RDA NSW
Rural Doctors' Association

Caring for the Country

THE BUSH TELEGRAPH
A Quarterly Newsletter | **Spring 2009**

Presidents Report

Dr Ian Kamerman

G'day and welcome to our rural colleagues. I do hope that spring blows away those winter blues and also brings us some welcome showers.

In NSW we now have "Caring Together" the state government's response to the Garling inquiry. Nationally the report of the National Health and Hospital Reform Commission has been released and the federal government is undertaking a community and health professional consultation process prior to releasing its response before the end of the year. Your Executive and our colleagues nationally via the RDAA are participating in the consultation process and the "Caring Together" reform process. We do this in an effort to ensure that rural practice and rural people have a voice in these major structural reforms.

With a state election in 18 months the RDA Executive is developing a number of policies to take to all parties and independents prior to the election. If RDA has an opportunity to shape political health policies we will do so. To that end member feedback is vital and I would invite all our members to avail themselves to the opportunity of participating in our monthly teleconferences and also our annual meeting in Bondi in November, to help develop and refine the RDA position.

Over the last two months I have had the opportunity to travel fairly widely internationally in my own time.

As many of you would know I hold a long standing interest in rural practice training and I attend a US conference regularly run by the Society of Teachers of Family Medicine, which has a rural group in which I actively participate. I was stunned this trip to hear how demoralised rural doctors are currently. They earn relatively less than we do, work longer hours and have more procedural skills than we would commonly use. Less than 5% of current medical school graduates choose to go rural. Many of their patients cannot afford to access care. The Obama health reforms appear to be too little and too late.

I also caught up with a few friends in the United Kingdom. They are mostly looking for early retirement. The reforms

over the last decade have put a lot of money into their pockets, but have taken many of them away from doing what they enjoy in general practice, instead they are just trying to hit targets. This seems to be where the current Australian reforms are heading.

Lastly, I attended the World Rural Health Conference in Crete, where I heard the inspirational Barbara Starfield, Professor of the School of Public Health at Johns Hopkins. She states the "bleeding obvious" backed up with excellent research. People and communities do better when they can access generalist medical care in their own communities.

I will close this article with a quote from her and look forward to seeing all of our members at Bondi.

"Primary care deals with most health problems for most people most of the time. Its priorities are to be accessible as health needs arise; to focus on individuals over the long term; to offer comprehensive care for all common problems; and to coordinate services when care from elsewhere is needed.

There is lots of evidence that a good relationship with a freely chosen primary-care doctor, preferably over several years, is associated with better care, more appropriate care, better health, and much lower health costs. In contrast, little is known about most of the benefits of specialty care, although we do know that the greater the supply of specialists, the greater the rates of visits to specialists. We also know that when specialists care for problems outside their main area of expertise, the results are not as good as with primary care. Since most people

with health problems have more than one ailment, it makes sense to have a primary-care practitioner who can help decide when specialist care is appropriate.

It is not surprising then, that areas with more primary-care physicians have better health, even after demographic differences (such as age distribution and income levels) are taken into account. A nationally representative survey showed that adults who reported having a primary-care physician rather than a specialist as their regular source of care, had lower subsequent five-year mortality rates, regardless of their initial health or various demographic characteristics.

Furthermore, areas with higher ratios of primary-care physicians to population had much lower total health-care costs than other areas, possibly because of the better preventive care and lower hospitalisation rates that accompany good primary care. Care for illnesses common in the population—for example, community-acquired pneumonia—was more expensive if provided by specialists rather than generalists, with no difference in outcomes.

In short, primary-care physicians do at least as well as specialists in caring for specific common diseases, and they do better overall when the measures of quality are generic."

NSW Rural Doctors' Network / NSW Rural Doctors Association 2009 Rural GPs Conference

The NSW RDN / RDA (NSW) invites rural general practitioners, medical specialists, overseas trained doctors and medical students interested in rural general practice to the annual Rural GPs Conference (formerly known as the AGM Conference) on November 26-29.

The conference offers an extensive partners and kids program, making it a perfect opportunity to update your clinical skills, gain CPD Points and catch up with colleagues and their families.

