

Medical services model for Charleville

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Charleville is a medium sized rural community with a population of 3500 located 760 kilometres west of Brisbane in Queensland.

In recent times the community has been serviced by a medical workforce consisting of the following:

- two Medical Officers employed by Queensland Health (QH) – one position being a Medical Superintendent and One a Senior Medical Officer;
- two full-time general practitioners (GP);
- one part-time GP;
- one Medical Officer employed by the Royal Flying Doctors Service based at Charleville.

The two QH Medical Officers had been employed since 1998. These two doctors originally came from South Africa and were admitted to the Doctors for the Bush Program in 2000. Their Doctors in the Bush Program contract ended in December 2004.

The South African trained doctors came to Charleville with a well developed skill set which was ideal for work in rural communities. Their training had provided them with significant advanced clinical skills in the management of trauma, emergencies and obstetrics. It was recognised that their departure from Charleville would leave a significant gap in medical service provision to the local community.

It was also recognised that the recruitment environment for doctors was that much more challenging than when these doctors commenced in Charleville seven years ago. It was accepted that the Doctors in the Bush program was less likely by itself to be able to provide doctors with the skill sets suitable to work in complex rural setting such as Charleville.

Across Rural Queensland, and indeed across Australia, the ability to fill salaried Medical Officer Positions has been getting harder. In order to be competitive in the doctor recruitment market there was a need to differentiate one's product so to speak and build in significant financial and lifestyle incentives.

In the case of Charleville the initial view was that it was time to carefully consider the option of converting the salaried Medical Officer Positions to Right of Private Practice (ROPP) positions.

In order to be strategic and consultative about any possible change in the local Medical service model a review was commissioned by the District Manager, Charleville Health Service District (CHSD). It was recognised that one of the strengths of the local medical community was the positive and constructive relationship dynamic which existed between the key players namely QH, local GPs, RFDS staff and AMS. It was also understood and appreciated that every endeavour should be made to ensure that this positive dynamic was not compromised in any potential change process.

This review was undertaken by a Senior QH Executive Director of Medical Services and a Senior Administrator from the Southern Zonal Management Unit.

The review involved consultations with the following local stakeholders:

- District Manager, CHSD;
- Medical Superintendent and Senior Medical Officer, Charleville Hospital;
- Local GPs;
- Aboriginal Medical Service (AMS) Representatives;
- Royal Flying Doctors Service Medical Officer and Queensland Medical Director;
- Southern Queensland Rural Division of General Practice representatives.

The review would normally have included discussions with local government representatives but as the process took place only a couple of weeks prior to local government elections it was viewed that this may not be particularly helpful. This view was supported in time as there were significant changes in council representations as a result of the election.

Engagement with the local council happened at a later date and will be discussed further at a later point in this paper.

The review sort support and input from all stakeholders on the need to work co-operatively and in partnership in order to firstly attract suitably qualified medical staff to Charleville and secondly address significant lifestyle issues around 'on-call' and examining ways of addressing this issue through a shared roster arrangement.

It also took account of the fact that the Charleville Hospital outpatients Department has historically represented a GP type clinic where the salaried medical staff conducted daily outpatients clinics (up to 80% of patients seen would be classed as GP type patients). Other specialist clinics such as fracture, antenatal and pre-operative clinic are also conducted.

One of the problems highlighted through this process was that while there were essentially four local doctors providing GP type services in the Charleville community there was an issue with the distribution of these doctors and their services. For instance the hospital based doctors would each normally see eight outpatients per day. This refers to standard category four and five classified patients as opposed to emergency presentations who were seen based on clinical priority following triage.

Essentially though there was no incentive for these doctors to see anymore than a standard number of patients on any one day. This number was determined by what could be described as arbitrary organisational needs and did not represent the real level of primary care which the local population required. The private GPs on the other hand were extremely busy. This in part reflected the valued GP services they provided but also took account of the economic drivers which a fee for service system creates. That is the more patients seen the more revenue generated. This obviously benefits the doctor's bottom line but importantly means that parts of the local population are being well serviced by a GP.

