses in rural hospitals
- genuine State support measures to prevent closure of those rural maternity units still open
- a minimum standard of medical equipment and training for advanced life support in all hospitals and health facilities, with guaranteed recurrent funding for upgrades and training
- continuance of the present program of renewal and expansion of hospital/health service infrastructure, but with better State matching of local fundraising
- increased co-location of medical practices, health facilities, hospitals and ambulance services in small towns
- infrastructure support for rural medical practice
- improved and systematic support for and expansion in numbers of Bush Nursing locations, given present disparities and the increasing number of doctor-less locations
- integration of rural mental health services into the general medical system rather than as a separate and stigmatised service
- annual reporting of obstetric outcomes from rural postcodes retrospective for at least a decade to track adverse outcomes from delivering far from home

Emergency transfer structure set at a national standard: Despite improvements to perinatal and neonatal transfer, it has to be accepted that Victoria has a standard of other transfer, as well as access to critical care, set somewhat below that of other major States.

Until now, Victoria's rural medical capability has traditionally compensated for this. Weather conditions can prevent airlift for over 24 hours, making it often safer to stay put. With rural GP proceduralists disappearing, the situation is less acceptable.

It is recommended that Government commits policy to:

- the creation of a single dedicated critical transport service with its own air transport
- an increase in intensive care beds to a population ratio comparable to best States
- geographical responsibility for receiving Melbourne hospitals to have a 'no closed doors' policy
- an ambulance communications system that allows direct communication between transport and all destination hospitals including rural
- provision of better monitors for road ambulances carrying serious cases

Proper and adequate rural input into statewide provision of rural services: Political direction is requested to lessen the invariable metropolitan and regional dominance of rural matters, with disproportionate representation on taskforces, working groups and committees. The summary termination of Red Cross Blood Transfusion Service volunteer collection after a massive rural effort lasting many years is a good example. Key measures required are:

- restitution of rural volunteer Red Cross blood donor collection units
- institution of non-onerous consultation mechanisms

Due consideration for high poverty rates in rural areas, in particular to minimise travel to all forms of care: Poverty, mental and physical illness, adverse occurrences such as the present drought, and lack of accessible medical and social services, all interact to maintain inequitable distribution of wealth and health in the State. Lumping rural and regional health policy-making together disguises the real situation, skews policy and has a net effect of maintaining both poverty and inexorable pressure on rural families to leave their sector, often not to their benefit. Travel assistance must include:

- expansion and improved funding of the Victorian Patient Transport Assistance Scheme. (The current subsidy is 14 cents per kilometre versus an actual cost of 60 cents)
- systematic provision of free accommodation close to major urban and provincial hospitals
- properly funded transport and accommodation assistance for the families of women forced to give birth out of their local community because of maternity unit closure

Strategies to provide more rural doctors and nurses in the short, medium and long term: Government policy is urgently requested to address the accelerating shortage of properly trained rural doctors, particularly those with emergency, anaesthetic, obstetric and surgical skills. A transient, and now disappearing, influx of overseas trained doctors has disguised this critical shortage for the last 5 years or so. Rural requirements are markedly different from regional and require distinct affirmative policies. Rural medical manpower provision is a joint State and Commonwealth responsibility but lacks State policy. Health Insurance Commission funded community practice medical manpower in regional centres is purely a Commonwealth responsibility.

Approximately 550 rural doctors are required in Victoria, all with emergency skills, and up to half with training in either obstetrics or anaesthetics. Current State policy initiatives are directed solely at medical scope and standards and ignore workforce supply. With the average age of the remaining rural GP proceduralists in Victoria topping 50 years, a critical shortage is rapidly approaching. Rural medical schools are being created but there is no future guarantee that rural doctors will be there to teach. The present generation of rural doctors must be used to train the next before they retire or become too over-burdened to teach. Matters to be addressed include:

- a need for increased immediate and medium term supply of doctors through overseas recruitment for 5-8 years until the success of rural training programs and incentives is guaranteed, with proper support processes to ensure settling in of the recruited doctors
- consistent and appropriate policy, remuneration and support statewide for rural doctors working in rural hospitals to replace the present system of individual contracts. This should be set at a level which competes favourably with federally funded community medical practice, especially in metropolitan and large regional centres. It should also encourage doctors to reside in, and be available for after-hours on-call work, in the town of practice.
- consideration of additional support for doctors in certain towns without hospitals, particularly with infrastructure, equipment and emergency attendance item numbers
- systematic provision of adequate hospital training posts in obstetrics, anaesthetics and surgery (minimum 20 posts) for medical graduates willing to commit to a future rural career
- provision of rural doctor combined community and hospital residencies for first and second year medical graduates to make use of the expected medical school output

In addition to specific measures to boost the number of rural doctors in Victoria, State policy must also ensure an adequate number of specialists in major regional centres.

Expanded genuine and effective State and Commonwealth collaboration where responsibilities are shared. As stated above, rural medical manpower provision is a joint State and Commonwealth responsibility. Recent very preliminary COAG co-operation signalled recognition for rural medicine and extra funding for attendances at small rural hospitals. This needs progression to real acknowledgement of rural realities and problems and specific strategies for the rural situation.

For further information and contact details:
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