This years conference and AGM is again being held at the 'Swiss Grand Hotel' Bondi Beach.

It is a great weekend and being located in Sydney gives families the chance of Christmas shopping and enjoying the beach at Bondi.

We recommend you book early to ensure your accommodation at the Swiss Grand.

There is a link to registration on our website www.rdansw.com.au or return the registration form included with this newsletter.

Membership Update

Membership now stands at 409 rural doctors in NSW. Our membership year is now 1st July to 30th June.

RDA NSW is one of the few representative organisations that is almost wholly dependant on membership subscriptions, and is run by a small dedicated group whose only brief is the interests of our members.

We need membership subscriptions to stay afloat so we appreciate members paying early and letting us know of any problems.

Please encourage other doctors and your registrars to become members of the Rural Doctors Association of NSW.

Membership forms are available at www.rdansw.com.au

Workforce Enquiries

Our partner organisation, the Rural Doctors Network of NSW handles all enquiries about Australian or overseas trained doctors looking to work in rural NSW.

They also have an excellent tool on their webpage to help medical students to determine which scholarships they are able to apply for.

They can be contacted on 02 4924 8000 or visit their webpage at www.nswrdn.com.au

Rural Doctors Association NSW Committee of Management 2010

Please consider standing as a Committee of Management member or taking on one of the senior positions in the executive for the coming year. The Committee of Management meets for 90 minutes (strictly adhered to) once a month by teleconference.

These meetings are currently held at 8:00pm the second Wednesday of the month, with the Advisory Council joining at 8:30pm.

Settlement Package Item Number Queries

Dr Geoff White

Question

I can't see how it (the disk) will help me convert item numbers not on the 1987 schedule. Examples are items 30332, 30336, 30405, and 31512. I have around 20 item numbers to use that are new since 1987. To do this I will need a copy of the 1987 Medicare Schedule to enable me to calculate the fee. Are you able to help me with this. Alternatively if you can supply me with the calculations from the current Medicare Schedule.

Answer

Calculations are very straightforward as per Clause 4.1 of the Fee Schedule Clarifications Document 1995 (available on the RDA NSW Website www.rdansw.com.au).

If an Item was not covered by the 1987 Schedule (every 1987 Item is on the disk) then you take the current CMBS Fee and multiply it by the RDA Multiplier which is listed at the end of the sample schedule we send out - currently 1.486, if you look at '4.1 current RDA/CMBS ratio' at the end of both the alpha and the numeric listings.

Question

What fee schedule item number do I use for a Sexual Assault Assessment?

Answer

As explained in the notes in the front of the fee schedule there are 6 different fee schedule item numbers used for claiming for a Sexual Assault Forensic Consultation. The relevant fee depends on the length of the consultation and whether it is conducted during anti social hours.

The relevant item numbers are:

1500- Less than 2 hrs other than in anti social hours

1502- Less than 2 hrs during anti social hours

1504- 2-3 hrs other than in anti social hours

1506- 2-3 hrs during anti social hours

1508- Over 3 hrs other than in anti social hours

1510- Over 3 hrs during anti social hours

Anti social hours are classed as any day between 12am and 7am.

Report on National Registration and Accreditation for Health Professionals Meeting 24/06/2009

Dr Les Woollard

This meeting was held in Parliament House Sydney chaired by Karen Crawshaw. The Minister gave a five minute speech.

NSW Bill

Draft bill B is at http://www.nhwt.gov.au/natreg.asp. The next version, Draft C will be the final bill. Pilot Registration Starts December 2009.

National Board and State Boards

The national office will be located in Melbourne; there will be state and territory boards which will be ministerial appointments. Registration and complaints procedures will be at state board level.

NSW is so impressed with its own complaints mechanisms that it will be retained There will be an independent accreditation process which will advise the boards.

