Towards a sustainable medical healthcare workforce in Portland

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1. Executive Summary

Current Situation at Portland District Health

Healthcare for Australia's rural population is complex, being challenged by distance and geography. Portland District Health (PDH) provides clinical services in an Outer Regional area of Victoria (1). Providing a sustainable profile around its medical staff and associated health services is particularly difficult reflecting the increasing challenges of recruiting and retaining staff in regional and remote areas.

The current model of service is provided by a mixture of salaried Specialist Staff and Fee for Service Visiting Medical Officers. They are supported by a junior medical staff profile of International Medical Graduates, often in their earliest stages of supervision as they enter the Australian medical workforce. There is only very limited involvement by the local general practitioners. The reasons for this are complex and are found in many regional areas. However, it is accentuated in Portland by a previous but substantial dispute between influential local medical practitioners and the hospital. Unfortunately, this and other factors has impacted clinical services, the culture and educational opportunities that are available, all important to a sustainable workforce.

Of necessity, Portland District Health projects itself as a small specialist based hospital. However, it lacks and will continue to lack the critical mass of clinical activity to provide sustainable clinical services and the vital educational or training opportunities to support them. Australian qualified and recognised specialists only infrequently apply for positions to become based in the local area. This has not facilitated a collaborative approach to health service delivery in the region. The ability to network services across South West Victoria based around Warrnambool or Barwon Health has been tentative and without a cohesive solution. Hospitals are still perceived as isolated entities rather than part of an integrated health system. As a consequence clinical governance, medical interactions and educational opportunities have struggled to become established or add value. These are all issues that contribute to a lack of sustainability in the workforce and Portland remaining an 'Area of Need' in all medical specialties.

The outcome has been an overdependence on a single person approach to specialty service provision backed up by locum services if available, with the inevitable and substantial gaps in coverage. Continuity of care and reasonable on-call rosters demand a critical mass of involved practitioners to 'share the load'. There is increasing recognition that four in an on-call service would be an appropriate number (2). Otherwise gaps in coverage are inevitable. Gaps impact on the quality of clinical service. Without sufficient numbers of specialists there are also substantial issues in meeting the supervision requirements for trainees or international medical graduates. This supervision involves the various medical colleges and the Medical Board of Australia / Ahpra at both a junior staff level and senior staff level when more comprehensive staffing is attempted. There is dependence on specialists who are resident in Portland for a number of days and then have employment commitments in other parts of Victoria or interstate. This results in variability in on-call coverage, clinical supervision, referral patterns from local general practitioners and limited cohesion to develop a culture of teaching, learning and research within the organisation. The absence of the right 'culture' was frequently mentioned in interviews with stakeholders and remains a key impediment to the recruitment, retention, and training of staff.

The current management and Board of Portland District Health have strenuously explored avenues of becoming self-sufficient in specialist services and now have a range of medical services. Like many small outer regional hospitals this reflects the attraction of the region, employment arrangements and availability of hospital related support and infrastructure. Comparative expenditure per capita for hospital based services as well as the configuration and inherent quality of clinical services remains a concern to the Department of Health and Human Services (DHHS). Despite substantial medical staff expenditure, the profile of the specialist hospital remains fragile with its weakness demonstrated by substantial locum and short term appointments.

The management team have made substantial efforts around clinical governance and there is close monitoring by both themselves and the Board of Portland District Health. PDH achieves good outcomes in most of the DHHS quality based reports. However concerns were frequently raised by interviewees for this report around the turnover of staff, the supervision of junior staff, the lack of effective medical peer review, the safety, quality, and capacity of clinical services available to the population of Portland. These are not issues that are readily identified or measured in the DHHS reports. Unfortunately, despite enormous effort and financial commitment, the stand alone specialist hospital model remains flawed. The service is often driven by the patchy availability of medical specialists. In addition, the overall Commonwealth and State based health systems and their strategy frameworks are not working effectively in Portland, to support the community and the hospital.

Previous Reviews and Regionalisation

These issues are not new. There have been many reviews of Portland District Health, health service delivery in South Western Victoria, regionalisation of health services in Victoria, training of health practitioners and clinical safety across Victoria. Indeed ‘Targeting Zero’ (3) dramatically stressed the importance of clinical partnerships between small hospitals and larger hospitals to benefit clinical governance. The recommendations from these reviews have been broad and have included strengthening governance particularly clinical governance, senior management capability and financial controls. Addressing staffing profiles particularly around the Urgent Care Centre, reliance on locums, having regionalisation of key clinical services, credentialing and appointments, re-engaging with the local General Practitioners and ensuring better use of infrastructure particularly beds and operating theatres are consistently highlighted.

Significant efforts have been expended to address some of the concerns identified. However, key recommendations around regionalisation or service delineation have barely progressed. As a previous reviewer highlighted ‘It is however acknowledged that (as at July 2017), PDH would not agree that the sustainability and stability of services delivered to the catchment over the last five years has been problematic. PDH recognise that structural issues exist, and attribute these issues to the funding method’ (4). Funding is not the key issue. It is the structural concerns that dominate. An isolated specialist hospital, not effectively integrated into regional services, staffed with very junior resident medical officers and with limited effective hospital-local general practitioner interaction is not achieving the level of care required. The model needs to change.

Regionalisation requires a ‘win-win’ approach and there are substantial concerns in Portland about loss of services in health related areas but also in other government funded areas such as education. It will require a highly positive and supportive approach from all parties but particularly the medical specialists within South West Victoria to ensure a ‘win-win’ outcome. Being in regional partnerships is very different from ‘being absorbed’. That is why a federated partnership was previously recommended (4), but this has not progressed due to challenges in creating ongoing trust. Indeed the lack of trust or the inability to deliver on commitments is

frequently mentioned as to the lack of progress. In the Victorian health model of devolved governance the more difficult areas of regionalisation are often handicapped by local autonomy for strategic and operational decisions. Parochial agendas, fears of 'loss', history and commitments already made, frequently complicate progress of regionalisation.

Health Professional Workforce for Regional and Remote Areas

The past 30 years has seen substantial recognition of the requirements to both train for and practice sustainably as a health professional in the more regional and remote areas. This has been elaborated internationally by the World Health Organisation, as well as individual countries with geographical challenges similar to Australia. There is growing recognition of the requirements for a substantial, sophisticated, and multi-faceted approach to the training, support and professional development of health professionals who wish to practice in these regions.

In addressing health workforce shortages, there has been significant enhancement of nursing roles with Nurse Practitioner training and recognition being an important component in Victoria. Some health services have been effective in provision of health services particularly of a more acute / urgent nature through a Nurse Practitioner workforce, although the ability to provide 24 hour a day coverage in outer regional areas remains an ongoing concern.

Within this 30 year period, the rural generalist model in Australia and internationally has substantially developed. As an example, the Queensland Rural Generalist Pathway is based on four pillars of activity that are recognition of the profession, value of practice, training pathway, and workforce redesign. After fifteen years the Queensland pathway has been demonstrated as an effective model for medical practitioner staffing in the more regional areas of Australia. It has been accepted and broadened to become the National Rural Generalist Pathway. Although endorsed by the various State Health Departments it continues to be variably implemented. Where successful in developing a critical mass of rural generalists, hospitals have now been able to provide a more stable and sustainable medical workforce profile. The rural generalist profile provides self-sufficiency in a number of areas through their extended skills. This is particularly relevant in the areas of emergency medicine, anaesthetics and obstetrics and the rural generalist can effectively interface to regional services of a more specialised nature. The rural generalist model can comprehensively support a hospital like Portland providing an effective supervisory role to junior staff and sophisticated interface to regional services. A well-respected training program would have substantial appeal.

Victorian Workforce Strategy

Unfortunately in Victoria the medical workforce strategy is not working effectively in outer regional areas as particularly demonstrated at PDH. It leaves PDH and many other outer regional hospitals as locum-led outposts providing an inadequate service to the community. Although acknowledging the commitment of Victoria to the concept of Rural Generalists, interviewees were frequently concerned about the lack of effective training pathways and the inadequate recruitment to the program of those wanting to have a career in this specialty in regional Victoria. The State's medical workforce strategy needs to adjust to this reality and comprehensively change with urgency.

The workforce challenges confronting Portland District Health are not unique. Relative geographical isolation with heavy health service demands and the requirement to staff a busy Urgent Care Centre and also maintain hospital services occurs in many areas of Victoria. The critical mass to be a specialist stand-alone facility or advanced specialist medical training site is not able to be achieved. With growth projected to be limited (4, 5) this situation is not likely to

change into the future. However, the fuller implementation of the National Rural Generalist Pathway could address many of the structural issues at Portland (6).

Frequency of Reviews

As already stated, there have been a number of reviews of the health service delivery in South West Victoria. Substantial resources have been expended in obtaining this advice and during this review frustration was frequently expressed that the clinical service issues have not been addressed appropriately. To many, it appears that the decision makers lack the courage to make the appropriate decisions to benefit the health services for the community. This report provides a number of recommendations and options, many of them made previously. If these recommendations are positively accepted by the Board and Executive of Portland District Health and positively supported by DHHS and other key stakeholders, the sustainability of the medical workforce can be substantially addressed in South West Victoria.

In addition, it is most strongly recommended that no further reviews be undertaken until the recommendations accepted by the Department of Health and Human Services and Portland District Health are implemented.

2. Recommendations

Organisational Alignment

In 2017, Aspex Consulting (4) proposed four structural options to improve service planning and delivery in South West Victoria. These were

1. Ad hoc collaboration that represented the model of the day. It is characterised as the continuation of areas of mutual interests that are developed from time to time. There is no systemic or structured basis for collaboration.

2. Formal collaboration that they felt represented incremental improvement. It differed by having a contemporary agreed Memorandum of Understanding (MoU) between the three health services. The MoU would describe the type and level of collaboration. That could lead to a series of changes over time, consistent with the principles of system integration, service integration, role delineation, patient safety and clinical governance, and consistent and sustainable services.

