The factors affecting the supply of health services and medical professionals in rural areas.

The area for my discussion is East Arnhem land. The centre is the town of Nhulunbuy which includes the Gove District Hospital. The remote communities of Yirrkala, Ramingining, Milingimbi and Gapuwiyak are serviced through Gove District Hospital.

Factors limiting the supply of medical personnel.

1) Application of suburban formulae for calculating medical needs is inadequate.
   It is often stated that there should be one doctor per 800 population(suburban formula). In remote Aboriginal communities it is well accepted that the burden of disease should make this formula one per 600 or less. It is also well recognised that most Aboriginal people in East Arnhem do not speak English as their first language. Again this is an argument for having a formula of one per 500 or thereabouts.
   The funded medical positions in remote communities in East Arnhem Land are less than half the levels in Metropolitan areas based upon suburban formulae. If one bases numbers on formulae taking into account the increased burden of disease and having English as a second language, the actual levels required are in the order of approximately 100% - 200% increase in current numbers of doctors. The same could be said for the need for Nursing personnel.
   FACTS
   Gapuwiyak has 0.2 - 0.4 (0.3 on average) doctors per 1433 population (one doctor per 4777 population). It has one funded position. If this position were filled then one doctor would still be inadequate for the needs of the Community.
   Milingimbi has less than 0.5 doctors per 1825 population (one doctor per 3650 population). It has one funded position. If this position were ,filled one doctor would still be inadequate for the needs of the Community.
   Ramingining has 0.2 doctors per 1253 population (one doctor per 6265 population). It has one funded position. If filled one doctor would still be inadequate for the needs of the Community.
   The above population figures are from the clinic records derived from clinic records of patients registered at that community clinic as their principle place of residence. Actual population numbers would be higher than those quoted here.
   Up until recently there was no funding for a doctor at Ramingining. However if a doctor could be found **there is no accommodation**.
   SOLUTION
   allocate funding as per properly calculated community needs based upon realistic population figures.
2) Failure to recognise that rural and remote medical practice as a unique speciality.
   This is particularly relevant to Aboriginal Community areas. The average urban doctor might not get to diagnose a single case of Rheumatic Fever in their entire medical lifetime. In East Arnhem this is a weekly (sometimes) daily occurrence. There are many more examples, but regrettably it is a complete myth that any doctor can work successfully in rural and remote Australia.
   Not only is remote medicine a unique speciality, it requires unique personalities, and unique training. Most of the training is unsuitable for large and Metropolitan Hospitals.
   FACTS

Gove District Hospital requires at least 12 FTE doctors simply to manage the inpatient needs of the East Arnhem Population. However it is only funded for 9.6 FTEs. 3.5 of those FTEs provide 24 hour support to the remote communities by being on call via the telephone. This leaves 6 FTEs to run the Hospital - approximately half of what is required. Due to the inadequate medical staffing levels in the remote communities, these shifts are usually very busy. Only recently have we been able to attract and retain the 9.6 FTE levels and now we are in a position where we could provide proper remote area training, but we need an increase in FTE funding to be able to employ trainees. Once we have funding for trainee positions we will not have sufficient accommodation.

Even if we can get bureaucrats to recognise the need for remote training we are unable to fund these positions because our base levels of medical staffing are grossly deficient. I strongly suspect that people have not reviewed the proper staffing levels for many years, based upon an assumption that it has been thought to be impossible to fill the positions. However the facts of the past 2 years at Gove District Hospital have clearly demonstrated that young doctors will come to remote areas to work if

a) the overall staffing levels are adequate,
b) if the training is of a high standard, and
c) if they are properly supported, and
d) if they have appropriate accommodation.

SOLUTION

Re-evaluate historical medical staffing levels and fund accordingly.

Allocate funding for training positions in remote locations as appropriate for specialised training in remote health.

3) Foster and develop an appropriate accountability and clinical governance models suitable for rural and remote medicine.

Remote health should be accountable. However using suburban accountability models (and urban KPIs) is farcical.

FACTS

The urban concept of chronic disease management is killing the finances of remote medicine. Best practice dictates the use of specialist participation. In remote Australia there are insufficient specialists to manage patients in their home environment. Also, sophisticated diagnostic equipment is usually only found vast distances from the patient in a remote Aboriginal Community. This means that **cost of travel is fast becoming the major limiting factor to remote health care**.

There are better ways of providing the required services.

Most KPIs linked to funding in remote areas involve referral to specialists. In the Metropolitan areas the major expense is the cost of the specialist visit. In remote Australia the cost of transport is many times the cost of the specialist treatment. This is often made much worse in Aboriginal Communities because large numbers of Aboriginal people do not like travelling to distant services. Currently we often purchase as many empty seats on chartered aircraft as occupied seats travelling to specialist appointments. It is not uncommon for a specialist consultation normally costing a couple of hundred dollars to have a travel component of over a thousand per specialist consultation.

Australian people seem to have reached an understanding that medical work in remote areas is different from what is required in Metropolitan areas. However we force failure into this

system by maintaining the same KPIs which led to previous failures even though we know that the path leads to failure. **We need a new accountability system with appropriate KPIs**.

SOLUTION

We need to develop KPIs that are appropriate to remote and Aboriginal needs.

We need to develop clinical governance models that dramatically reduce the need for high cost transport.

To that end we need to equip doctors prepared to travel to remote areas with appropriate skills to fulfil our requirements for a high standard of medical care without the exorbitant costs of charter aircraft.

There may be several way to achieve this desirable outcome but in my opinion none are more appropriate than the Rural Generalist Training Pathway which is being developed by Qld Health and is now being explored by the Northern Territory.

The Rural Generalist Training pathway will provide GPs prepared to work in remote communities with the appropriate advanced skills to minimise the unnecessary evacuation of routine medical management problems.