Key new elements

- State boards
- Mandatory reporting. This means reporting inappropriate or incompetent work by doctors. Interestingly only doctors will be required to report on their colleagues. Further I asked what would happen to anyone who was found not to have reported a colleague who later (? decades later) has found to be incompetent/inappropriate. It appears that such an individual will rely on the good sense of any future board and there are no defined penalties for NOT dobbing in your colleagues, just the chance that you might end up at the new state board being investigated
- Criminal history identity checks. Self explanatory and I note that this year after working for 27 years at Moree District Hospital I was asked to prove my identity!
- Simplified complaints arrangement:- as above. NSW believes it has the answers, so will not change
- Student registration - a new initiative
- Independent accreditation process. This means independent of the boards and I believe the Health Minister. However the Minister will have some "reserve" powers
- 3 new regulated professions by 2012 They are ATSI Health Worker, Medical Radiation, Chinese Medicine
- Privacy protection for practitioners and consumers
- Mandatory CPD

Registration Categories

- General - this is most of us I believe
- Specialist
- Provisional, mainly interns
- Limited, this includes postgraduate, supervised practice, area of need, public interest, teaching or research
- Non practising
- Student

There will be grandfathering and I gather all doctors will be advised of their categories prior to the start date.

As far as the NSW RDA is concerned it appears there will be cosmetic changes only in NSW.

We are reliant on RDAA and AMA to represent us as these are largely national issues

CanNET Meeting 24/06/2009

Dr Les Woollard

I have a personal interest in the provision of chemotherapy/oncology services in rural NSW, specifically in campaigning for services to be provided locally in Moree to prevent ill and dying patients making exhausting and mostly unnecessary 6 hour round trips to Tamworth. This has made some slow progress over the last decade or so with some chemotherapy being offered in Moree.

I was a late invite to this meeting in Sydney, organised by the NSW cancer institute to discuss CanNET NSW .

I had little if any knowledge of this initiative prior to my invite but one of its goals was "to improve access to quality, clinically effective cancer services throughout Australia, particularly for specific population groups that have poorer outcomes." Some key elements and principles that underpin CanNET are:

- Active consumer involvement;
- Active general practitioner involvement;
- Formalised linkages between cancer services;
- Enhanced communication and data systems; and
- Continuous quality review and improvement.

This particular initiative involved the Northern AHS in NSW, specifically NCAHS, HNEAHS and NSCCAHS and I believe this has attracted several million dollars of funding over several years. My comments on the day were as follows:

1. Meeting Composition

I was the only GP present, to my knowledge, and invited as an afterthought my invite arriving after the closing date. On many occasions reference was made to being inclusive of GPs in any initiatives. The emphasis seems to be on instituting Multi disciplinary teams (MDTs) that follow treatment guidelines.

There are apparently 160 MDTs across NSW with titles such as "General, Urology, GI, Breast, Lung, General (palliative care) and Haematology".

Each of these MDTs is supposed to have 9-11 clinicians and I note GP is in top 3 of all of these MDTs composition.

There are 19 different titled MDTs which include those mentioned above and others to numerous to mention here.

Only 9% of the 160 MDTs have apparently met the composition guidelines which means, I assume, GPs do not sit on many of the MDTs in the state at this time.

I am not one of those to my knowledge despite being the only GP present at the meeting.

2. My Overall Impression

Firstly the good points. It seems someone is trying to improve access for rural patients to oncology services which is a fantastic initiative.

If they take advantage of 21st century technology this should be possible within 100 km of most cancer patients. I fail to understand why patients are made to travel ridiculous distances to have an IVI set up and pre packaged drugs infused to a pre determined protocol. They then get less than 5 minutes on many occasions to see the oncologist.

Whilst applauding any initiative that aims to improve cancer care in rural areas I have serious concerns.

The meeting attracted few GPs (1 only) and worryingly seemed to concentrate on building empires.

When Norman Swan asked the question whether a young male with a superficial melanoma adequately excised should be referred to an MDT there was a significant yes response.

This is despite well publicised guidelines on the management of melanoma being available and being non controversial.

My concern is that all "cancer" patients will get forced into these teams regardless of benefit and this will just be another strategy to increase the health workforce in major centres where MDTs must be based. It may also insist on patients travelling to be seen at these clinics

Despite continually referring about the need to involve GPs and ensure timely information exchange the group appears to have been unsuccessful in involving GPs to this stage.