3. A federated partnership would formalise the arrangements established between South West Healthcare, Portland District Healthcare and West District Health Services. In this partnership each legal entity (health service) voluntarily establishes a permanent structure (or standing body that is not an incorporated body) that brings each of them under a common voluntary framework for the stewardship of health services in the sub-region. This can be done without subjugating the rights or responsibilities of their respective health services under the Health Services Act 1988.

4. Voluntary Merger of health services represented the most significant change of all the options. It would provide for a change in governance structures and may apply to two or more health services.

Since 2017, although there have been many discussions around Regionalisation, there has been limited material change and ad hoc collaboration is still the model of service delivery. The ad hoc collaboration unfortunately includes multiple examples across South West Victoria of medical appointments or changes in medical staff profiles that actively undermine the regional provision of clinical services. This will not encourage retention of staff and the sustainability of the medical workforce in Portland.

Effective regionalisation is the critical outcome to improving health service delivery in South West Victoria and addressing sustainability of the medical workforce in Portland. Substantial progression in this can only be achieved through a federated partnership or voluntary merger. This reality must be addressed by the Department of Health and Human Services and the health services involved.

Medical Workforce Sustainability

In addressing challenging medical workforce requirements alternative health workforces need to be seriously considered. The enhanced role of Nurse Practitioners has shown system-wide benefit. Their role could be enhanced at Portland, particularly involving the Urgent Care Centre. This should also be in combination with enhanced telehealth functionality that is not ‘personality’ dependent. However, Nurse Practitioners will not address the sustainability of the medical workforce which is impacted dominantly by issues of critical mass, culture, educational opportunities, and the integration with regional services.

Structural concerns, particularly around regionalisation of services must be addressed to achieve sustainability of medical services. Continuation of the current ad hoc collaboration with other health services will almost certainly perpetuate the current lack of sustainability and clinical risk. This is despite the ongoing endeavours of the PDH management.

This report proposes two specific options, both which require a substantial and immediate progression of regionalisation but are focused on the medical services. Importantly, the current ad hoc collaboration including appointments and changes in the profile of medical staff that undermine the regionalisation of clinical services needs to cease.

1. **Contracting out of the medical clinical service.**

   Contracting out of the medical clinical services would formalise a Hub and Spoke approach to medical services from the selected contractor to PDH. The medical clinical services would be defined, and Expressions of Interest would be obtained to provide the services. There would need to be explicit guarantees to the ongoing staffing with appropriate seniority and supervision on a 24 hour a day, 365 day a year basis. The responsibility and accountability of providing the medical workforce would clearly align to the contracted provider.

   Although South West Health (Warrnambool) is the more regionally based and evident provider, other health services such as Barwon Health and to a lesser degree Ballarat Health Services should be considered. They could also apply a clinical service model that supports regionalisation. Due to their greater critical mass, all three of these health services would have an ability to rotate medical staff between a larger health service and Portland. Their stronger University relationships, as well as being able to supervise clinical activities more fully at Portland with senior staff would enhance the ability to recruit medical staff. Deliberate rotations of staff could be incorporated into ongoing appointments in a variety of models. Credentialing of medical staff would be required on a regional basis. Importantly regional service planning and regional appointments would be necessary immediately. Rapid progression of regional clinical audit, regional peer review and regional clinical governance activities is essential.

   PDH would maintain overall responsibility for the clinical services at Portland, the employment of non-medical staff and contract management of the outsourced medical service. To be successful, it will be most important for the Victorian Health Department to commit to the ongoing support of this model to ensure implementation issues are effectively addressed and appropriately resourced.

   This option would see the effective regionalisation of specialised services. Although it does address issues of sustainability more fully, it does little to directly build effective relationships with the General Practitioners of Portland or the Portland community. There is no doubt that concerns about service profile and effective liaison will continue. The hub and spoke arrangements would need to be particularly alert to this and actively manage community and political concerns.

2. **Re-design of the medical workforce model at Portland.**

   Although re-designing the medical workforce model is the more complex option, this will assist in addressing substantial medical workforce issues present in Portland, at Portland District Health but also in other outer regional areas of Victoria. This relates not only to hospital based care but also to community based care at the Specialist and

General Practice level. The re-designed model will see the core medical staff at Portland District Health being Rural Generalists, recruited to provide a range of clinical services both in the hospital as well as in general practice. They will support and supervise the junior medical staff, preferably trainees within the rural generalist training pathway, and also interface to all regionalised services.

It is again critical that more structured regionalisation of specialist medical services occurs. This should be considered under a federated model. The current ad-hoc model must cease. The regionalised services need to progressively expand allowing for more thorough coverage of the core clinical services, reliable on-call availability, and fuller utilisation of Portland infrastructure. Importantly regional appointments, audit, peer review and clinical governance is essential. The key differences from Option 1 are the increased capacity at Portland through the rural generalist workforce and the active co-ordination and involvement that PDH will provide to the federated regionalisation model. What is common to both options is that credentialing of medical staff would be required on a regional basis. Regional service planning and regional appointments would be necessary immediately. Rapid progression of regional clinical audit, regional peer review and regional clinical governance activities is essential.

This will require a highly collaborative model of key stakeholders, led by the State Department of Health and Human Services, to bring together health service providers, medical and health education providers (Universities, Medical Colleges and Regional Training Organisations), as well as Commonwealth Government and State Government medical workforce strategists. The progression of the National Rural Generalist program will see the effective introduction of the Queensland Rural Generalist model into Victoria. In Portland this will need to be accompanied by effective interfacing with the progressive regionalisation of more specialised medical services.

Rural generalists would need to be recruited in phases. A ‘champion’ for the rural generalist redesign would need to be appointed immediately to forward plan the required workforce changes and gain an understanding of the interface required between the rural generalists, local general practitioners, and regional specialist services. Initially four (4) Rural Generalists would be recruited with Emergency Medicine expertise and additional Rural Generalists would be appointed to supplement the two GP and one Specialist Anaesthetists currently employed. Rural generalists with advanced obstetric skills could be recruited to support the specialist obstetrician. It is anticipated that they would provide general practice services through Active Health and supplement the teaching staff for University and Medical College related teaching.

This change of workforce model is not a decision for Portland District Health alone. Indeed Portland District health could not achieve this change by itself. The number of stakeholders involved in workforce strategies is large and they all must be involved both strategically and, in the detail, to ensure the workforce shortages at Portland are addressed. This will take a medium to long term commitment of at least 5 to 10 years. The history of the involvement of the stakeholders is provided in this report to appreciate that the solutions for Portland must involve multiple parties who bring different but important perspectives. The implementation plan (section 11 of this report) highlights the number of key decisions that need to made and supported over a multi-year timeframe.

The critical issue for Portland District Health is to commit to a cohesive and collaborative approach to regionalisation. The ad-hoc approach of the past needs to cease. They need

to contribute fully to the federated model for regionalisation of clinical services to ensure the increased capacity provided at Portland by the Rural Generalists is recognised.

The second option is recommended by the author. Hospitals in outer regional areas exist not only for the services they provide themselves but also for the strong relationships and integration of activities with other service providers. The hospital is part of the community, and the community's health services, culture and educational opportunities. For these reasons and issues of sustainability, the rural generalist model provides a more complete solution to safer clinical care and better health care in Portland.

Workforce sustainability is a growing concern across multiple outer regional hospitals. There is now a recognised national rural generalist model in Australia that has been successfully implemented and evaluated thoroughly in other States. There are also substantial changes underway in the Victorian Workforce Strategy as well as the delivery of vocational medical education in general practice at a national level. All of these can benefit Portland District Health and if the Rural Generalist model is embraced by the hospital, funders and education providers, Portland could be a highly successful demonstration site of the National Rural Generalist Pathway in Victoria.

3. Review Terms of Reference

3.1 Purpose

The Department of Health and Human Services and Portland District Health engaged Associate Professor David Hillis to review the medical workforce model at PDH and make recommendations on improving the current model and to also consider alternative models. The outcome of the review will ensure services at Portland District Health continue to be high quality, accessible and sustainable at least to the same level currently provided to the Portland and surrounding community.

3.2 Objectives

The review will take into account the policies and drivers governing the current medical workforce model at Portland District Health including how this has changed over time, the relevance to service provision and to inform future planning in rural health.

Areas included but not limited to be:

1. Employment – engagement methods (salaried, Sessional, VMO)
2. Medical / AMA EBA changes - conditions
3. Medical College practices and policies
4. Australia Health Practitioner Regulatory Agency – Medical Board requirements
5. International Medical Graduate employment conditions
6. PMCV accreditation changes
7. Changing role of General Practitioners in Rural Communities
8. Supply and Demand of medical staff
9. Safer Care Victoria standards
10. Australian Quality and Safety Standards in Health care

Review the effectiveness of the current medical workforce model at Portland District Health and propose options and detail as how to improve this against the criteria:

1. Quality of Care
2. Access to healthcare
3. Sustainability

This was to be undertaken in the context of the Aspex consulting service report (2017) of the Outer West subregional clinical service plan (4) and the Biruu consulting local clinical service plan (5), as well as the current service profile as stated within the Board of Management approved Capability Framework of August 2019 (7).

3.3 Outcomes

A comprehensive report detailing the findings from the review and the recommendations to maintain or improve the quality, accessibly and sustainability at Portland District Health medical workforce.

The report will provide information to inform on the impacts of current policy and practices on the provision of services to rural Victorians.

The report will be made available to the Board and Executive of Portland District Health and to relevant areas within the Department of Health and Human Services prior to being finalised and will include DHHS program area and Portland District Health board and management comments.

Portland District Health and the DHHS will agree on the next steps following the report being finalised.

4. Methodology

The reviewer was first contacted by Mr Terry Symonds, Deputy Secretary, Health and Wellbeing Division, Department of Health and Human Services (DHHS) in September 2019. Discussions continued with DHHS with the contractual arrangements being finalised in December 2019. An initial teleconference was arranged with Ms Christine Giles, CEO of Portland District Health in December 2019 with subsequent site visits arranged on 28th to 30th January. During this visit and subsequent teleconferences, 52 individuals were interviewed. This included clinicians, senior staff and Board members at Portland District Health, South West Healthcare, Barwon Health, Western District Health Service, East Grampians Health Service, other health care providers in outer regional areas of Victoria and Queensland, DHHS, Safer Care Victoria, Commonwealth Department of Health, National Rural Health Commissioner, Murray City Country Coast GP Training, Ambulance Victoria, Deakin University and the Australian College of Rural and Remote Medicine.