4) Provide adequate accommodation for all medical and nursing personnel.

   I know that accommodation issues have been mentioned earlier, but it is really so important that it needs to be mentioned twice.

5) Provide incentives to go remote.

   Governments seem to have heard the message about adequate remuneration to attract doctors to remote locations. This is good. But there are other areas where incentives are very important. Educational needs of families is a major consideration to attracting doctors to remote areas. Doctors who come and are retained in remote areas do so if their family needs are achievable and affordable.

   Consideration of the career path for the non-medical spouse is a major contributing factor to medical staffing in remote areas.

   I have deliberately not gone into detail here because incentives are more appropriate to retention, in my opinion.

   Recruitment issues revolve more around training, and understanding the training needs of the new generation.

   I am a GP of 38 years. I was not groomed into any remote role but I was simply thrust into it. A lot has been done more recently to train young doctors in a much more appropriate manner. However what is poorly understood by administrators is the need to train remote doctors to be "Independent Practitioners". This aspect of training is just as important as the curriculum. The small District Hospital with close Community links is an ideal environment to train young doctors to become Independent Practitioners, a skill that is not wasted if they later migrate to Metropolitan Practice for family reasons at a later time. **Young doctors who have an interest in rural and remote medicine are screaming out to be trained as "independent practitioners".**

The effect of the introduction of Medicare Locals on the provision of medical services in rural areas.

Little is understood in the Northern Territory about what will be the effect of Medicare Locals on the provision of medical services because we do not yet have an understanding of the structure.

However due to the large geographical areas and low population levels in the NT there is a real danger that the separation of health services into Local Hospital Networks and Medicare Locals have the potential to fragment services. We only have three small hospitals in the NT; Gove, Katherine and Tennant Creek. These are very much primary care hospitals that function best if they continue to have strong links to the Community. The population of the NT is so small that medical workforce depends upon cooperative and collaborative arrangements between Government and Other Medical Services including Aboriginal Medical Services to maintain a "critical mass".

Transportability of Industrial benefits such as holidays, sick leave and other entitlements would increase the efficiency of a medical workforce in the NT. If the Medicare Local is capable of negotiating some of this then it will probably be successful.

Also similar issues occur with a mobile workforce involving Western Australia and Queensland. If entitlements and other industrial benefits can be transported across State boundaries, then this will add to the stability and growth of a sustainable remote medical workforce. While it is well known that a Northern Network would be beneficial it should not be forgotten that other States such as Victoria have contributed to many of the successful remote placements in East Arnhem Land to date.

The role, structure and effectiveness of incentive programs for recruitment and retention of doctors and dentists in small rural communities including delivery models and geographical classifications.

The Government has incentives to reimburse wages for Registrar training in remote Communities. This is good. However there are no full time (remote) doctors in East Arnhem Land to train young doctors to take full advantage of this. Because we are required to properly supervise Registrar trainees we are limited in where we can send them for training. We need to develop training models that are properly supervised and visit the remote communities, so that we might have a remote medical workforce into the future. We cannot train people to work in remote communities unless they train in those communities.

In Gove we are trying to develop a responsible model where a Registrar and a Supervisor can travel to a remote Community for a two day period and return to Gove for the remaining three days of the week. Other work that does not rely upon direct patient contact (pathology results and other paper work) can be undertaken while in Gove so that the distribution of remote work is about 50% of the time in remote and 50% of the time spent on other training in Gove Hospital.

The "patient journey" afforded by this model is of very high quality. Telephone contact from the nursing staff in the remote Community is the starting point, with a continuity of care involving evacuation (when required) and inpatient care right through to follow up back in the Community. All this can be carried out by the same team of doctors who very soon become familiar with the patient both in the Community environment as well as the Hospital environment.

We currently do not have funding for the teaching component in Gove Hospital as current models only provide incentive for the remote visitation part of the model.

Other retention incentives are linked to Medicare revenue. There are alternative pathways to access these incentives but they are far too complicated to be useful. Some doctors provide a lot of supervision and therefore have reduced Medicare revenue. This is potentially a very good program but does need to be reviewed to allow for more training and supervision in the remote setting.

The recent changes to the geographical classification in the NT has seen a reduction in the available trainees to the remote areas because of the upgrading of Darwin to rural and remote status.

The financial benefits of the "Intervention" also known as "Closing the Gap" are poorly visible at the remote level. The only benefit seen by medical staff working in remote Communities (including myself) has been the formation of middle management positions. Any increase in service delivery remains illusionary.

I have previously discussed KPIs and their effect on service delivery. I would like to now state a couple of specific examples.

Numerous blood tests are performed on numerous patients for the purpose of developing chronic disease profiles so that remote clinics can develop long lists of specialist referrals that less than half the patients attend.

This produces data that may or may not be useful. However we now know more about a person's blood than we do about the person. We know more about the person's disease than we do about their health.

You might understand this better when I tell this story. I met with an Ophthalmologist who was running a clinic at Gove Hospital. I explained to him that many of the patients who attended the clinic (mostly diabetics) were given very little notice of the visit and often did not know why they were attending the clinic.

He said to me "that's nothing, many of the diabetics attending for diabetic eye checks did not know that they were diabetic."

Personally I think it more appropriate to fund "service delivery" rather than "disease management".

In short, to address the Workforce shortages in rural and remote Australia, you first of all need to visit (reside in) the remote community until you feel uncomfortable. Usually a day or two is all that is required. The next step is to realise that you know nothing at all about how to survive, let alone enjoy yourself in this environment. The third step is the realisation that virtually none of your suggestions as how to improve the situation (things that work for you in suburbia) are going to be useful. Then, and only then will you be in a mindset to properly listen to solutions.