



RURAL DOCTORS ASSOCIATION OF QUEENSLAND

MEMBER NEWSLETTER

December 2009



PRESIDENT'S MESSAGE

Sheilagh Cronin

It's the time of year when we like to take the opportunity to relax (if our work schedules permit); look back on the year's major milestones and perhaps even do a bit of planning for 2010!

RDAQ has continued its lobbying and advocacy over the past three months. In September, I held an interesting meeting with the Deputy Premier and Minister for Health, the Hon Paul Lucas. This meeting went well over its scheduled time, and we discussed a number of issues, including factors impacting on the viability of rural private practice; the potential for more coordination and cooperation between the public and private sectors; and the need to reduce inefficiencies within Queensland Health. The Minister was particularly interested in increasing the number of intern training places, and the conversation turned to ways in which rural hospitals might play a part in this.

More recently, I have been involved in advocacy for Overseas Trained Doctors. Some of these doctors who are working in Areas of Need, and particularly those progressing towards full registration via the General Practice pathway, have been affected by the Medical Board's retrospective changes to the progress requirements. This will not impact on every OTD, but it is certainly very stressful for those who are involved. There have also been some other instances of confusion in dealings with the Board, and once again, these are extremely stressful for those doctors involved.

RDAQ does recognise the huge contribution made by Overseas Trained Doctors to our rural and remote workforce. Whilst we obviously support the maintenance of professional standards, it is imperative that our OTD colleagues are given as much support as possible to ensure that they are able to meet these standards. I think we sometimes underestimate the stressful position in which these doctors, particularly those working on Temporary Visas, can find themselves.

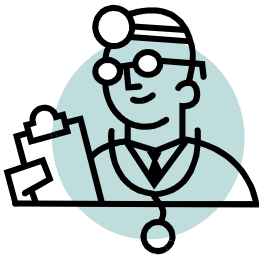
I encourage any OTD who is confused or having any difficulties to contact me. RDAQ needs to be aware of these situations and in some cases we can assist with advocacy. As an OTD myself, I am well aware that it can be difficult to negotiate the system and this is where the Association can provide some help.

During the past few weeks I have been in contact with the Medical Board; the Minister's Office; the Shadow Minister and the Office of Rural Health to discuss issues impacting on OTDs, and I have made it clear that these doctors need to be treated better, or they simply will not come to Queensland. Workforce projects show that, in spite of the large number of Australian graduates who will be coming to the workplace in the next few years, there will still be a shortfall which will need to be met by the continued recruitment of doctors from other countries.

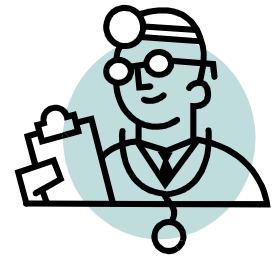
On to other issues: You will be aware that planning is well under way for the 2010 conference, under the leadership of Convener Dr Dan Halliday. I hope you have already marked the dates in your diary. We've already received great support from sponsors and the program is already almost filled.

Membership renewals are in full swing, and we've had a great response to date. This year, RRQC, has taken the decision to provide its Registrars with RDAQ membership for 2010. I am sure that these doctors will benefit from RDAQ membership, and it is obviously also a great boost for our Association. I warmly welcome these doctors, and other new RDAQ members.

Finally, I'd like to wish all RDAQ members and their families, a very Happy Christmas. I hope that you will have the opportunity to enjoy some time with your families over the festive season, and I also hope that 2010 is a successful and rewarding year for you all.



RDAQ NOTICEBOARD



RDAQ's 21st ANNUAL CONFERENCE

Coming of Age: *Innovations in Rural Health*

Mackay Entertainment and Convention Centre
11-13 June 2010

- ⇒ Excellent location and great venue
- ⇒ Pre-conference workshops
- ⇒ Great program covering policy and professional issues
- ⇒ All social events included in registration
- ⇒ Family program

Registrations open late January 2010.

Information and updates and the Conference website:
www.rdaq.com.au/conference

RDAQ thanks Platinum sponsor Pfizer, and Gold sponsor Queensland Health for their support

WELCOME TO ALL NEW RDAQ MEMBERS

RDAQ acknowledges the support of the Rural and Remote Training Consortium Ltd in providing RDAQ membership for Registrars in 2010.

DATE CLAIMERS

Rural Medicine Australia 2010 Scientific

The 2010 national conference and scientific forum of ACRRM and RDAA will be in Perth in October. The scientific forum is a significant part of the conference and is held every second year. There will be a call for abstracts early in the new year.