The above point is important as it reinforces the anomaly which exists in the Medicare system where people living in the most affluent urban suburbs, who also happen to have the highest national population health status, have the highest Medicare access rates. Compare this to small rural communities where health status through morbidity and mortality measures are significantly poorer than urban communities and yet the rural populations have the lowest access rates to Medicare services.

While there are Australian Government programs which aim to address some of these imbalances (i.e. Regional Health Service and Primary Care funding) the funding allocations and access to quality primary care services are somewhat short of providing true equity to rural populations.

The key recommendations from the review relating to the restructuring of the QH Medical Officer positions at the Charleville Hospital from two salaried positions to three Right of Private Practice (ROPP) positions. The ROPP positions would be employed by QH on what is essentially a flat rate retainer which requires the doctors to be available to provide 24 hour public services to the hospital in return for a set remuneration rate. Outside of these obligations the Medical Officers are provided with access to a fully maintained surgery facility at which the doctor can operate in a General Practice capacity.

This arrangement has a two-fold benefit for rural communities. Firstly, there is a significant financial incentive created for Medical Officers to work in a rural setting as they are provided with a 'walk-in, walk-out' arrangement thus reducing the need for significant capital outlays. The only real cost incurred is that of staff wages. Low input costs result in immediate ability to generate significant revenue through the Medicare Billing System (MBS).

Secondly, with the 'shift' of costs to the Commonwealth Medicare system it means that local QH services will incur some financial savings which allow for greater discretionary expenditure to address locally identified health needs. It allows QH to focus on service delivery which is more in line with the brief of state health services as opposed to continually being responsible for the delivery of GP type services through public outpatients department.

The review recommended that once appointed the ROPP doctors should be encouraged to practice from one of the two GP surgeries located down town and/or also from the local AMS clinic. QH would also retain the option of setting up a private practice clinic at the Charleville Hospital if appointed doctors choose to work independently of the local surgeries or AMS centre. This final option is in keeping with the organisational obligations under the Medical Superintendent with Right of Private Practice (MSROPP) Award.

What is clear is that the state of General Practice infrastructure in Charleville is in need of upgrading. In fact both of the general practice surgeries located in Charleville are in need of an upgrade. It makes no economic sense for private GPs to invest capital in a venture which they will never get a viable return. This fact is clearly recognised by the Commonwealth Government through its funding support to construct doctors' surgeries in rural communities.

This is further recognised through initiatives such as the New South Wales (NSW) based project titled "Easy entry gracious Exit" which is an initiative of the NSW Rural Doctors Network and supports the provision of medical practice infrastructure which doctors entering rural practice can access. The initiative supports the 'smooth' departure of rural doctors from communities in that the doctor does not have the stress of trying to sell and 'wind-up' a practice and 'hopefully' there is an ability to attract another suitably qualified practitioner to fill this role using the same support mechanisms.

These facilities are walk-in walk-out and provide incentive for doctors to commit to rural practice knowing that they won't be left out of pocket when they leave town by having to try and sell an over capitalised surgery.

Key to driving the proposed changes in the Charleville Medical Model involved engaging with the local government authority, the Murweh Shire Council, in the process of reviewing and restructuring the medical services model. This was found to be a successful vehicle in commencing the process of engaging the broader community in the proposed changes.

Another requirement identified to assist in establishing a sustainable medical model in Charleville involves the ability of the local doctors to operate some form of shared roster arrangement. Previously there was the crazy situation where up to four doctors based in Charleville would be on-call at any one time with little or no overlap in the on-call responsibilities or jurisdiction. This situation arose where there may have been the two fulltime private GPs, hospital medical officer and RFDS doctor all on call at the same time.

In order to have a sustainable model it is imperative that when the ROPP doctors have been recruited by QH that there is a commitment by local doctors to develop a shared on-call roster. This would have the advantage of sharing the 'on call' workload which will decrease fatigue and stress levels whilst dramatically improving quality of life for the participating medical practitioners.

While it is difficult to see how the RFDS Medical Officer could be part of this arrangement it should at least be examined particularly in light of the fact that there was previously an the case that the local Medical Officer undertook call for the RFDS (this was some time ago).