I would like to acknowledge the willingness of all individuals to be interviewed and their frankness in addressing the issues of concern. A number of them requested not to be identified individually and that will be respected.

I would like to thank Ms Cindy Huppatz, Executive Assistant to the CEO, Portland District Health for her invaluable assistance in arranging many of the interviews and the details of the site visit.

I also need to acknowledge the extensive and high quality work undertaken by previous reviewers of the workforce issues in South West Victoria and also the reviewers of the various training or supporting programs for rural generalists. This review has deliberately tried not to duplicate their work but to utilise and acknowledge their work to highlight key issues that need to be addressed to form a view around the recommendations for sustainability of the Portland District Health workforce.

5. About the reviewer

A / Prof David Hillis of Oban Consulting has substantial experiences as a rural general practitioner, senior executive / CEO of health facilities across Victoria and also CEO roles within the educational sector. He has consulted broadly on organisational design, cultural and change management issues as well as having broad governance experience across community, health and educational organisations.

6. Portland

The population of Portland is 10,900 (2018) with the entire Shire of Glenelg being 19,600 (2018). The projection for population growth from 2016 to 2036 is stated as being a small decrease of 0.3% annually (8). The population of the Barwon South West Region in 2018 was 412,000. Although not isolated in the context of Australia more broadly, Portland is isolated in the sense of metro-centric Victoria. Historically it was the first settlement in Victoria due to its harbour profile. It continues to have substantial Port facilities and deep harbour access for shipping as well as key industries including the Alcoa Aluminium smelter and Keppel Prince Engineering.

Glenelg Shire as a whole has comparatively poor health status and high levels of social disadvantage as well as relative remoteness. Health outcomes and activities data also indicate higher than state average rates of avoidable deaths, alcohol and drug treatment services and registered mental health clients, cancer incidents, disability support pension and age pension recipients, potentially preventable hospitalisations, and a range of self-reported health conditions. There are also higher rates of admission per 100,000 Indigenous population for acute urinary tract infections, chronic diabetes complications, cancers, respiratory system disease and others (4, 5). These issues are not unique to Portland and are evident in more remote communities, but these communities are not generally of the size of Portland and the Portland population has a high hospital utilisation rate.

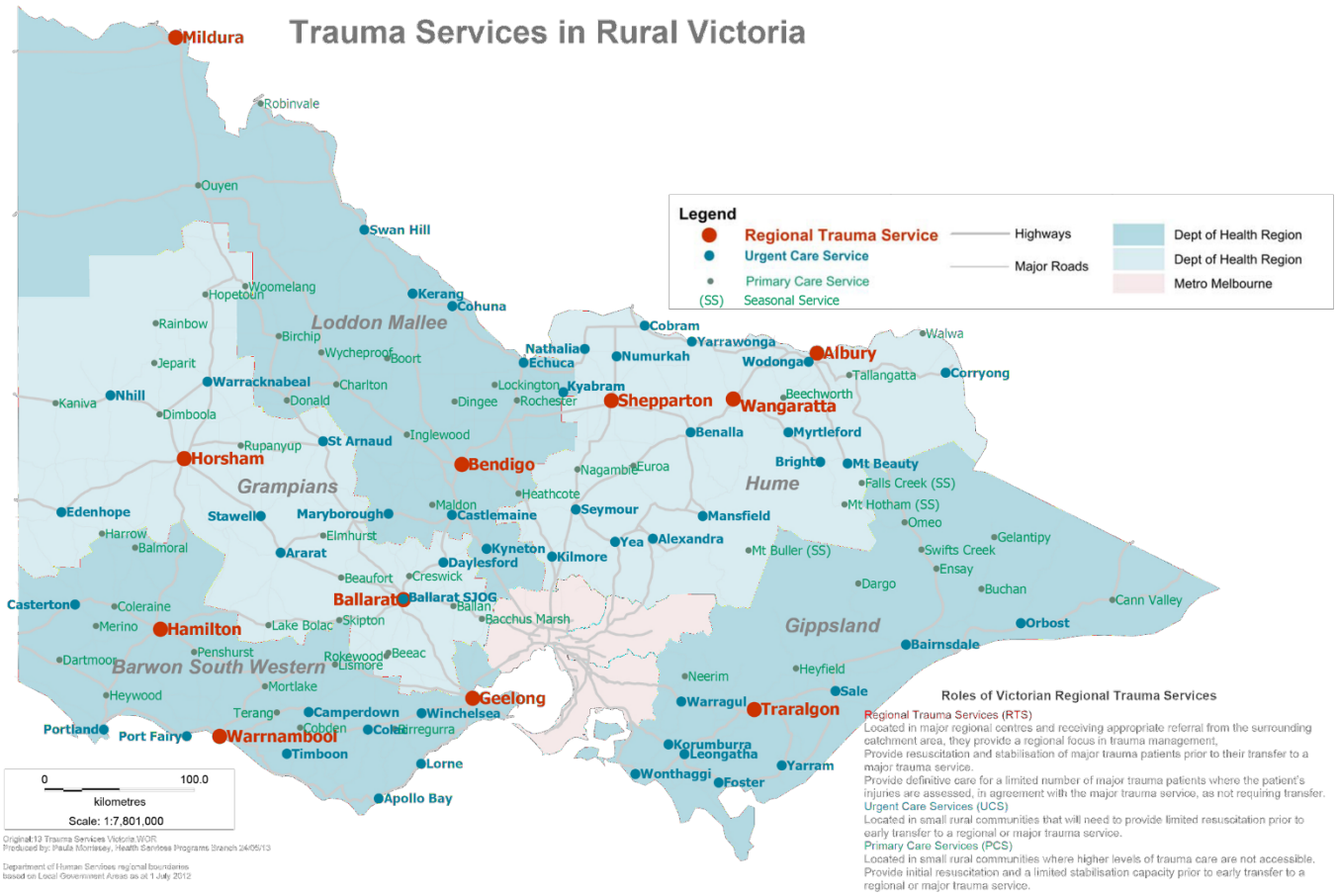
Demographic projections for Portland show limited population growth and subsequently limited growth in demand. (4, 5) The growth in service provision demands will continue to be in areas of aged care, chronic care and complex medical care. (4, 5) With self-sufficiency already at a high level, it is unlikely that a greater percentage of the local population will satisfy their health requirements by attending Portland District Health.

7. Portland District Health

Portland District Health commenced operation in July 2003 following the amalgamation of the Portland District Hospital and the Portland Community Health Service. It is classified as a local health service providing acute medical and surgical services, aged care services, allied health and primary care services. It is acknowledged as operating at the higher end of the description of a local health service which includes maternity and lower complexity surgery. The acute services also include providing a 24 hour a day Urgent Care Centre in the city of Portland.

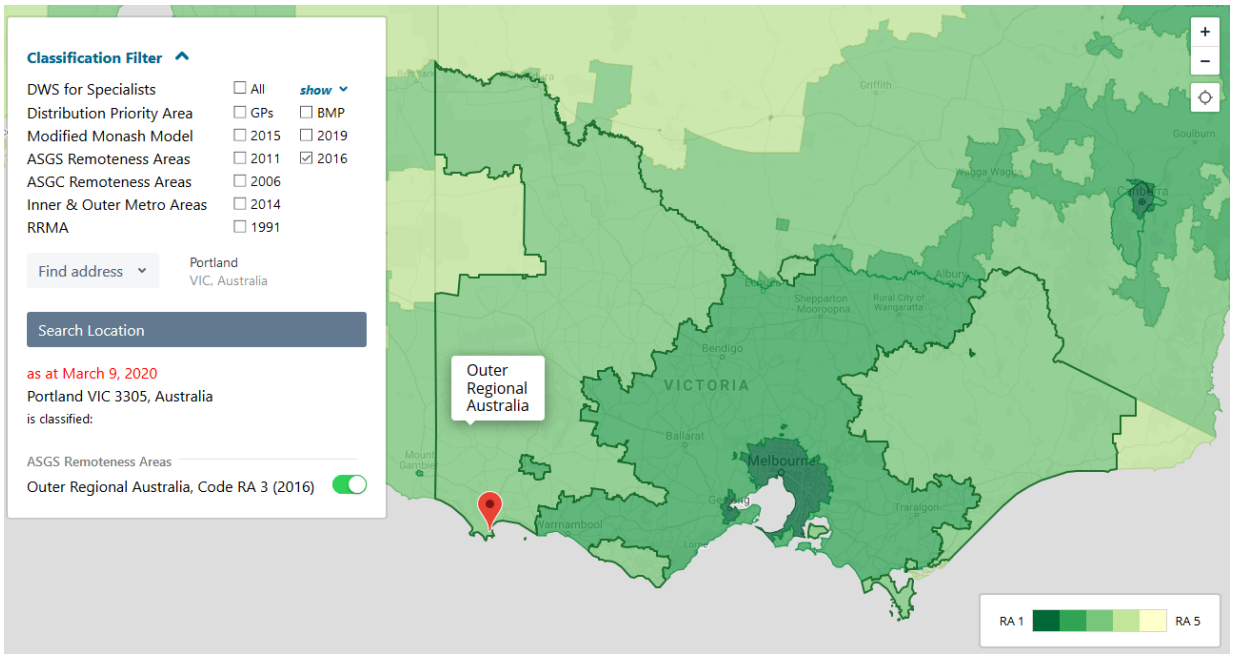
Portland District Health is a member of the Great South Coast Regional Partnership, which includes Western District Health Service, South West Healthcare, Terang & Mortlake Health Service, Timboon & District Healthcare Service, Moyne Health Services, Heywood Rural Health, and Casterton Memorial Hospital. The geographical area of these hospitals within the partnership are schematically demonstrated with primary care service, urgent care centres and region trauma services highlighted (9).

