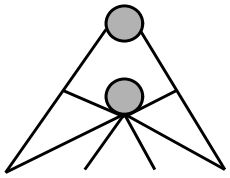

Australian Paediatric Society.

The voice of rural child health

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Senate Submission Paper.

Australian Rural Child Health Services

Introduction

The aim of this paper is to advise the Federal Senate Inquiry on the state of rural child health and rural paediatrics in an endeavor to plan for the future of child health in rural Australia. The paper has been updated from a discussion paper produced in consultation with the members of the Australian Paediatric Society. The APS is a national group of about 200 rural and regional general paediatricians. The APS expresses significant concerns regarding the future of rural and regional child health in Australia unless concerted action by Government occurs.

Content:

1. Workforce:

Overview. The capacity to recruit and retain Paediatricians to remote and rural Australia, like many professionals, is a significant issue. There has been little commitment from tertiary health service institutions to support a rural attraction and retention process. The Royal Australasian College of Physicians (RACP) has had rural workforce committees that have not been successful in supporting the recruitment and retention process.

The Australian Paediatric Society's primary aim is to ensure that equity of access to specialist services are provided to children in rural Australia. Services must be close to where the children live rather than necessitating children, many of who have significant disability, having to travel long distances for specialist services which causes family disruption and loss of school or work time.

There is no Australia wide rural statistical database indicating the ages of practising Paediatricians in regional and rural areas. An informal survey of Victorian rural Paediatricians puts the practising average age 3 years ago at around 55 years of age. Many Paediatricians are continuing in practice beyond the retirement age of their metropolitan peers because of their commitment to their local communities and the inability to recruit replacements.

***Recommendation 1: Government should support a demographic profile of the Australian rural paediatric workforce*.**

1.1 Deterrents to rural practice

1.2.1. Workload

The Paediatrician in the rural community acts as consultant, registrar and frequently resident. The lack of junior medical officer support available in rural hospitals creates an increased workload for the rural Paediatrician. The lack of funding for dedicated senior registrar positions has not kept pace with the equivalent funding for adult positions. More recently junior registrar positions have been proposed for some regional areas, but that level of registrar must have appropriate training by the regional paediatrician further stretching the regional paediatrician's time. Most major base hospitals have medical and surgical registrar cover 24 hours a day in comparison with paediatrics. Unlike paediatricians in larger metropolitan centres, the rural paediatrician does proportionally more on-call without the support of junior medical officers.

Recommendation 2: More paediatric training positions must be established in rural Australia and a paediatric rural locum scheme be supported.

1.2.2. Gender

Currently in paediatrics 76% of advanced trainees are female. Rural areas are less attractive than city practice because of issues in relation to partner employment, child rearing and the viability of part time practice in communities with high workload demands.

1.2.3. Family issues

The families of rural doctors are also disadvantaged. The quality of educational services in the rural settings is inferior to that of metropolitan areas, for both secondary and tertiary education facilities. City schools and familiar social networks within the city seem more attractive to new graduated paediatricians, especially if they have had no rural exposure. If rural doctors choose to educate their children in city schools, they experience significant financial and family disadvantage.

The families of rural doctors are faced with separation when the doctor wishes to satisfy their own educational needs which are usually available only in metropolitan areas.

1.2.4. Reduced income

In rural communities private practice is significantly less financially rewarding than practice in metropolitan areas This is because of a combination of reduced revenue generation from poorer people, lack of private paediatric inpatient facilities and high practice overheads. The cost of living is substantially greater in rural areas with increased cost of fuel (with minimal public transport) groceries and essential services such as telephone and Internet connection. Private hospital facilities are sparse and rarely sustain a paediatric or neonatal service. In rural areas, general specialist private practice is cost neutral and the viability of the paediatrician's practice usually relies upon public health service remuneration. Paediatric practice is the poorest income earner of all medical specialties and rural and regional practice of paediatrics is significantly less financially attractive than city practice.

Recommendation 3:– Government should consider a loading on CMBS for paediatric item numbers of 25% for practices beyond 100km from a capital city.