The RFDS has unilaterally initiated two important initiatives which will work to strengthen local medical services. The first is the appointment of a second medical officer to the local RFDS base. And secondly the senior RFDS Medical Officer works two days a fortnight at the local AMS clinic. This arrangement has been well received by the community. The doctors practice continues to grow to the point where both of his days at the AMS are now almost always fully booked. This service has been embraced by Indigenous and non-Indigenous clients.

OUTCOMES AND POLICY IMPLICATIONS

Recruitment for the three ROPP positions was commenced in September 2004. To date this process has been partly successful in that a Medical Superintendent with Right of Private Practice (MSROPP) has been appointed. The two Medical Officer with Right of Private Practice (MOROPP) remain unfilled.

The newly appointed MSROPP has also practices as a local GP since 1999. Thus in effect there is no immediate net GP gain into the community.

The difficulty in recruitment experienced to date reflects, in part, the significant challenges which exist in rural Australia when it comes to employing suitably qualified Medical staff. There is little doubt that without altering the local Medical Model the health service would not have even had the opportunity to even have recruited a MSROPP.

As mentioned earlier the General Practice 'infrastructure' in Charleville is in need of an upgrade. Both private surgeries have key design and functionality deficits. The hospital option while having that ability to comfortably accommodate two doctors may struggle to comfortably support a third doctor when there is a need to continue to provide specialist outpatient clinics. It is also noted that the private pharmacy is located 'downtown' (close to the two private GP surgeries).

The hospital option does however present some integration benefits in that Radiology, Pathology and Allied Health services are based at this location.

The construction of a new purpose built medical centre could represent an effective way of imbedding the new Medical Model at Charleville. It could allow the QH ROPP doctors and local GPs to operate out of one stand alone integrated facility. It is also possible, dependent upon funding to create an integrated facility which even housed community based staff etc.

In theory such a structure could represent an ideal 'walk-in walk-out' facility.

The challenge with this proposal lies around funding access and responsibilities. The Australian Government has funding available to allocate to Local Government authorities to construct medical practices in rural locations. However, in Queensland there is reluctance on the part of local councils to get involved in these types of ventures. This is seen as a clear responsibility of QH. The Australian Government funding will not be provided directly to State Governments.

The particular situation in Charleville is further complicated by the fact that with the appointment of one local GP to the MSROPP position there remains only one fulltime private GP in town who, at the moment, is supported by a part-time GP. In towns where there is no private GPs operating QH has historically provided a fully maintained private practice surgery. In Charleville the situation is somewhat different in that there is private GP infrastructure and private GPs in operation. Across Australia it has been usual in these situations to seek Commonwealth Government funding to support the construction of 'walk-in walk-out' surgeries.

The take home message from the Charleville experience to date is that there was a new medical model developed and it was initially embraced by medical staff and local community leaders who were supportive of the model. However, in the cold light of day it has been relationship and personality issues which have complicated the establishment of the model in Charleville. This includes both recruiting suitably qualified doctors to the two vacant MOROPP positions but also maintaining suitable medical cover to the community during what has become an extended 'transition' period which still does not have an 'end point' in sight.

The ability to get any 'model' to work is based on the fundamental tenet of relationships. Individual stakeholders may be keen and committed but if the relationships are not managed well and simply 'do not work' regardless of the model the arrangements will end in tears.

There was a plan for Charleville put in place but six months down the track there is a continued struggle (as mentioned above) to recruit to two out of three positions. This in turn puts further pressure on the doctors currently delivering medical services locally which can result in further pressure being brought to bear to strain relationships. It is difficult to have sustainability in a medical service when there are only one or two experienced doctors constantly bearing the greatest load in terms of providing medical service and coverage.

The same applies for the construction of a any proposed doctors surgery in the town. While the private GP infrastructure is in need of an upgrade the surgeries remain functional. There is also the option of accessing existing facilities on site at the Charleville Hospital. In part looking at the use of QH facilities is in keeping with the principle of maximising the use of local resources.

It is possible that even if a new doctors surgery was contracted that this would only work as long as relationships worked. That is not to say that this isn't happening presently but reflects the fact that just like developing a new model of medical services delivery a new building in itself is not necessarily going to address the challenge of doctor recruitment and retention.