Figure 1



In discussing overall health workforce shortages it is advantageous to compare the Victorian Trauma Service map to the ASGS Remoteness chart below. It is well recognised that health workforce self-sufficiency is more difficult in the outer regional zones which includes substantial areas of outer Western and outer Eastern Victoria. (1)

Figure 2: ASGS Remoteness Chart



https://www.health.gov.au/resources/apps-and-tools/health-workforce-locator/health-workforce-locator

Portland is a District of workforce shortage area for all medical specialties and a distribution priority area for General Practitioners. On activity levels Portland is also one of the busier Urgent Care Centres in outer regional areas with approximately 9000 presentations per annum.

8. Portland District Hospital

8.1 Portland District Hospital – Infrastructure

The profile of PDH, its services and infrastructure in comparison to other nearby hospitals has been reviewed extensively (4, 5). In comparative sizes Hamilton (WDHS) is slightly bigger than PDH. Warrnambool (SWH) is approximately four times as large with responsibility for a number of sub-regional services. Aspex undertook an analysis of beds, operating theatres and cubicle capacity at these three hospitals. The capacity and expected requirement in 2036-2037 are described in the following tables.

Table 1: South West Victoria bed projections, 2015-2016 to 2036-2037 (4)

HEALTH SERVICE	STAY TYPE	2015-2016 BEDS*	2036-2037 PROJECTED BEDS
SWH	Same Day	23	30
	Multi-day	141	176
	Total	**164**	**206**
WDHS	Same Day	12	9
	Multi-day	69	43
	Total	**81**	**52**
PDH	Same Day	20	18
	Multi-day	51	36
	Total	**71**	**54**
TOTAL	Same Day	55	57
	Multi-day	261	255
	Total	**316**	**312**

**Bed numbers have been rounded to the nearest whole*

Table 2: Total Operating theatre capacity, per health service 2015-2016 to 2036-2037 (4)

HEALTH SERVICE	2015-2016	BASLINE 2036-2037	PROJECTED 2036-2037
SWH	4	4	6
WDHS	2	2	2
PDH	2	2	2
Total	**8**	**8**	**10**

The emergency facility at a Sub-Regional Hospital is deemed an Emergency Department and at Portland as a local hospital is classified an Urgent Care Centre. The projected Cubicle Capacity is in the following table.

Table 3: Projected ED cubicle capacity, SWH and WDHS, 2015-2016 to 2036-2037 (4)

HEALTH SERVICE	2015-2016	BASLINE 2036-2037	PROJECTED 2036-2037
SWH	19	31	12
WDHS	5	10	5
Total	**24**	**41**	**17**

The projected ED cubicle capacity excludes short-stay beds

Table 4: Projected UCC cubicle capacity, PDH, 2015-2016 to 2036-2037 (4)

HEALTH SERVICE	2015-2016	BASLINE 2036-2037	PROJECTED 2036-2037
PDH	5	8	3

The projected UCC cubicle capacity excludes short-stay beds

Although a local hospital and not a sub-regional service, Portland District Health has a significant component of the infrastructure required to provided health services across the South West region. It is a vital component for health service delivery. Given the expense of developing new infrastructure, the issue confronting regional planning in the South-west is how to more fully utilise all infrastructure that is available for the delivery of health services for the community.

8.2 Portland District Healthcare – Clinical Care

Currently the complexity of care at Portland District Health is summarised by the following capability chart taken from the PDH Capability Framework (7)

Table 5: The complexity of clinical care provided by Portland District Health

The complexity of clinical care provided by Portland District Health setting out details of the above requirements is highlighted in green.								
		PAGE NUMBER	**LEVEL 1**	**LEVEL 2**	**LEVEL 3**	**LEVEL 4**	**LEVEL 5**	**LEVEL 6**
SECTION ONE - ACUTE SERVICES								
1.1 Emergency Services	1.1.1 Urgent Care	4	✓	✓	3B			
	1.1.2 Intensive, Critical Care and Mental Health	5	Assessment, stabilisation and transfer					
1.2 Surgical Services	1.2.1 General Surgery	6	✓	✓	✓	✓		
	1.2.2 Gynaecology	7	✓	✓	✓	✓		
	1.2.3 Orthopaedics	8	✓	✓	✓			
	1.2.4 Anaesthetics	9	✓	✓	✓	✓		
1.3 Medical Services	1.3.1 General Medicine	10	✓	✓	✓	✓		
	1.3.2 Dialysis	11	✓	✓	✓	✓		
	1.3.3 Oncology (Cancer Services)	12	✓	✓	✓	✓		
1.4 Women and Children	1.4.1 Maternity	13	✓	✓				
	1.4.2 Neonatal	15	✓					
	1.4.3 Paediatrics	16	✓					
	1.4.4 Paediatric Surgery	16	✓	✓	✓			
1.5 Acute Care	1.5.1 Acute Care Unit	17	✓	✓				
1.6 Sub-Acute	1.6.1 Inpatient Sub-Acute	18	✓	✓	✓	✓		
	1.6.2 Inpatient Drug and Alcohol	19	✓	✓	✓	✓		
	1.6.3 Inpatient Palliative Care	20	✓			N/A	N/A	N/A
1.7 Bariatric Care	1.7.7 Bariatric Care	21	✓	✓	✓	✓		
1.8 Support Services	1.8.1 Operating Theatre	23	✓	✓	✓	✓		
	1.8.2 Pathology	23	✓	✓	✓	✓		
	1.8.3 Pharmacy	24	✓	✓	✓	✓		
	1.8.4 Radiology	25	✓	✓	✓	✓		
	1.8.5 Organ Donation	25	PDH currently cannot provide this service					
SECTION TWO – COMMUNITY SERVICES								
2.1 Health Independence Programs	2.1.1 Ambulatory Care – (SACS - Community Rehab)	26	✓	✓				N/A
	2.1.2 Hospital Admission Risk Program (HARP)	27	✓	✓				N/A
2.2 Community Palliative Care		28	✓	✓		N/A	N/A	N/A
2.3 Community Drug and Alcohol		29	✓	✓	✓	✓		
2.4 Health Promotion		30	✓	✓	✓	✓		
SECTION THREE – AGED CARE								
3.1 Aged Care.		31	✓	✓	✓	✓		

Most services are provided at Level 4, which usually requires the capacity to care for low risk patients with services provided by specialist medical practitioners. The lack of both a High Dependency Unit and a reliable profile of junior medical staff means that complex or more-at-risk patients are referred to other facilities.

Of particular note, the Urgent Care Centre capability is at Level 3B which requires careful consideration within the State Capability framework (10).

Table 6: Section One – Acute Services – Emergency Services – Urgent Care

LEVEL 1	LEVEL 2	LEVEL 3A	LEVEL 3B	LEVEL 4	LEVEL 5	LEVEL 6
• Able to provide first aid and treatment prior to referral to a facility able to provide a higher level of service, if necessary. • Access to a medical practitioner – this may be by telephone.	**As for Level 1:** • Can cope with minor injuries and ailments. • Resuscitation and limited stabilisation capacity prior to referral to a facility able to provide a higher level of service. • Nursing staff from ward available to cover emergency presentations. • Visiting medical officer (includes general practitioner) on call. • Emergency service in a small hospital.	**As for Level 2** • Designated UCC nursing staff available 24 hours a day and nursing unit manager. - Medical staff available for recall to the hospital within 20 minutes, 24 hours a day. • Specialists appropriate to the role delineation of the hospital available for consultation, plus arrangements in place for other specialties. • Access to allied health professionals. - Specialist psychiatric /mental health assessment personnel available for consultation. • Purpose designed area, with full resuscitation facilities in separate area such as a cubicle.	**As for Level 2:** • Designated UCC nursing staff available 24 hours a day and nursing unit manager. • Medical staff available in the hospital 24 hours a day (though may have other commitments in the hospital). • Specialists appropriate to the role delineation of the hospital available for consultation, plus arrangements in place for other specialties. • Access to allied health professionals. • Specialist psychiatric • /mental health assessment personnel available for consultation.	• Can manage most emergencies. • Participation in regional adult retrieval system (rural base hospitals). • Registered nurses with emergency nursing experience or qualifications on site 24 hours a day. • ED specific medical officer(s) on site 24 hours a day. • ED Medical director.	**As for Level 4:** • Has undergraduate and postgraduate teaching and a research program. • Access to clinical nurse consultant or similar. • Has designated ED registrars on site 24 hours a day. • Sub-specialists available on rosters.	**As for Level 5:** • Can manage all emergencies and provide definitive care. • State-wide referral role and/or major trauma centre.

A level 3 service provides urgent and unscheduled care for adults and children of a minor and low complexity level and also those needing an emergency response for potentially serious and life threatening conditions. This includes advanced life support and expeditious transfer to an emergency department of a higher level facility.

Services are delivered by appropriately skilled multidisciplinary teams who have access to the required infrastructure including specialist emergency telehealth support. At Level 3B, the team can be led by appropriately trained and authorised nursing staff or a nurse practitioner with medical practitioners being available 24 hours a day. Appropriate supervision and support systems need to be in place such as with medical practitioners with advanced skills (FACRRM / FRACP-FARGP) or specialist Emergency Physician qualifications.

The model of medical coverage at PDH is strained with a mixture of International Medical Graduate junior and senior medical staff with Fellows of the College of Emergency Medicine on some day shifts. There is no general practitioner support within Portland, and there is lack of onsite senior medical staff to provide a higher level of supervision.

Recruiting more Australian trained senior staff for supervision of the junior staff is difficult if not impossible and supervision requirements of International Medical Graduates as stipulated by Ahpra / MBA / Medical Colleges limit their possible recruitment. These requirements will almost certainly not change substantially as they have been actively and repeatedly reviewed over the past twenty years.