<http://www.acrrm.org.au/news/rural-medicine-australia-2010>

The 11th National Rural Health Conference will be held in Perth on 13-16 March 2011

The Department of Veterans' Affairs (DVA) has developed an *Information for Medical Practitioners* package, particularly aimed at newly graduating GPs, those practising in rural and regional areas, and GPs who are International Medical Graduates (IMGs). It can also be utilised as a 'refresher' for any GP who treats members of the veteran community.

The package consists of:

- an Introduction;
- three information modules;
- a list of web links to information referred to in the modules;
- two useful DVA reference documents - the *DVA Funded Health Services* and *DVA Treatment Entitlement Cards* Charts; and
- a feedback form.

The modules, which can be used either individually or sequentially, consist of:

- Module 1: *Introduction to DVA*
- Module 2: *DVA's Health Programs – Hospital, Medical and Allied Health Services*
- Module 3: *DVA's Health Programs – Health and Related Services*

The package is designed to be downloaded from the DVA website and the modules used either in PowerPoint presentation form as training tools by GP educators/organisations or in hard copy form, along with the other components of the package, as a reference document for individuals/practices.

The package will provide GPs (in any location) with a broad overview - a 'snapshot' - of DVA and its health services, together with relevant links and contact details to gain further detailed information.

The *Information for Medical Practitioners* package is available at:
http://www.dva.gov.au/service_providers/doctors/Pages/info.aspx

SOME SNIPPETS...

Rural and Regional Aged Care Workers to Benefit from \$2.6 Million Training

Minister for Ageing, Justine Elliot has announced \$2.6 million to provide training for 4000 staff working in rural and regional aged care homes. The Support for Aged Care Training (SACT) short courses focus on specialised areas such as wound management, diabetes care, medication management, falls prevention and manual handling.

<http://www.health.gov.au/internet/ministers/publishing>

LIFELINE INFORMATION SERVICE

This service provides rural mental health information including: referral to services and web sites, printed material and a range of self help resources. The self-help resources focus on practical steps to help promote mental health in a range of areas. For information and copies of resources call or visit

<http://www.lifeline.org.au/infoservice>
and further information is available at infoservice@lifeline.org.au

Bridging the Gap in Indigenous Health: The tools required ...

This is a summary of a presentation made by Dr Lara Wieland for the Indigenous Health Delivery Forum which was held in Brisbane in October. Please contact Jenny at the RDAQ office if you would like the full text of Lara's presentation.

Thanks to Lara for representing RDAQ at the Forum.

I'm sure we all agree that bridging the gaps in Indigenous Health requires also addressing all of the social determinants of health. Personally, I'm particularly passionate about the role of education, but I'll be limiting this discussion to the tools related to health service delivery. However I believe that sometimes it is important for those of us working in the field of Indigenous Health to do the best we can in our area of expertise, and not be overwhelmed by all that has to be done and end up doing nothing or trying to do a multitude of things that are not effective.

There are many challenges in the delivery of health care services to Indigenous communities. Vast distances, poor access to transport, under funding, miscommunication and under staffing are all factors which add to the difficulty of health delivery. But none of these are insurmountable problems. RDAQ's long-standing indigenous health policy outlines actions that would address many of these issues.

Support for community controlled health services.

Why support a community controlled model for remote communities? Work with communities in Cape York on a model of health reform has resulted in a clear message - increasing resources alone is not going to be enough. There has to be an increase in responsibility and community control. Of course increased resources are also important – but the two have to work together or else you risk wasting any of the extra resources provided.

Community control can work in ways that governments and other organisations can't. They can better shape services to meet community need, and they can have the flexibility and ability to appropriately manage primary health care services in small remote indigenous communities.

True community control and empowerment, not lip service, is a vital step in closing the gap. Those of us who work in this field know that solutions are always best based on actions that are sensitive to specific local problems and draw upon local resources.

Funding models.

It's no secret that Aboriginal and Torres Strait Health remains grossly underfunded relative to real need. Additional funding is needed, not only to address the funding deficit, but also to bridge the health status gap that currently exists. This may mean more money per capita to address health inequities. Evidence suggests that there are big returns in both cost-savings and benefits to society and quality of life years from investing in primary health care.

State and Federal Governments need to work toward developing effective and innovative funding models that reduce the barriers to accessing care and enhance the viability of the community controlled sector. This includes the ability of Community Controlled Health Services to pool funds from Commonwealth and State sources. Tell me which one you'd rather be dealing with?

Removing barriers to accessing healthcare.

Aboriginal and Torres Strait Islander peoples use significantly lower levels of Medicare and Pharmaceutical Benefits. Even when programs such as Aboriginal Community Controlled Health Services are included, expenditure is still well below that for other Australians, and this particularly so for remote areas.

Lower access to primary care partly explains why Aboriginal and Torres Strait Islander Australians are twice as likely as other Australians to present at hospital outpatient/casualty services, leading to higher State/Territory expenditure for secondary and tertiary care.