Thus we cut to the fundamental issues surrounding attracting suitably qualified doctors to rural areas. With the implementation of a ROPP model it is really no longer an argument about money. Doctors in rural ROPP arrangements have a significant earning capacity. However, this in itself needs to be balanced by lifestyle and a sense of inclusion and acceptance by rural communities.

The lifestyle issue is one trying to be addressed at Charleville. A shared on-call arrangement with three QH ROPP medical Officers and local GPs would assist in this regard.

Part of the sense of inclusion and acceptance refers to not only the community in general but also the hospital work environment in which the doctors operate. It is imperative that hospital staff are engaged, welcoming and supportive to new doctors entering rural towns. Too often here has been resentment in the rural setting of the doctor's use of the Medicare Billing System when treating patients eligible for such billing in the hospital environment (this refers to doctors employed in a ROPP role).

Staff can see such billing as 'wrong' in that the doctor is seen to be 'lining' their pockets and that this undermines the state funded public health system and that patients have the right to receive free medical treatment. This view is at times difficult to understand where doctors are bulk billing for treatments and not charging any co-payments.

In reality this view is incorrect as the doctors use of the MBS actually adds to the health dollar investment into the rural community. In the hospital setting (where appropriate) it means that the doctor can receive a deserved remuneration benefit for treating patients, usually out of hours. This in turn assists to encourage doctors to feel valued for their services and adds a financial incentive for doctors to continue to practice in the community.

Where nursing time is used (e.g. taking an ECG) the doctor can be charged a facility fee. Thus the Medicare investment coming into the community for each occasion of service can be shared between the doctor and the health service. The facility fees represent additional funds invested into the local health service which enables it to have a greater discretion in the reinvestment into local health initiatives.

There is a key responsibility on the organisation to educate and engage with staff to discuss and highlight the benefits of these arrangements. In keeping with this approach it is important to educate the community on the benefits of this approach. Using the local council was an effective way to initially provide information to the community on the benefits of adopting the ROPP model.

In a broader context it would possibly be useful to use a formal community forum which included key community participants which would keep the key players accountable in terms of the success or otherwise of recruitment and retention of doctors. The forums could involve QH officials, local doctors, community leaders and other relevant stakeholders. This forum would allow for information dissemination, clear communication and ensure that individuals remained accountable to the community for their actions in supporting the recruitment and retention of suitably qualified medical officers.

In concluding it is also worth noting some general policy initiatives which need to be considered when examining ways to recruit and retain suitably qualified doctors into rural Australia. These include:

- recognising rural practice as an area of specialty medicine;
- developing partnerships with equivalent overseas General Practice training authorities to facilitate rotational placements into rural GP settings within Australia;
- bonding new medical graduates to state health systems for a period of up to two years service.

These are only a sample of the initiatives which need to be considered however there are significant structural initiatives which need to be instigated if there is going to be meaningful progress in addressing the chronic shortage of doctors into rural Australia. Locally there needs to be collective responsibility taken, as has happened in Charleville, to develop a medical model and attempt to create a corresponding environment both in a physical and supportive

sense which will be conducive to doctors to commit to a reasonable tenure in a rural environment.

However, while local community responsibility is integral in this process so is the structural initiatives which are needed to improve the doctor supply side of the ledger. Communities can move to differentiate themselves from other communities in terms of attracting doctors but when all we have is an ever increasing number of rural communities competing for an ever decreasing pool of available doctors there is also going to be a problem of major proportion affecting the provision of doctors into rural communities.

PRESENTER

Rob Pulsford has worked in the health industry for 19 years, originally completing hospital-based Registered Nurse Training at the Royal Brisbane Hospital in 1989. Since then he has completed both Midwifery and Psychiatric Nursing Qualifications and a Bachelor of Nursing. Further postgraduate studies have been completed in project management, health economics, further education and training and business administration. Rob has worked extensively in rural, remote and regional settings and is currently the District Manager at the Charleville Health Service District in Queensland. Particular areas of interest include the development of sustainable models of health care service delivery into rural and remote areas of Australia with an emphasis on the challenges presented in recruiting and retaining suitably qualified health practitioners.