The impact of the junior and inexperienced profile is substantial particularly in the variability of clinical care decision making and also in the capacity of PDH to provide expected levels of care 24 hours a day. It is acknowledged that PDH has formal diversion processes in place when specialists are not available. However, there were frequent comments by interviewees about the variability and lack of effective or consistent communication about the arrangements. This has substantial effects not only in the perceived service profile of the hospital but also on the community and the Ambulance service. With this variability in service provision, the Ambulance service does actively triage patients away from Portland or are required to undertake transfer of patients between hospitals. This is very consuming of resources particularly when it is for observation only purposes.

In the Biruu report (5) it was highlighted that in order to make the urgent care service sustainable, new workforce structures and new models of care are required. One measure of success with this would be to ‘minimise the number of ambulance transfers to Warrnambool’ (5). This recommendation is endorsed by the current reviewer with the Rural Generalist profile ideally suited to address the concerns outlined.

In providing health services PDH provides a substantial range of support services. It has recorded the following activity across areas of the health service (11)

Table 7

ACTIVITY / INDICATOR	2018/19	2017/18	2016/17	2015/16	2014/15
Number of inpatients - Hospital	5617	5207	4928	5000	4903
Number of inpatients - Nursing Home	58	61	52	50	45
Number of inpatient days - Hospital	14063	11354	11592	11897	11314
Number of inpatient days - Nursing Home	10501	10401	9934	10472	9757
Daily Average (days - Hospital)	39	31	32	33	31
Daily Average (days - Nursing Home)	29	29	27	29	27
Average stay (days - Hospital)	2.50	2.18	2.35	2.37	2.31
Average stay (days - Nursing Home)	181.05	170.51	191.03	209.4	216.8
Number of beds available (same day) Hospital	15	15	15	15	15
Number of beds available (overnight stay)	55	55	55	55	55
Number of beds available - Nursing Home	30	30	30	30	30
Emergency Presentations	8748	7535	6861	6960	7479
Births	75	67	56	81	64
Hospital in the Home	9	11	8	10	2
Meals on Wheels delivered	5996	6016	4039	3438	4468
Meals served (total)	97722	94648	86791	88335	85629
Operations performed	2584	2432	2235	2203	2853
Mammogram & Breast screens	1333	1312	1215	1285	1250
CT Examinations	2814	2867	2482	2091	2384
OPG / Dental Examinations	465	517	484	454	466
Procedures	1014	673	134	154	160
Ultrasound Examinations	6427	5946	5230	5258	5638
DEXA Scans	456	324	285	286	280
General X-rays	7839	7925	7439	7248	7852
X-ray - Inpatients	1416	1371	549	843	1103
X-ray - Outpatients	17868	13758	15262	14153	14009
Examinations including Breastscreens (Total)	20394	19564	16294	15680	18034

8.3 Portland District Healthcare – Budget for Medical Staff

The overall budget to support these activities is approximately $41 M and this is compared to the 2018-2019 Budget / Actuals below (12)

Table 8

	2018/19 Budget $	2018/19 Forecast $	2019/20 Budget $
Operating revenue	43,966,604	47,213,855	40,970,42
Salaries and Wages	34,467,920	36,155,269	38,083,704
Non-Salary Expenditure	9,738,064	10,787,161	10,625,412
Grand Total surplus /(deficit)	**(239,380)**	**271,455**	**(7,739,074)**

The increasing cost of the Medical staff is of concern. The model is dominantly salaried and with a 100% contribution back to the hospital of any medicare fees raised through billing.

Table 9

MEDICAL SERVICES TOTAL			
	2018/19 Budget $	2018/19 Forecast $	2019/20 Budget $
Operating revenue	2,878,621	3,077,251	3,419,627
Salaries and Wages	7,998,286	9,067,497	9,898,348
Non-Salary Expenditure	1,904,503	2,578,490	2,372,960
Grand Total surplus /(deficit)	**(7,024,168)**	**(8,568,737)**	**(8,851,681)**

Table 10

FULL TIME EQUIVALENT		
2018/19 Budget	2018/19 Budget	2018/19 Forecast
26.62	24.54	30.98

The Board, CEO and Director of Medical Services try to address issues of clinical safety through appropriate recruitment of medical staff. There is always a tension between access to services, quality of those services and financial cost effectiveness. This is demonstrated clearly at PDH. The combined use of salaried staff supported by locum services is expensive. Despite efforts to recruit staff and consequently reduce the use of locums they remain a significant component of the Other Agency Expense / External Contract Staff expenditure. The actual expenditure for this line item being $3.3 M of the $8.5 M medical labour costs in 2018/2019 (13).

Portland District Health is not alone in the expensive challenge of obtaining locum medical staff. Across the state of Victoria locums are difficult to attract and can cost $2500 per day which may be multiples of the income of resident rural doctors. In addition on call periods require payment from $300 to $700, based on a 100% donation model of fees raised

At a state wide, strategic level, it is disappointing that increasing budgets for hospital based locum staff across Victoria has appeared an easier outcome than having a substantially more effective workforce strategy (14).

When the junior International Medical Graduates are recruited they need to leave Portland to be able to progress into the Australian medical workforce. A number have been successful in accessing training programs however their overall standard and competence has varied substantially. In the consultation stage of this review it was a common reflection that the IMGs lack confidence in their clinical decision making because of their junior status, the unknowns of the health system, their provisional registration, their fear of making mistakes not only because of their duty of care but they also need to succeed to access their planned exit out of PDH. At the core of this issue, is that the junior staff are recruited with the required career path being to leave Portland.

8.4 Portland District Healthcare – Staff Profiles

8.4.1 Junior Medical Staff

The current profile of Junior Medical staff constitute three broad classes.

PGY2 rotate from SWHC for 10 weeks but there is a substantial vacancy rate as SWHC is not able to fully recruit. PDH has endeavoured to recruit staff to these positions directly. The PGY2 are all Australian trained PGYs but need to be replaced with IMGs as the vacancies occur.

The second category is one unaccredited registrar position in surgery. The role will not be considered for accreditation until the number of general surgeons (FRACS) is increased.

The third category is the 8 junior doctors who are all International Medical Graduates. They are all on limited or Provisional registration with Ahpra with one person on Level 1 supervision. Seven are in their first job in Australia. Due to their lack of local knowledge and experience, it has been necessary to also have a larger number of locums with its own financial and continuity of care concerns.

8.4.2 Senior Medical Staff

Credentialing of the Senior Medical Staff does occur on a regional basis, with the coordination of the activity through SWHC. However, there has been no or only very limited progression of any regional approach to service delivery or appointments. Indeed, the reviewer was provided with multiple examples of where a co-ordinated approach had been undermined by the various Hospitals or groups of medical specialists. Where appointments are made across a number of hospitals, they are individual appointments, often with different employment arrangements.

PDH presently has 0.6FTE physician, who works as a general physician with a specific interest in cardiology. There is an established need for another 3.0 FTE, which is being covered by locums. Two Overseas Trained Physicians have been recruited but supervision requirements are still being resolved.

PDH has employed two general surgeons who alternate week on / week off.

PDH has budgeted for two GP Anaesthetists and recently recruited a specialist anaesthetist.

There is also 1.0 EFT Obstetrician & Gynaecologist, 1.0 EFT Paediatrician, 0.6 EFT Ophthalmologist, 0.1 Plastic surgeon and 0.1 Geriatrician. In the Urgent Care Centre 3 Emergency Physicians are appointed to 0.4 EFT. There is also an overseas dually trained physician and specialist in emergency medicine as a senior medical officer in the UCC.

8.4.3 Visiting Specialists to Portland.

There are multiple Visiting Medical Officers at PDH, encompassing the disciplines of Cardiology, Endocrinology, General Medicine, Nephrology, Dermatology, General Surgery, Orthopaedics, Plastic Surgery, Urology, Maxillofacial Surgery and ENT. A number of these appointments are long term. Their credentialing is undertaken on a regional basis. Many of them have appointments at other hospitals with separate arrangements or appointment profiles. A number of these specialists visit from interstate. Some of them provide on-site service, some use telehealth while others may use a combination. Some of the proceduralists have operating sessions at PDH and some of these proceduralists may stay in Portland the night after surgery is performed. Following this, telephone support is provided with limited on-call ability. This structure only allows limited interaction in educational, supervisory, or training activities.

Mental health services are provided through the Glenelg service which is one of 18 funded mental health services in the state, is based mainly in Warrnambool and provides ambulatory and multi-disciplinary services in Portland. Initially provided through offices distant to PDH it is moving to new facilities on the hospital grounds. It is hoped this will improve liaison between the hospital and the service which is acknowledged by all parties to be limited at the moment. There is a heavy reliance on International Medical Graduates for mental health staff and they have persistent challenges with continuity in the position of the Authorised psychiatrist position who has the conferred powers and functions of the Mental Health Act 2014

8.4.4 General Practitioners

Active Health

Active Health is a GP super clinic that opened in 2012 with funding for its development provided through the Commonwealth Government's Super clinic initiative. It is located adjacent to the hospital campus but there is little interaction at the clinical level. None of the General Practitioners have admitting rights. Administratively, the CEO of PDH is also the CEO of Active Health but reports to a separate Board for the Super clinic. It provides multidisciplinary care through general practitioners, practice nurses and allied health staff. It has links with Deakin University for medical student teaching and also has GP registrars with one of the senior General Practitioners having a substantial educational role. Two medical intern (PGY 1) positions at PDH have been provisionally approved for 2021 through a longitudinal program approach of experience in the Urgent Care Centre (Monday) / Ward Work (Tuesday to Thursday) / General practice at Active Health (Friday).

There is one general practitioner in another clinic who infrequently admits patients.

None of the other General Practices in Portland have any direct clinical involvement at the hospital. The 'business model' for these practices is now totally non-hospital focused. There is no desire to provide on-call services or hospital based care with the associated impact on work-life balance. With a relative shortage of General Practitioners in the area, the seventeen (17) identified General Practitioners are all significantly busy. It was noted that a Tri-Star clinic had been established in Portland but had since closed.