I sincerely hope this improves in the future and this group fulfils its admirable objectives.

NSW doctor drive hampered by rural funding vacuum

Dr Les Woollard

Media Release - 17/07/2009

The Rural Doctors Association of New South Wales (RDA NSW) says while it welcomes NSW Government funding to recruit more Junior Medical Officers (JMOs) and trainee specialists in the state, there is little chance these doctors will be attracted to rural communities in the long-term.

RDA NSW immediate past-President Dr Les Woollard said as long as NSW has no dedicated rural medical training program and the rural hospital system is a shadow of its former self, these much-needed rural doctors won't stay.

"It is great to see the NSW Government advertising 3000 JMO positions for the state's public hospitals, including some additional JMO and trainee specialist positions on last year's intake—but the reality is these young doctors will only stay in the bush for their one year as hospital interns and then head back to the big smoke. In the continuing absence of a dedicated rural medical training program there's nothing to keep them. We are desperate for more rural doctors and RDA NSW has been calling for such a program for many years," Dr Woollard said.

"The NSW Government provided $3 million about eight years ago to establish a rural medical training program for the state, but this program has been largely ignored by NSW health and health ministers recently.

"What we really need is a training pathway like that recently introduced in Queensland, where junior doctors enter a dedicated rural medical training pathway which is funded by the Queensland Government and provided by the Australian College of Rural and Remote Medicine.

"This dedicated pathway, which is also being combined with an impressive support and remuneration scheme (also provided by the Queensland Government) for doctors who elect to work in the bush, is already delivering well-trained rural doctors to Queensland's rural communities. In fact a maternity unit is going to reopen in Cooktown as a result of these initiatives in Queensland

"Unless the JMOs going through the NSW public hospital system can access a dedicated training program that will equip them with the advanced skills necessary for a career as a rural doctor, they will finish their one year internship at a rural or regional hospital, hop in the car and head straight back to the city to take up the raft of city-based training programs available there.

"The dedicated rural medical training program that RDA NSW has been calling for would include training in obstetrics, anaesthetics and general surgical skills—because these are exactly the skills that doctors working in our isolated communities need.

"The very nature of rural practice means that doctors working in the bush are also the local hospital doctor—so they need to be able to resuscitate accident victims and keep them stabilised until they can be transported to major hospitals. They also need to be able to undertake emergency surgery, deliver babies and administer general anaesthetic (often to save lives).

"It is also well and good for the Government to say that it will encourage JMOs and trainee specialists to undertake their intern years in rural and regional towns, but the reality is that over 50% of the state's rural hospitals have been downgraded or closed in the past decade alone—and there's simply no point undertaking your training in an emergency ward or maternity ward that was closed two years ago.

"In short, the NSW Government needs to make a substantial investment both in the state's small rural hospitals and in a dedicated rural medical training pathway for junior doctors if there is to be any hope of saving NSW's rural doctor workforce from extinction in the next five to 10 years—at the moment, we are simply not attracting enough new doctors to rural NSW to replace those who are retiring."

Rural Doctors Liaison Committee 17/09/2009

Dr Geoff White

Ian Kamerman, Tilak Dissanayake, and Geoff White present from RDANSW

Indexation of Rural Doctors Settlement Package Rates

It was agreed to Index at 4.16% and use NSW Health weightings in the formula for next year. GDW gave NSW Health a copy of what RDA Sample Schedule would look like at that Indexation level. NSW Health gave GDW a copy of what they proposed. GDW noted several errors on their first page which NSW Health agreed to correct. It was noted that again this year some Item fees will be 10 cents different between the two. NSW Health to email GDW their Draft Schedule to compare these using a Spreadsheet for speed to ensure no often used Items are disputed.