Barriers to accessing health care services, including preventive programs, are part of the social and economic conditions which can lead to health inequalities. In remote areas they include:

- Workforce shortages
- A lack of awareness of existing services
- Health services being ill equipped to deal with the complexity of the health, social and emotional wellbeing and cultural needs of indigenous people
- A lack of culturally appropriate services and information;
- Feelings of shame and embarrassment in the area of reproductive and sexual health
- A philosophy and concept of health that is not holistic
- Distance to health care services; lack of affordable transport and staying away from home to receive treatment often without family support and with increased financial costs.

Many of the recommendations discussed earlier would address several of these access issues.

Support and resourcing of remote indigenous health services to provide training for GPs and other health professionals.

I think this is a particularly important tool for increasing a sustainable workforce across all disciplines. Providing positive experiences can lead to better recruitment of long term staff that are appropriate for that service or other indigenous health services. This takes time and resources, for instance, supervisors need to take time away from revenue generating activities to mentor their charges. Aboriginal Medical Services must be robustly resourced and supported to take GP Registrars. Funding for Registrar accommodation, salary packaging and other incentives must be put in place to encourage the recruitment and retention of GP Registrars in Indigenous Health.

Other recommendations that would assist in workforce support are:

- Aboriginal Medical Services, regardless of RRMA locality, being reinstated as an eligible "rural" term for the compulsory rural term in General Practice vocational training
- Career pathways underpinned by academic qualifications for doctors working in Aboriginal Health
- Recruitment and retention benefits available to GPs in RRMA 4-7 be extended to doctors working in ACCHS/AMSS regardless of RRMA with perhaps an extra loading for indigenous health services in the more rural and remote areas.
- All ACCHS/AMSS be regarded as districts of workforce shortage/need and accorded the same benefits and supports attributable to those posts.

Aboriginal Medical Services must be adequately resourced to be able to offer competitive salaries and conditions to recruit and retain doctors.

Conclusion.

There is nothing earth-shatteringly new in any of this. Nor is any of it really that difficult. All of these actions are supported by evidence and/or have precedents. None of them requires any major changes in legislation or policy. Most of them require some more money but as COAG has been committing increased funds to closing the gap, the key is ensuring that those funds are targeted to the right actions. And besides which, what will be the cost of not acting where we know we can make a difference?



PHYSICIAN'S ASSISTANT PILOT PROJECT—FIRST PROGRESS REPORT RELEASED

The Queensland Physician's Assistant Pilot began in May 2009 and is expected to conclude in May 2010. Urbis Consulting has been contracted by Queensland Health to undertake the evaluation of the Pilot.

In the first three months, five PAs have begun work at three Queensland Health locations. Q'ld Health staff at each site were invited to complete a baseline survey of perceptions regarding the PA role. Members of the evaluation team have visited each site and interviewed PAs and staff members.

PAs and their supervisors have agreed practice plans which define their scope of practice, and data has been collected for each clinical consultation undertaken by the PA. The Quality Assurance Committee for the Pilot has examined practice plans, supervisor reports, and scope of practice records.

In general, PAs have been well received at the Pilot sites, and it has been reported that PAs have integrated well into the Australian health system. No clinical concerns have been expressed by anyone with regard to the PAs' competence, experience, or knowledge. Supervisory reports have been positive, and the scope of practice of the PAs is gradually expanding, most recently with amendments to their prescribing authority.

The concerns which have been made known to the evaluation team are those of process, particularly communication regarding the Pilot, and of workforce implications. A number of participants felt that they had not been fully informed from the beginning of the Pilot re-

garding the role of the PA and the way in which the role would interact with other clinical staff.

This led to a related concern, which was about the potential place of the PA within the clinical team and, particularly, the implications for nursing staff, nurse practitioners, and junior doctors.

Some early themes have emerged from the limited discussions with staff at the participating Pilot sites. They remain to be tested more broadly in consultations with external stakeholders, ongoing analysis of service activity and practice reports, and additional visits to the sites.

These early themes include the following:

- the influence of communication strategies on people's responses to the PA role
- the transition from the USA to the Australian context, and implications of that reality for the establishment of the role in Australia: the USA PAs have brought considerable experience with them but have had to adjust to a new system, while home-grown PAs will understand the system but will not enter the clinical environment with the level of experience and ease which the PAs have demonstrated.
- the level of medical supervision required on a sustainable basis
- the relation of the PA role to existing clinical roles, and the ways in which those relations should be negotiated
- the impact of the PA role on medical training
- the impact of the PA role on nursing workloads.

If you would like an electronic copy of the full report, contact Jenny at the RDAQ office: rdaq@rdaq.com.au



*Merry Christmas and a
Happy New Year to all
Rural Doctors and
their Families*