8.4.5 Nurse Practitioner models

Nurse Practitioners as well as RIPERNs (Rural and isolated practice endorsed registered nurses) are highly regarded and have been successful in providing workforce solutions for some areas. However, they are seen more as supplementary to the medical workforce requirements rather than a substitute or replacement. With the correct approach and structure they should be cost effective and sustainable (15, 16). However, the identified educational pipeline is not large, and it is reported that recruitment issues are also a challenge in regional areas. This particularly relates to the demands of staffing a 24 hours a day, 365 day a year service. However, increasing the Nurse Practitioner profile at PDH, particularly around the Urgent Care Centre, will be an important component of addressing workforce shortage issues. Nurse Practitioners are certainly part of the solution but do not negate the requirement for the medical workforce. This can occur regardless of the model accepted to address the sustainability of the medical workforce.

8.5 Technology

The advances in telehealth have been substantial. Some attempts have been made to have a dedicated link from Portland to Warrnambool. Apparently it was initially highly successful but is now reported as being largely personality dependent. Across Victoria there appears to be limited cohesion in utilising telehealth. Rural CEOs now rely on a number of models but particularly the NSW based 'My Emergency Doctor' (myemergencydr.com). This service also has Australian government funded linkages with some Primary Health Networks but relies primarily on a $280 per consultation business model.

8.6 Culture of education and learning.

Despite efforts of the current hospital leadership and external groups like Primary health networks it was stated repeatedly in the consultative phase of this review that there was little supportive educational structure. Although there is a regular journal club there appeared to be limited peer review, limited library and educational resources, few collegiate relationships and limited sharing amongst peers. This was confirmed indirectly by Deakin University and the Murray City Coast GP Training (MCCC) who found it difficult to identify additional teaching practices for General Practice or other programs.

It is this environmental and cultural perspective that is most disturbing. It fights against effective clinical governance. It must be addressed to develop sustainability across the workforce. Moving from a 'service only' approach to one of re-building the medical workforce requires a nurturing and professionally supportive environment. There is a shortage of educational opportunities at multiple levels in the region. Sustainable workforces are known to thrive in an educational and supportive environment. Without it, single enthusiastic practitioners struggle, become frustrated and will seek better opportunities.

8.7 Options for a more sustainable medical workforce at Portland District Health

The Aspex report (4) made recommendations about the possible structures that could assist in the health service planning and delivery in South West Victoria. The emphasis was on the delivery of more regionalised service models of service which are critical for sustainability. They felt that moving to an organisational alignment such as a federated partnership or voluntary merger would provide much greater impetus to the regionalisation and development of clinical services. Although there have been many discussions around regionalisation since 2017, there has been limited material change in the current ad hoc collaborative approach. The ad hoc collaboration unfortunately includes medical appointments or changes in medical staff profiles that actively undermine the regional provision of clinical services. Regionalisation is

demonstrated through the approach to credentialing of medical staff, but there are no regional clinical services, no regional appointments and limited if any regional approach to clinical governance. More effective regionalisation remains critical to address workforce sustainability concerns.

Although continuation of the current ad hoc collaboration with other hospitals is possible it is unlikely to effectively address sustainability, even if additional funding is provided and the medical employment costs are substantially increased. A more comprehensive range of specialist medical staff may decrease some of the locum use, but the critical mass of Portland District Health will not meet the requirements needed by the speciality training programs of the various medical colleges. Consequently the profile of the junior staff will always be of concern, even if it is augmented by an effective nurse practitioner program. It is the issues of critical mass and stand-alone profile that predominantly contribute to the very junior status of staff in the Urgent Care Centre and heavy reliance on locums.

To progress the required regionalisation of medical services that should support improved sustainability of the medical workforce, the reviewer proposes two options. Both of these options provide substantial and immediate progression towards a more cohesive regionalisation of medical services. Importantly, the current ad hoc collaboration including appointments and changes in the profile of medical staff that undermine the regionalisation of clinical services needs to cease.

Option 1 provides for the regionalisation through a formal hub and spoke arrangement with a preferred provider. Although addressing the regionalisation requirements, more could be done to address the important hospital to general practice to community interface. Consequently Option 2 of developing a fuller rural generalist model is proposed. This is also based on regionalised specialist services but recognising the increased capacity at Portland from the Rural Generalists and a more federated approach to the decision making around the regionalisation of services.

Option 1

Contracting out of the medical clinical service.

This would formalise a Hub and Spoke approach to medical services from the contractor to PDH. The services would need to be defined around hours of service for the hospital and Urgent Care Centre, activity and complexity throughput, commitment to teaching and education as well as budgetary parameters. There need to be very strong requirements around the accountability and responsibility of providing the breadth and seniority of staff required to deliver the level of clinical services expected by the community of Portland. Possible providers of contracted medical services could be South West Healthcare, Barwon Health or Ballarat Health. Credentialing of medical staff would be required on a regional basis. Importantly regional service planning and regional appointments would be necessary immediately. Rapid progression of regional clinical audit, regional peer review and regional clinical governance activities is essential.

The initial contract would need to be for five years to allow for the establishment and stabilisation phases of the workforce. Portland District Health would remain responsible for the overall clinical services at Portland, the employment of non-medical staff and contract management of the outsourced medical service.

The option of contracting out the medical clinical services would provide more effective regionalisation of clinical services, improved clinical governance and the ability to attract more staff to the region. Adjustments to current contracts of appointment would need to be negotiated with the senior medical staff to provide a regionalised role. However, many already have a regional perspective on their clinical activities, it is the lack of regional clinical service planning and delivery that has confounded them. Most would be willing contributors to a regionalised service if appropriately managed. Combined with ongoing rotations from the parent hospital to Portland and the responsibility for staffing those services being clearly with the parent hospital, there should be improvement in the recruitment and retention of junior medical staff. However, there will be management challenges and both community and political concerns. Strong support from the Department of Health and Human Services will be required to ensure that issues are addressed promptly and resourced appropriately.

Although sustainability will be addressed by this first option it is not addressing many of the issues of attracting staff to Outer Regional Hospitals in Victoria. It does little to build effective relationships with the General Practitioners of Portland or the Portland community. For these reasons, the second option around workforce re-design needs to be considered.

Option 2

Re-design of the medical workforce model at Portland through adoption of a rural generalist model with an appropriate interface to all regionalised specialist workforces.

This is a more complex option but will address more fully the hospital to general practice to community requirements. Regionalisation must continue in a collaborative and cohesive manner but in a more federated model that will allow recognition of the capacity of the rural generalist work-force. The current ad-hoc planning approach needs to cease. The key differences from Option 1 are the increased capacity at Portland through the rural generalist workforce and the active co-ordination and involvement that PDH will provide to the federated regionalisation model. What is common to both options is that credentialing of medical staff would be required on a regional basis. Regional service planning and regional appointments would be necessary immediately. Rapid progression of regional clinical audit, regional peer review and regional clinical governance activities is essential.

The re-designed model will see the core medical staff being Rural Generalists, recruited to provide a range of clinical services both in the hospital as well as in general practice. They will support and supervise the junior medial staff, preferably trainees within the rural generalist training program.

Rural generalists would need to be recruited in phases. A ‘champion’ for the rural generalist redesign would be appointed to forward plan the required workforce changes and gain an understanding of the interface required between the rural generalists, local general practitioners, and regional specialist services. Initially four (4) Rural Generalists would be recruited with Emergency Medicine expertise and additional Rural Generalists would be appointed to supplement the two GP and one Specialist Anaesthetists currently employed. Rural generalists with advanced obstetric skills could be recruited to support the specialist obstetrician. It is anticipated that they would provide general practice services through Active Health and supplement the teaching staff for University and Medical College related teaching.

This change of workforce model is not a decision for Portland District Health alone. Indeed Portland District health could not achieve this change by itself. The number of stakeholders

involved in workforce strategies is large and they all must be involved both strategically and, in the detail, to ensure the workforce shortages at Portland are addressed. This will take a medium to long term commitment of at least 5 to 10 years.

The critical issue for Portland District Health is to commit to a cohesive and collaborative approach to regionalisation. The ad-hoc approach of the past that allowed undermining of regional clinical services needs to cease immediately. They need to contribute fully to the federated model for regionalisation of clinical services to ensure the increased capacity provided at Portland by the Rural Generalists is recognised.

Option 2, the workforce re-design option is recommended by this reviewer as it is the most appropriate model for outer regional services.

Changes in workforce strategies both nationally and in Victoria present opportunities that could be explored and implemented with advantage. The history of the involvement of the stakeholders is provided in this report to emphasise that the solutions for Portland must involve multiple parties who bring different but important perspectives. The implementation plan (section 11 of this report) highlights the number of key decisions that need to made and supported over a multi-year timeframe. Understanding and ensuring the multiple stakeholders are effectively involved will be critical to the success of Option 2.

9. Rural Generalist

9.1 Global recognition of Rural Generalists.

The attraction, recruitment and retention of health workers in rural and remote areas is a world-wide challenge. This has received substantial profile internationally and Australia contributes to both the analysis and discussion. The increasing international and Australian recognition of Rural Generalist roles in sustaining this workforce requires discussion of the required parameters of its success and the multiple government policies that have developed to achieve successful implementation.

In 2010 the World Health Organization conducted some analysis of the four types of interventions that were crucial in achieving greater retention of health care workers in rural and remote areas (17). These are summarised in the following table.

Table 11

Category of intervention	Examples
A. Education	A1 Students from rural backgrounds
	A2 Health professional schools outside of major cities
	A3 Clinical rotations in rural areas during studies
	A4 Curricula that reflect rural health issues
	A5 Continuous professional development for rural health workers
B. Regulatory	B1 Enhanced scope of practice
	B2 Different types of health workers
	B3 Compulsory service
	B4 Subsidised education for return of service
C. Financial Incentives	C1 Appropriate financial incentives
D. Professional and personal support	D1 Better living conditions
	D2 Safe and supportive working environment
	D3 Outreach support
	D4 Career development programmes
	D5 Professional networks
	D6 Public recognition measures

These interventions can be applied to a number of health service delivery models and workforce configurations that are developed internationally. Different models include traditional fixed services, to “hub-and-spoke” models, visiting services, and telehealth and telemedicine. Regardless of the model, however, all services will need to be underpinned by a number of essential requirements — including adequate funding through an appropriate financing

mechanism; sufficient number and mix of health professionals; adequate infrastructure, both physical and information and communication technology; strong internal and external linkages; high-quality management, governance and leadership; and rigorous performance evaluation (18).

