Moura & Districts Health Care Association Inc

ABN 22 412 437 365 Incorporation No. IA30591
PO Box 31, Moura Qld 4718

President: John MacTaggart
Phone: 07 4997 3440
Fax: 07 4997 3441
Email: jj2m@bigpond.com

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Moura and District Health Care Assoc Inc is a voluntary community association with membership free for all local ratepayers. Our mission is Sustainable Quality Healthcare for our community.

Moura's pro-active District Healthcare Association (MDHCA) was formed in 2001 with its main objective 'to attract and retain appropriate health care services for the community of Moura and adjoining districts'.

MDHCA constantly strives to achieve sustainable quality healthcare, and recognises as a priority, the attraction and retention of Doctors and supporting health professionals for the district. MDHCA also plays a critical role as the principal facilitator of the collaboration between Queensland Health and the community. A community profile also developed by MDHCA aims to answer any questions that may arise by health professionals considering re-location. Over the last ten years we have raised the funds and built an executive style house to help to attract a second fulltime doctor to our community.

The amalgamation of the former single doctor private practice (owned by the Moura Community) with that of the Medical Superintendent demonstrates clearly that the community fully appreciates the critical role of doctors operating in regional centres and the need to provide where possible, support mechanisms (e.g. Medical Officer with Right to Private Practice) to ensure long-term sustainability.

In further support of this recognised critical role, the Moura District Healthcare Association was instrumental in lobbying Queensland Health to build a modern purpose-built Medical Centre with the capacity to meet future demands. Through the Banana Shire council we applied for and received a NRRHIP grant to fully equip our then new GP clinic.

MDHCA also has the support of Anglo Coal with a generous donation of land for the new doctor's house, and the ongoing support of other industries and businesses within the Moura and district community.

Our town is in the heart of the Dawson Valley in the Bowen Basin. The main industries are open cut coal mining, explosives manufacturing and agriculture, irrigated and dryland grain, pulse and cotton cropping and ginning. Much of the surrounding area is involved in large scale beef production. The Coal Seam Gas industry is in production and in the midst of a massive ramping up phase. Many of these industries have high statistical injury rates.
The vast bulk of all production is exported through the port of Gladstone earning overseas currency to help to sustain our Australian high standard of living.
Current mining exploration within the Moura district indicates the population could double in the next five to ten years.

Just prior to Christmas we became aware, indirectly, that the new local hospitals board was intending to close our 10 bed hospital forthwith and replace it with a 16 hour a day , triage and ship-out service based in our GP clinic. An as yet undefined call out system would be intended to cover the other 9 hours.
This is in spite of the current Central Queensland Health Service plan showing a need for 4 acute beds in 2021.
We have been told that the motivation for this drastic action results from the cuts in funding under the National Health reform process. The urgency we understand is because of the need for our Central Queensland Health and Hospital Board to find extra savings of $4.8m before the end June on top of the cut of many millions that were already factored into their budget early in the financial year. We are also told to expect further cuts to funding next year.

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Our community accepts the need for change and the efficient use of taxpayer's funds. However we believe that as outlined in the reform documentation we are entitled to a health service approaching that of urban areas.

A third of Australia's population lives outside major cities. Many residents of the 1500 rural and remote communities with fewer than 5000 inhabitants face significant health disadvantage and reduced access to services. In a wealthy country such as Australia, this inequity is unacceptable.[1]

[1] https://www.mja.com.au/journal/2009/191/2/features-effective-primary-health-care-models-rural-and-remote-australia-case

The CQHHB eventually presented their proposal to a public meeting on 17th January. A very large crowd of over 550 extremely concerned citizens listened intently and then soundly rejected the proposed closure.
Currently a community reference group is meeting weekly with senior staff of CQHHB trying to find a mutually acceptable solution. This is proving a difficult task as 4 weeks later the proposal to close the hospital is still on the table and it is very difficult to extract financial details etc from the board staff.