Next meeting date: 10 December 2009

"Closing Pambula's busy maternity unit and forcing experienced doctors off the roster...is that really the safest option?" rural doctors ask NSW Government

Rural Doctors Association of Australia and Rural Doctors Association of NSW

Joint Media Release - 23/09/2009

Rural doctors have 'rejected outright' claims by a NSW Health employee on ABC TV's 7.30 Report that closing the maternity unit at Pambula Hospital on the NSW Far South Coast has led to a safer model of obstetric care for mothers and babies in the entire Bega Valley Shire.

"On Monday's program, Dr Joe McGirr from the Greater Southern Area Health Service repeatedly indicated that centralising maternity services at Bega Hospital was the best option to ensure the safety of mothers and babies in the Bega Valley Shire" RDAA President, Dr Nola Maxfield, said.

"This is despite the fact that closure of Pambula Hospital's maternity unit has left the southern part of Bega Valley Shire without a local maternity unit and dramatically increased the patient load on Bega Hospital.

"It is also despite the fact that closure of Pambula's maternity unit has forced 4 of the region's 6 local GP obstetricians from the Shire's obstetric roster, due to the logistical difficulties in them attending deliveries at Bega Hospital from their bases at Pambula and Merimbula (an hour's round trip away).

"And it is despite the fact that while there were once two busy maternity units in the Bega Valley Shire, now there is just one—but there has been no subsequent increase in the number of maternity beds at Bega Hospital and a significant decrease in the number of local obstetricians now participating in the Shire's obstetrics roster.

"How can halving the Shire's maternity units, reducing by two-thirds the available local GP obstetricians, and relying on a locum roster at a cost per locum of more than $2500 per day really lead to a safer model of maternity care for the mothers and babies of the Bega Valley Shire?

"And what is the best option—a locum who is in town for a couple of weeks and only sees you on the night you deliver, or your local GP obstetrician who has cared for you throughout your pregnancy?

"It is high time the maternity unit at Pambula Hospital is re-opened, to enable all of Bega Valley Shire's local GP obstetricians to again provide local women and babies with the high quality, safe obstetric care—and continuity of care—they deserve."

RDA NSW President, Dr Ian Kamerman, said the safety record of small rural maternity units had been endorsed by studies in recent years, with one showing that—for low-risk women—smaller maternity units are actually safer places to give birth than larger units.

"Given the critical medical workforce shortages we have in rural Australia, it beggars belief that NSW Health would choose to deprive a significant part of the NSW South Coast from safe local obstetric care. Once these doctors become deskilled it may mean their vital skills are lost to the Australian community forever.

"RDA NSW once again invites the new NSW Minister for Health, Ms Carmel Tebbutt, to see for herself the care that is provided safely at any one of the remaining small maternity units in rural NSW.

"It is also imperative that, while-ever Bega Hospital has to rely on locums to try to meet the increased demand being placed on its maternity unit, those locums must have proper Australian credentials or experience and be fully endorsed by the appropriate Australian medical colleges."

Rural doctors invite new NSW Health Minister on fact-finding tour of country hospitals and practices

Dr Ian Kamerman

Media Release 15/09/2009

The Rural Doctors Association of NSW (RDA NSW) says it would welcome the opportunity to host the new NSW Health Minister, Carmel Tebbutt, on a fact-finding tour of rural hospitals, health centres and medical practices, so she can see first-hand the important role these services are providing for those living in country NSW and the range of challenges they are facing.

"We welcome Minister Tebbutt to the health portfolio and look forward to working with her to improve access to healthcare in rural and remote communities right across NSW" RDA NSW President, Dr Ian Kamerman, said.

"It is great to see that this portfolio is now under the responsibility of the Deputy Premier—we fervently hope this means key rural health issues will be heard and acted upon at the highest levels of the NSW Government.

"As a first priority, our rural doctor members right across NSW would welcome the opportunity to discuss key issues with Minister Tebbutt on-the-ground at their local hospitals, health services and medical practices, so she can see for herself the essential services these doctors and other health professionals are providing in country NSW, often under extreme budgetary and other pressures such as health workforce shortages.

"We would like her to visit a range of rural and remote locations—including those where hospital services have been downgraded (so she can see the direct impact this is having on local communities and rural patients) as well as those where positive initiatives and positive healthcare models are making a real difference in ensuring better access to healthcare for rural people.