Substantial research in Australia has also confirmed factors that substantially enhance the likelihood of rural practice. These are rural origin 2.5X (Range 1.68 to 3.9), Rural schooling 2.5X (Range 2.2 to 5.42), Rural spouse 3.5X, Rural undergraduate 2.05X, Rural Internship 3X, Rural Training 2.5X, and Rural upskilling/support (18).

9.2 Development of National Rural Generalist Pathway

Factors to enhance rural generalist practice have been progressively incorporated into the ROMA agreement (19) and the Cairns consensus statement on rural general medicine (20) and supported the implementation of the successful Queensland Rural General Pathway (QRGP) which promoted distinct action through four pillars of activity. These are recognition of rural generalist medicine, practice value for its true worth, a supply line / pathway to vocational practice; and responsiveness to workforce re-design (21). The QRGP has been evaluated extensively from the perspective of the success of its implementation in providing a solution to the rural medical workforce issues faced in Queensland. QRGP is based on a high quality training program with commitment by the senior educators and supervisors. It also met the needs of the community and represented value for money invested by the Queensland government with a return on investment ratio estimated to be in the vicinity of 1.2 (22). The critical factors for success included early immersion in rural medicine, due recognition given to the rural generalist profession, the quality and fast-track nature of the program, appropriate quarantining of training placements with preferences given to QRGP trainees, comprehensive coordination and career management and distinct career opportunities.

Separately, national transferability of the QRGP has been reviewed. There are many elements that are distinctly transferable despite Queensland having different approaches on some management and industrial issues (23)

The National Rural Generalist Pathway uses the Collingrove agreement definition of rural generalist as “a medical practitioner who is trained to meet the specific current and future health care needs of Australian rural and remote communities, in a sustainable and cost-effective way, by providing both comprehensive general practice and emergency care, and required components of other medical specialist care in hospital and community settings as part of a rural health care team”(14) .The emphasis of the rural generalist program is to have the capacity to work flexibly in a range of environments, both procedural and ambulatory.

The National Pathway needs to be attractive to future graduates and trainees in order to create a sustainable supply of appropriately-trained workforce for rural communities. To understand this a comprehensive analysis of the current gaps in rural workforce training opportunities and service provision in each jurisdiction was undertaken through the Office of the National Rural Health Commissioner. The outcomes included the FACRRM and FRACGP / FARGP being recognised as the postgraduate endpoint qualifications for the pathway. The principles along with nineteen further recommendations saw the four pillars of action that underpinned the QRGP and the programs key success factors being enhanced in a flexible yet national model (6).If the rural generalist model is to be more effectively delivered in Victoria, then these become most important.

In Australia, to progress towards a national training program it has been repeatedly highlighted that linkages between Commonwealth and State programs need to be improved; increased

support needs to be provided to Universities who are fully committed to rural generalism and the vocational pathways into Rural Generalist Medicine need to be accelerated. Equally, disincentives to rural practice need to be addressed. These are reliably reported as negativity in metropolitan based specialist rotations, lack of connectedness in the training pipeline, conflicting administrative structures and priorities in the selection processes and frequently changing locations for placements particularly if they lack social, educational or partner-required-opportunities (18, 24).

9.3 How many Rural Generalists are required?

It has been estimated by a number of methods that the national pathway needs to graduate approximately 350 Rural Generalist doctors per year with up to 2000 doctors in training at any one time (6).This represents approximately 10% of the annual graduation from Australian Medical Schools and just under a quarter of the annual 1,500 Australian General Practice Training [AGPT] intake. Given that the Victorian population is approximately 25% of the overall Australian population the figures are 85 Rural Generalist doctors (FACRRM or RACGP-FARGP) being graduated with about 500 doctors in training at any time. The National Rural Health Commissioner has specifically confirmed these projections. This is a most substantial increase from the current levels. Jurisdictional mapping for the rural generalist pathway shows that the number of trainees in the Queensland rural generalist program in 2017 was approximately 310. The number of rural generalist trainees in the program in Victoria was 15 (25).

9.4 Changes in the roles of Medical Colleges

The importance and different requirements of rural general practice was the central focus of significant dysfunctionality within the College of General Practitioners in the 1980s and 1990s. The history has been well described (26, 27). The outcome saw the fracturing of Rural and Remote Medicine across Australia with the formation of a separate College (ACRRM) as well as the eventual greater profile of the RACGP Rural faculty. An additional outcome was the College of General Practice became the only medical college to not be responsible for its own training program. The Commonwealth Government created GPET (General Practice and Education Training Pty Ltd) to administer the training within the standards established by the Colleges with the FACRRM or FRACGP-FARGP being viewed as the appropriate standard for practice as a rural generalist. Both Colleges are accredited by the Australian Medical Council to oversight training in general practice. Work has started on the formal application to the Australian Medical Council to have Rural Generalist Medicine recognised as a specialised field within the specialty of General Practice.

Importantly, the Commonwealth Government has now made the policy decision of returning the direct administrative responsibility of general practice training to both Colleges. The model of delivery for General Practice training overall and in remote and rural areas specifically is yet to be determined. However, the presence of regional training nodes will be an important part of the ACRRM model. Both ACRRM and RACGP will now have an increasing role and possibly be a key part of the solution to these workforce issues.

These changes could be of enormous benefit to providing solutions to the medical workforce shortage in Outer Regional Victoria. The Medical Colleges will have a much closer relationship in the training of the Rural Generalist workforce. The change in the Commonwealth Government approach will apparently be accompanied by changes in the funding allocations. Victoria should partner more effectively with these Colleges as key stakeholders in the workforce solutions.

9.5 A sustainable and viable rural and remote generalist practice.

For a sustainable workforce, there also needs to be a viable career and practice achievable at the end of the training. The viability framework was created in 2003 to look at the specific medical needs of the community and also to take into account the professional, organisational, economic and personal needs of the practitioners and their families (2). It is becoming increasingly important to continue to address issues of professional isolation and work-life balance.

The professional issues include education, training and skills of practitioners, workforce and workload. Most of these specifics are still highly relevant. The framework provided workforce to population ratios and anticipated consultations per week. Most importantly it confirmed a viable on-call roster of 1:4 and this applies to each area of advanced skill interest. So to have a rural generalist workforce for obstetrics or anaesthetics would require four medical practitioners for each area.

The economics and remuneration issues included core remuneration from Fee for service and Practice Incentive Payments, rural grants and incentives and hospital remuneration. Organisational issues included leadership and strategic planning, staffing, equipment, information management and technology and also the practice premises and facilities. The family and social dimensions reflected the community infrastructure such as the community commitment to invest in the practice, access to good quality secondary education and the standard of the hospital or multi-purpose facility (2).

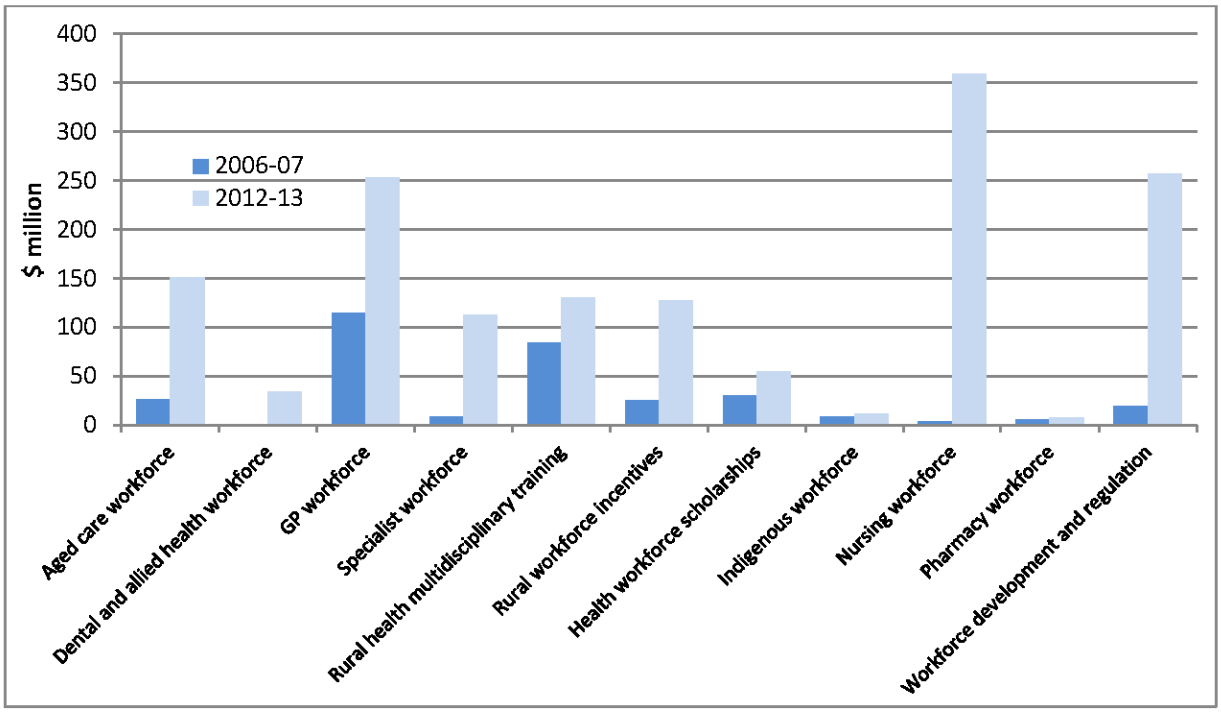
10. Government Initiatives

10.1 Commonwealth Government

10.1.1 Funding commitments into workforce strategies

The challenges of addressing Australia's workforce sustainability are well known at the Commonwealth Government level. Indeed the 2005 Productivity Commission Report (28) highlighted that 'a number of systemic barriers and impediments have prevented Australia's health workforce from achieving its full potential and from providing Australians with accessible, high quality and safe health services in the most efficient, effective and financially sustainable manner'. These included the large number of entities involved with resulting fragmentation of responsibilities, ineffective coordination, rigid regulatory arrangements, funding and payment arrangements that inhibit efficient outcomes as well as entrenched workplace behaviours and internal resistance. Other reports have highlighted the issues that need to addressed for a sustainable response to rural workforce requirements (18).