The community's reasons for rejection include there then being no facility for inpatients, elderly or children, who might only need observation or minor treatment over a number of hours especially at night. There would be no service, other than by calling out a stand-by nurse, who would not probably be on the premises, between midnight and 9 am. We do not have a residential aged care facility. The cost of the Helicopter to our regional hospital is $6000 per patient plus $1500 in ambulance fees.

The clinic does not include a Holding bed facility for patients waiting to be transferred out; the wait is often many hours. Nor does it have such things such as x-ray facility, piped oxygen, back-up electricity system and has no dedicated space for patient records currently the responsibility of QH etc. No attempt appears to have been made to address the multitude of problems for patients, staff or doctors with regard to public patients, who are QH responsibility, being treated in a private practice scenario, or QH staff working with private practice equipment and supplies in the out of hours timeframe.

Accurate statistics are somewhat hard to obtain as the area of our footprint covers more than one postcode area .Our best estimate for the covered area is in excess of 4250 residents and between 1600 and 2000 drive in drive out workers in camps on any one night.
Surely large enough to sustain a small efficiently run inpatient hospital.

Moura is by no means the smallest or least efficient of the 70 odd rural hospitals in Queensland. It is patently obvious that should Moura hospital be closed a precedent would have been set and many other small rural hospitals would follow.

The change in direction from in-patient treatment to hospital-in-the-home is quite simply impractical in much of our area. Families who use Moura facilities are up to 100km from town often over roads of dubious quality.

Several incidents which we have monitored over the last two months have shown that reliance on availability of transport to transfer patients to larger regional hospitals in a timely manner is not a reliable option. This applies to road, fixed wing and helicopter modes of transport. Good as telehealth is it also does not work when the telephone system is down.
A competent doctor and appropriately staffed local hospital is by far the most accessible and reliable method of providing acceptable community health care especially when time is a critical factor.

A well-staffed hospital is a recognised support base for the often young doctors who do come to the bush and can relieve the doctor of numerous minor problems. In a town with so many working twelve hour shifts there are often these types of problems presenting to the hospital outside normal surgery hours.
If we are to see the doctors having to work longer hours and have no in-patients then it will be even more difficult to attract and retain a doctor as their job satisfaction will fall rapidly. Registrars will no longer wish to come as the breadth of the experiences will become limited, the last thing a young aspiring doctor wishes.

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Moura has had a succession of locum doctors since 2008. This has turned citizens away from using local services toward practices elsewhere where they continue to build up a longer term relationship and confidence in the doctor whom they see on successive visits.
Rural health services are being made to pay with reducing services for the grossly excessive remuneration given to locums. This problem is across several states and can only be contained in the short term by determined action by all states acting in unison. Longer term the flow through of expanding numbers of young doctors will correct the problem. However the nation has an obligation to ensure that there are sufficient places in large and small hospitals for graduates to complete their practical training.
A reasonably large scale local industrial accident this week reinforces the need to maintain a fully functional hospital.

Closure of our hospital to inpatients will have unintended consequences and collateral damage.
More shift workers with families will decide to take the option of a Drive In Drive Out lifestyle with all its well documented problems to ensure there are better services for their family's health. This fall in residents will flow on to reduced numbers of children in schools, and consequent reduced teacher numbers and choice of courses available to the children.
Voluntary positions are hard enough to fill in small towns. A reducing population together with the rostered 12 hour shifts would make it very hard for our sporting and service clubs to continue. This would be particularly hard on our junior sports clubs.
Other government and privately operated services will be withdrawn as population falls eg police.
A smaller population will see less money circulating in the town which will adversely affect our shop keepers across the board. When citizens are forced to travel to the large centres for medical attention they normally shop in those centres. Currently when they have no need to travel they are prepared to pay a little more to shop locally.
Real estate values of both homes and business premises will gradually fall leading to a loss of the rate base for our council and either a loss of local services or higher rates for those remaining.

We will have no palliative care or respite facility and still no aged residential care. This is a large gap in our overall healthcare which we continue to seek to fill.

In summary we would see an accelerating downward spiral in our town's fortunes.

John MacTaggart
President
M&D HCA