Attention:

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In response to the Federal Government Inquiry into the provision of General Practitioner and related primary health services to Outer Metropolitan, Rural, and Regional Australians. Clermont4Doctors (C4D) is an initiative of the Clermont community, funded by the Clermont Mine, Glencore. The initiative was formed by Clermont residents, driving to improve access to available appointments, continuity of care, and consistency of health care from doctors.

3 months ago, Clermont had 1 locum doctor (1 SMO) at the hospital to service 3000+ residence and provide a general practice surgery. This population GP ratio was insufficient, without the added burden of the FIFO population of Glencore Mine on our services, or lack thereof. The model was failing, leaving times where the hospital had no doctor on duty due to burn out / on call demands, requiring very sick patients to travel to Emerald (1hour drive) or Mackay (2.5-hour drive) to access health services, an experience ensured by too many families in our community.

C4D brought all parties together, the local private practice doctor, The Clermont surgery manager, Clermont Hospital DON and MHHS to find a solution. While the solution isn't perfect, it has allowed for 2 hospital doctors to be permanently allocated & filled at the hospital, and a community-based GP Dr Sarah, always seeing 3 doctors on the ground. The new model, while a business model and not a community owned model, allows the private practice to manage these positions and ensure doctors are benefitting from their time in Clermont are having a much more positive and supportive experience. C4D are also having the opportunity to fill these positions with permanent fulltime doctors, improving continuity of care, availability to care, and reducing doctor fatigue.

Dr Sarah and C4D have managed to fill the MO position with a fulltime permanent doctor and are currently negotiating the SMO position with a fulltime permanent doctor. An additional RVTS position is also being negotiated with a fulltime permanent doctor to start in February 2022, and several other qualified GP's are interested in visiting Clermont. It has been over 3 years since Clermont has had a permanent doctor, purely because MHHS does not have the capacity to do a recruitment and retention strategy for every town within their district, but communities do.

Communities are passionate about their health care. They have a vested interest to find the best fit doctors and to retain them. They take ownership when given the opportunity. Clermont has shown, through its community champion program, that communities are invested in health care outcomes. C4D's Community Champion program, facilitates community members to host, entertain and connect with visiting doctors, new doctors, and their families. It is a program that is working.

Community based models are successfully working all over Queensland. Community not-for-profit organisations have taken ownership of these models, they are models that focus solely on the best interests of their community. They are sustainable models as they are managed by those they serve and will always serve.
While the Clermont model is not yet perfect, as it is reliant on the continuity of the private practice, so is profit driven, it would be perfect if it was built on the foundation of a community not for profit umbrella organisation, like ClermontConnect.

While *Workforce Incentive Program-Doctor Stream* and *the Workforce Incentive Program – Practice Stream*, encourage doctors and practices into the bush, they do not ensure affordable & fair access to health services for the broader community. Practices and doctors are entitled to charge what they want to whomever they want to access their services, and this is not patient centred health care, this is doctors and practices profiting from the vulnerable. Incentive payments should be based on service provision, allowing for higher and broader bulk-billing incentives in these rural communities would not only provide equitable patient centred services but also encourage doctors into the bush. Community managed models, would support such a rural health strategy, ensuring the broader community could afford health care.

A local strategy is a strong strategy. No one strategy will ever meet the needs of every community. Let communities build what they need, allow accountability, provide support for these outcomes to be community designed and community driven. Support mining communities to build models that incorporate the demands of the FIFO communities around them and provide affordable and equitable health care to all communities' members.

While the RHMT & the Rural Generalist Pathway may be seen to attract and retain medical professionals in remote communities, M5-7 locations should be seen as unique training opportunities essential for all medical professionals. These locations offer diverse learning experiences that should be an essential component of all GP certification, not an optional placement. While the Monash Model appears to be great by design, take it one step further and require training GP's to practice medicine in M5-7 locations. These medical professionals will not only learn through diversity, but they will also experience what rural health and the rural lifestyle has to offer. This strategy to training would allow rural communities the opportunity to retain their own doctors and provide for their future health model requirements. While the Stronger Rural Health Strategy aims to regulate the number of overseas trained doctors and direct them to areas of workforce need, this strategy also needs to be applied to our local graduating doctors, bringing them to the bush. The Dept of Education gives communities the opportunity to retain teachers by placing them in the bush from the beginning of their careers and to a degree this is successful.

C4D has experienced firsthand the impact the COVID-19 pandemic has had on recruiting doctor to rural locations. The inability of doctors to cross boarders has hindered our recruitment process. Telehealth has allowed us to fill these gaps in the interim, however this is an unsatisfactory service for an ageing community.

Rural towns deserve continuity of care, this is not provided by locums. MHHS does not have the capacity to do a recruitment and retention strategy for every town within their district, but communities do. Community based models, community ownership, community accountability, community is a strong foundation for the design and sustainability of health models that is equitable and affordable to all, funding incentives based on service outcomes, not just the presence of a service makes for unbiased medical services for all.

Thank you for the opportunity to share our story

Regards