1.2.5. Postgraduate Education

Ongoing education and professional development for Paediatricians is an essential element of maintaining quality of practice. Paediatricians have to travel long distances to attend professional development events. Significant financial burdens are incurred in having to employ a locum paediatrician or closing down the practice lest the community be left without acute paediatric cover. Due to lack of travel options in rural areas traveling long distances by car is a significant safety issue. Queensland is the only state that has developed telemedicine facilities that enable professional development to be undertaken without the need to travel.

Recommendation 4: The Federal Government develop a scheme similar to Rural Retention Scheme that supports individual professional development of regional paediatricians removing the discrimination of only funding public hospital salaried paediatricians for professional development..

2. Clinical Issues:

2.1 Increased need

When the Australian Bureau of Statistics in 2001 advised that there would be a 7% reduction in the child population by 2010, children's services planning was based on that advice. The projections were wildly erroneous. The resultant reduction of children's services, particularly in rural settings with inpatient bed numbers, has now occurred in the face of a 14 to 21% increase in the child population *(compared to a predicted 20% decrease in some areas))* resulting in increased workloads and stress for health care providers.

2.2 Increase in Complexity of Care

2.2.1 - Increase in childhood disease prevalence

There is increased complexity of care for children expected in local settings. Children with cerebral palsy are undergoing new surgical techniques. Children with complex cardiac surgery are being returned to their communities earlier and require frequent follow-up. Children with diabetes, Crohns disease, allergy and coeliac disease are increasing in number and methods of therapy are becoming more complex. Children with complex developmental disabilities and needs including autism are surviving into adulthood with few facilities or services available to

support them. Behaviour disorders and school learning issues such as ADHD have increased in prevalence and are almost exclusively managed by paediatricians in rural areas.

Despite this there has been no additional support to facilitate the increased demand for the rural Paediatricians. Recent CMBS item numbers for complex paediatric patients for autism assessment acknowledge some of the problem but this does not provide a total solution. Rural areas require understanding and forward planning to increase the paediatric workforce in rural areas. Significant deficits in paediatric service care models have subsequently evolved. There should be encouragement of development of models of care outside the failing state public health system.

Currently in most rural settings with state government models it takes up to two years for assessment of a child suspected of having autism, up to six months to receive early intervention services for developmental disability and, in public hospitals, several years to have a regular general Paediatric outpatient appointment. There is a demonstrable failure to maintain services for children in the Australian rural community.

Recommendation 5a – State and Federal Governments initiate appointments within their public service structure that specifically addresses rural child health issues, planning and solutions.
Recommendation 5b – Federal Government should examine successful models of care in rural areas that are outside the state public health system and consider redirecting funds from the state government services to the private sector for allied health support in a multidisciplinary team.

2.2.2 -Adults with disability

Additionally there are no clinics for adults with developmental disability in rural areas. This group of patients is increasing in number due to improvements in paediatric care and is usually supported in the home situation by their parents. In rural areas, adult physicians will not take on a continuing developmental role for these patients and General Practitioners are not trained to manage them in a holistic basis. Hence many of these young people continue to access care with their Paediatrician well into adulthood because there is simply no one else to mange their care

2.3 Outreach services

Many Paediatricians provide extensive outreach services to smaller remote communities. This necessitates long-distance unremunerated travel, though the MSOAP has provided some support. In Queensland, telemedicine has been used in an attempt to address this issue but apart from psychiatry, there are no CMBS item numbers to support telemedicine.

Recommendation 6: That MSOAP continue to be supported and that telemedicine be further developed for paediatrics in rural and remote areas.

2.4 Indigenous child health

Many rural communities include indigenous communities. This group requires specific support from paediatric services but the capacity of the Paediatricians and the available facilities results in an inadequate service being provided at a primary, secondary, and tertiary level. Paediatricians working within these communities have consistently called for dedicated specific child health funding and support to provide the levels of care that these children require.

Recommendation 7: Government support locally driven indigenous child health services and listen to and act upon their respected opinions.

2.5 Refugee child health

Refugee child health services have been concentrated in tertiary centres yet there are many refugee communities now located in rural settings with no support services provided. For example, children have to travel to metropolitan tertiary institutions to obtain medications for treatment of HIV because of restrictions relating to the prescription of these drugs. Many of these children have unique clinical conditions not previously encountered in Australia and there is minimal backup support for local Paediatricians to obtain tertiary consultation.