"In addition to inviting the Minister on our rural health tour, we look forward to the opportunity to meet with her at her office in Sydney, to bring to her attention the key issues facing rural health professionals and health services in country NSW.

"With over half of all NSW's previously existing rural maternity units having been closed in the past decade, and the current cohort of rural GP obstetricians, rural GP anaesthetists and rural GP surgeons nearing retirement, now is the time for affirmative action to reverse this situation before it gets worse.

"We need new, positive measures to get and keep more doctors and other health professionals in rural NSW, and affirmative action to revive the state's rural hospital network, so those living in rural NSW once again can access the healthcare services they need and deserve.

"With the right investment and a genuine commitment, the NSW Government could deliver a world-class rural health system in this state—we would welcome the opportunity to work with Minister Tebbutt and the NSW Government to make this a reality."

RDA SP Annual Increase

At the last liaison meeting an indexation figure of 4.16% was agreed upon. Once again thanks to Geoff White for his efforts this year and for the last 20 plus in working this out. This will automatically be applied as back pay to August 1st sometime in the next 4 months.

Cuts to Procedural Services at District Hospitals

Dr Belinda Bailey

Last month the Greater Southern Area Health Service announced that it would be making wholesale cuts to procedural services at district hospitals. The cuts applied to every district hospital in Greater Southern Area Health Service (GSAHS). The day after these decisions were made they were reversed.

The number of cases that VMO's were allowed to operate on per year was going to be based on the waiting list, and because many of these hospitals don't have waiting lists they just book patients straight onto surgery lists GSAHS assumed that no one was waiting for surgery and therefore nobody needed surgery.

As a result of this they therefore ruled that the maximum number of cases that VMO's could do per year was varying between 5-7 which is virtually closing the services down.

Fortunately Dr Joe McGirr, Director of Clinical Services at GSAHS, has since said that this ruling was not supposed to apply to district hospitals, only to base hospitals, so the rulings have now been reversed at district hospitals. GSAHS, when it made this policy lost sight of how it impacted on smaller hospitals. It was good that when they realised that they had made the error they immediately reversed it, even though they scared everyone in the process!

Obstetric and Anaesthetic Grants

These grants, averaging $18,294.01 per annum per GP Obstetrician (2007/08), are designed to encourage rural doctors to continue treating public patients, and providing on call, in these fields. These grants are treated as taxable income by the ATO.

To be eligible the doctor must have been a GP with a VMO status, and privileges in the field of the grant, at a hospital which operates under the RDA Package. They must be appointed for the whole of the previous 3 months before receiving payment at the end of that quarter. It is expected that the position is bona fide e.g. 24 hour Obstetric cover is generally provided for all public patients and that each doctor receives only one Obstetric and/or Anaesthetic Incentive Grant (from the hospital where the most work is carried out). GP Registrars and Locums are not eligible unless they are present for over 12 months.

Doctors practicing in Areas of Need and doctors whose hospital credentialling expires during the period remain eligible as in most instances the appointment will be renewed without question. A set amount is available to each hospital per year, which is divided amoung the VMO's at the hospital equally* retrospectively for the quarter, regardless of whether the VMO was included in the original calculations for the year or not. *The only exception to this is the grant for a GP-Anaesthetist is now reduced by 50% if that doctor also receives the Obstetric Grant.

Each member of the RDA NSW executive has access to the total grant figure for each of the RDASP hospitals in NSW. If you wish to verify the amount offered by your hospital. The executive contact details are included on the back page of this newsletter. Grants for each hospital are not widely published to protect each doctor's privacy.

RDA NSW Committee Nominations

RDA NSW Committee meetings are held by teleconference at 8:00pm the Second Wednesday of the month.

If you would like to nominate a member of the Committee please complete the nomination form and return:

Phone: 1800 350 732

Email: admin@rdansw.com.au

Fax: to 02 6944 4336

I am interested in being on the RDANSW Committee

I nominate the following to the RDANSW Committee

Name: ....

Position Nominated for: ....

Hospital:..

Area Health Service: ....

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