2.6 Child Mental Health

There is an alarming paucity of child mental health services (most regions have chronic understaffing of mental health workers let alone a trained child psychiatrist), allied health services and community services (e.g. NGO services) in rural areas making it extremely difficult to provide quality mental health care.

The scandal of almost complete absence of such vital child health services in rural areas inevitably will lead to a generation of disturbed adolescents and dysfunctional adults.

Child mental health services in some areas are not linked with paediatric services, which creates a silo effect and a dislocation of services.

Recommendation 8: Governments urgently support a significant increase in the frequency and scope of mental health workers eligible for rebate for private services in rural areas and the linking of Paediatric and Child mental health services.

***2*.7 Overseas Trained Doctors**

Area of Need appointments, while allowing for an overseas trained paediatrician to provide a service, does accept a lesser quality of training so that the appointees are by definition, less qualified than RACP fellows. The bulk of the Area of Need positions are in a rural Australia and the increased workload associated with this lesser standard of care often falls on other rural Paediatricians, resulting in fragmented health care for children.

The RACP acknowledges that a lesser standard of care is delivered to rural communities as a result of acceptance of specialists without the RACP fellowship. Overseas trained practitioners should be more rigorously assessed by Panels which include rural practitioners, and if necessary upskilled in the tertiary training institutions prior to undertaking an Area of Need appointment in Australia.

The Australian Medical Council (AMC) guidelines have clear instructions on a process that should be strictly followed by health services to ensure community protection The process of declaration of Area of Need has been misused in recent times in Australia under political pressure.

Those practising in many Area of Need positions are currently inadequately supervised and are not engaged with ongoing professional development with the Royal Australasian College of Physicians. Australian medical graduates and trainee paediatricians are not allowed to undertake unsupervised practice yet this is allowed for overseas trained doctors of unknown

skill and competency. The RACP cannot intervene when inappropriate supervision occurs or when Area of Need guidelines are misused. After the period of 12 months supervised practice judged to be satisfactory, there is no ongoing scrutiny of the OTD in an Area of Need whereas for fully qualified RACP fellows there is both encouragement and expectation to undertake ongoing medical education.

The RACP has recently taken steps to ensure it has a better understanding of the requirements of a rural area. Unfortunately decisions by the RACP that a candidate is suitable for a job description as given by the rural health service management have been seriously flawed. The RACP has an obligation to ensure the OTD is supported locally, is encouraged to sit and pass the RACP fellowship standards and develops good working relationships with local and distant RACP fellows.

Recommendation 9: Governments and the RACP ensure that AMC Area of Need guidelines are adhered to and that RACP is given the authority to challenge misapplication of Area of need status and terminate what is considered inappropriate supervision of OTDs.

Recommendation 10: The current very poor standard of supervision of OTDs be addressed and appropriate action taken by the RACP if clinical concerns are raised by RACP members.

Recommendation 11: All AoN applicants must, unless directly specified by the OTD assessment panel, spend some initial time in a tertiary paediatric institution to improve their skills as required in the rural region and avail themselves of existing paediatric networks.

3. Training:

The rich postgraduate training experiences of rural practice cannot be underestimated. Training positions in rural areas not only provide quality training but also expose trainees to rural practice allowing greater insight into issues faced by patients and parents living in rural areas. This assists more appropriate management of rural families by those who eventually do practice in large tertiary hospitals .It also enhances the chances of a trainee choosing to become a rural paediatrician.

3.1 Current deterrents to rural training

Information obtained from the RACP Specialist Advisory Committee (General Paediatrics) rural exit questionnaires indicated there are several factors influencing trainee's perspective of training in rural areas notably-

- Social
- Gender
- Lack of positions
- Lack of ongoing education
- Appalling accommodation
- Lack of general facilities
- Being used as service fodder
- Lack of travel allowances
- Lack of adequate supervision.

Though there are programs in place to assist with the remuneration of registrars in rural training, these do not take into account the additional financial burden faced by trainees and employing hospitals such as providing accommodation, transport and relocation expenses.

Recommendation 13: Governments ensure the working conditions of trainees are at the very least equal, if not much better than the trainees experience in their native metropolitan centers.

3.2 Training in rural areas.

The general Paediatric training committee of the RACP decided that a rural rotation was an essential core element of training, not related to workforce, yet the trainees and many fellows of the College have been completely against this element of training. Fellows in tertiary hospitals have not been supportive of rural rotations and trainees are discouraged from rural rotations because of the family disruption and social inconvenience associated with the rural rotations.

When trainees do train in rural settings the availability of a formal training program is limited. The current Victorian Rural training program (nationally transmitted), which has been developed via telemedicine, has at best tenuous funding with no assurance of it being maintained.

Recommendation 14 – RACP continues to vigorously support the necessity for a rural rotation in the training for general pediatrics.

Recommendation 15 - Federal Government financial support be granted to ensure on going education for trainees in rural settings.

3.3 Lack of Metropolitan Hospital support

The lack of support from metropolitan hospitals for rural training is of great concern. Recruitment of trainees by metropolitan teaching hospitals is based purely upon their own service needs and not the needs of the trainee or the rural areas. There is not only lack of support for rural placements but there is evidence of deliberate undermining of some rural placements when the trainees are coerced to swap back to a metropolitan teaching hospital position.

Unfortunately, there is a current inequitable distribution with trainees filling up metro tertiary sites (often less beneficial for training) 1st with many rural sites left unfilled eg Mt Isa.

Recommendation 16 There be statewide fully funded training programs which ensure equitable and adequate placement of trainees in rural and regional sites

3.4 Federal Training support

Training programs funded by the Commonwealth government through State Governments (STP MSOAP) have been progressively underfunded over the past 10 years so that local hospitals and rural area health services are being asked to financially subsidise programs to ensure continuity of the training program. Funding of local hospitals is driven by inpatient clinical activity and because better paediatric care has caused most paediatric care to be conducted with minimal use of inpatient beds there is a reduced revenue for rural hospitals from paediatric services. Hence there is little interest in subsiding training positions in rural hospitals and some managers have ceased training positions for those reasons.

3.5 Paediatrics a low priority of rural health services

For most rural health service managers, paediatrics hold very little value compared to big revenue earners such as orthopedic surgery. When health service performance is measured in dollar amounts, it is not surprising that the needs of children and needs for maintaining sustainable paediatric (including allied health) workforce in rural areas are a very low priority. Many health services do not even consider succession planning or training to be their responsibility, with a pervasive attitude of short term solutions by filling immediate vacancies by use of frequently itinerant overseas trained doctors.

Recommendation 17: Governments must educate regional health administrations on the necessity for future succession planning through training of Australian graduates and insist that paediatric training is a core function of the rural health service entity.

Recommendation 18: Governments must ensure that regional administrators do not drive a political agenda for rural paediatric and neonatal services which excludes views of experienced clinicians to the detriment of rural health services

3.6 Training for a rural workforce

Unlike medical schools, there is no specific intent or selection bias to grant specialist training positions to those either originating from rural areas or more particularly intending to practice in rural areas. There needs to be specific targeting of rural candidates for postgraduate training

Recommendation 19: Governments ensure a 30% of paediatric training positions are allocated to those intending rural practice.

3.7 Future prospects

Some specialist graduates also fear that rural practice will potentially stagnate any ambitions to further their postgraduate career.

Recommendation 20: RACP and Governments ensure that those electing to enter rural practice have an equal opportunity to further a postgraduate career.

4. Education

4.1 Rural Medical Schools

The development of the rural medical schools has been a positive step in exposing medical students to rural medical practice. However while funding has been excellent in providing teaching facilities, the issue of who provides the teaching has not been adequately addressed. It falls upon the incumbent rural practitioners to become the teachers in addition to their existing clinical workload with minimal remuneration provided. It would appear while this provides financial savings it is at the expense of rural communities whose health-care needs have to be sacrificed in order to provide time for teaching. The alternative is to teach by salaried OTDs who are often under supervision themselves

Recommendation 21: – Governments support the appropriate funding of those paediatricians in rural areas prepared to teach medical students.