Figure 3: Total funding by workforce group



Source: Health Workforce Division Administered Funding Summary, 2012 (unpublished)

As demonstrated by the funding summary schematic above (24), the Commonwealth Government has made substantial investment into rural health education through a number of initiatives including the Rural Health Multidisciplinary Training (RHMT) program to enable medical students as well as other health professionals to undertake extended blocks of their clinical training in regional areas. It now funds a national network of 19 Rural Clinical Schools, 16 University Departments of Rural Health, six dental schools, as well as 26 regional training hubs which are charged with delivering significant components of the medical curriculum in a rural environment. In broad terms, rural clinical schools exist to encourage rural practice, increase rural academic positions, strengthen the rural workforce, and improve the range of services in rural communities. The Department's parameters for funding Rural Clinical Schools

include all Commonwealth supported students must complete at least 4 weeks at rural sites with 25% of them undertaking one year or more in a rural area, Universities are to recruit and appoint staff who will live and work locally and in addition a maximum of 5% of the budget is to be utilised in the capital city, unless otherwise approved by the Department. Also under the Australian Government's Rural Clinical Training and Support (RCTS) program 25% of Commonwealth supported medical students are to be from a rural background (ASGC-RA 2-5) (24, 29, 30).

The Mason report from 2013 (24) provides a comprehensive review of the various programs funded through the Commonwealth Government. It stressed a number of issues of significant relevance with regards to workforce. These included the view that it is imperative both economically and for population health to move beyond a focus on specialist medicine and acute care beds, to appropriate generalist skills, team based community care and the training and development of the nursing and allied health workforce. Separately, the most significant medical workforce issue, is one of distribution. This leads to inadequate or non-existent service provision in some rural and remote areas, and to populations of extreme disadvantage, most particularly the Aboriginal and Torres Strait Islander communities.

Strong recommendations arising from the Mason review included the imperative to create a coherent pathway for rural and regional education and training. This needs to be for generalist medical training as a matter of urgency but then also needs to provide resources for nursing, allied health and dentistry as well.

Integrated and coherent pathways need to link the investment in rural university medical training with new support for rural intern places and continued growth in specialist training positions. Also, the model needs to build on existing programs and maintain access to primary care and private sector training though the development of a more networked approach to delivering quality education. A highly collaborative approach involving consortia of key training/accreditation bodies and health service providers was felt to be the most successful model.

10.2 Victorian Government.

10.2.1 Workforce strategies.

In the consultative process for this report it was frequently stated that the Department of Health and Human Services needed to be more definite in determining the range of health services to be delivered by hospitals, the model of delivery, acceptance of clinical risk and then achieving better alignment between hospital capability planning and funding models. The balance between community demand for particular services and financial viability are particularly felt in the regional and remote areas. Small clinical services that are felt as 'needed by the community' may not be viable under activity based funding if appropriate resourcing for the safety of the services is maintained. Hospitals who provide emergency services through Urgent Care Centres are also vulnerable.

Also the profile of services required in regional and remote areas is changing. There is an increased requirement for aged care, rehabilitation, mental health and drug and alcohol services. Yet country hospitals still try to maintain specialist level services such as maternity / obstetrics like PDH. The changing community requirement needs to be acknowledged around the skills expected of clinicians particularly those who may work as generalists. The changes can still be included with advanced skills of emergency medicine including non-operative fracture care, anaesthesia and obstetrics. In Victoria there appears less requirement for other advanced procedural skills such as endoscopy or general surgery.

The Victorian rural generalist programs have not brought the outcomes of adequate workforce numbers in regional areas. Concerns were raised about fragmentation, lack of clear direction, commitment, continuity and cohesion. Focus is dominantly on service provision over training requirements with limited regard to building the culture required to nurture this workforce. Potential rural generalists are said to seek their careers in other states. In comparison, the Queensland Rural Generalist Program addressed four pillars of recognition of rural generalist medicine, practice value for its true worth, a supply line / pathway to vocational practice and re-design in a comprehensive manner with some success. The outcome is measured in the numbers. In Victoria, the posts that are available are often unsubscribed and are not filled by rural generalist trainees.

These concerns have been recognised and the Department is currently merging into the revamped Victorian Rural Generalist program the previous disparate areas of rural community intern training (RCIT), General Practitioner-Rural Generalist (GP-RG), Rural Extended and Advanced Procedural Skills (REAPS) and Consolidation of skills (CoS) programs. Victoria is also revisiting its policy approach on Schedule 19 as it relates to Medicare billing in more regional areas, which has been utilised more fully by other states to improve funding for rural and remote positions. It is hoped this more coordinated, profiled and 'branded' approach will improve the rural generalist training. However, much is needed to be done to increase involvement of Rural Generalists, ensure Universities are clearly committed to their training and this interfaces smoothly to the post graduate training provided through the two medical Colleges who will have more direct responsibility for the training programs from 2021.

There is still a potential for fragmentation as the revised program will be delivered through a consortia approach across the 5 health regions. It will be important that there is clear alignment with achieving the goals of the national rural generalist training pathway.

While the department re-organisation and the training program uncertainty continue, plans are being developed in the sub-region through the Directors of Medical Services and Chief Executive Officers as well as around Portland through Active Health and Portland District Health. Issues like locally placed end to end training are emphasised but still need fuller engagement with Universities, Medical Colleges and both State and Commonwealth governments.

10.2.2 Regionalisation and Clinical Governance

There are many strategies, policies, and reports that impact on service design particularly in the context of South West Victoria. These include the Rural and Regional health partnerships guidelines (31) as well as key reports like 'Targeting Zero' (3). Regional planning increasingly focuses on integration and collaboration. There is a particular emphasis on the importance of a suitably skilled workforce in rural areas. Clinical governance and reliable service quality is emphasised repeatedly through 'Targeting Zero'. Regionally this needs to be demonstrated through active clinician engagement in regional clinical frameworks, clinical protocols and regional credentialing. Regional clinical governance also needs to include active peer review, clinical networks and where possible regional employment models to facilitate active clinician involvement. There needs to be a consistency in clinical practice, patient referral, escalation protocols and active support for medical workforce capability. In the South West, the Health Accord (hA+) was established between Portland, Hamilton, and Colac to try and progress this. Although initially embraced, the endeavours have not continued due to changing leadership profiles and organisational structures.

The workforce solutions in South West Victoria need to acknowledge these important policy drivers. Multiple fragmented approaches do not provide the consistency in approach that is now expected.

Meaningful partnerships require shared vision and passion, clarity of roles, recognition of different skills and abilities, respect and support of other members' strengths and weaknesses as well as solid communication particularly through the more difficult issues. This needs to be achieved consistently over time and unfortunately this has not occurred in South West Victoria. There are multiple levels of hostility between Warrnambool, Portland and Hamilton in health and other government services. In the health area this is also compounded by different operating models and engagement of the medical staff which are structured locally and uniquely to achieve community and Department of Health requirements. Both Hamilton and Portland do not view themselves as 'giving up' services to Warrnambool particularly if it impacts on their organisational goals. Warrnambool does not see itself as necessarily supporting smaller facilities if the cost is disruptive of its own services. This complexity produces different definitions of success or required service delivery. Initiatives are not supported fully and there is a sense of increased fragmentation across the region and wariness of the larger entities. Collaboration becomes very difficult. This then impacts on significant strategic discussions around workforce with the educational, regulatory and funding bodies associated with healthcare such as Universities, Medical Colleges, Ahpra, Commonwealth and Victorian departments. Both sub-regional and regional discussions do not appear to be delivering tangible outcomes for the benefit of the community.

10.2.3 South West Victoria Reviews

In the Aspex report (4), regionalisation was required for service planning and design approach.

The report concluded that despite many years of significant effort, the capability to deliver the core clinical needs of the Portland community had 'waxed and waned' with recruitment and retention of specialists and senior medical officers being an ongoing issue. Meeting the future community needs would become even more problematic. The report also noted the challenges for Portland District Health would be shared across the region including the inability to achieve critical mass, the impact of service duplication and over-reliance on International Medical Graduates to achieve medical cover.

To address this, Aspex proposed a sub-regional approach to the development of clinical capability that involved shared clinical responsibility across health services. This would provide a more stable medical workforce and provide the right type of skills required for cores service in a more cost-effective manner. It saw an enhanced sub-regional role for South West Health and reduction in overlapping and competing services. Aspex advocated for a dispersed service model due to the topography and concentrations of populations in the three main centres that are each more than an hour apart. Core specialist services would include specialist general medicine, emergency medicine, general surgery, maternity, and anaesthetics, which will operate at each of the three hospitals. They supported a more differentiated service delivery model for specialties that are predominantly elective procedural services and non-urgent medical services such as diagnostic endoscopy, ENT, gynaecology, ophthalmology, urology, and vascular surgery.

Collaborative approaches to identifying gaps and setting recruitment priorities, and joint agreement to the service configuration with utilisation of the medical specialist workforce across the sub-region were anticipated. There also needs to be expanded roles for specialised nursing and allied health with consideration of regionalised appointments. A sub-regional approach to

in-service training, peer support, mentoring and professional supervision across services is required (4).

In the Biruu report of PDH, the reviewers made additional specific recommendations that included expanding and strengthening the community health service platform, particularly in regard to chronic disease and health promotion approaches and leading a service system-wide approach to developing a continuum of care for older people. Also emphasised was improving multidisciplinary care and referral pathways between mental health services and drug and alcohol services particularly from the Urgent Care Centre and developing a shared model of alcohol and drug treatment with Dhauwurd Wurrung Elderly and Community Health Service. The Biruu report identified that workforce issues would be assisted by expanding roles for nurse practitioners and allied health practitioners in the urgent care service (5).

11. Implementing Rural Generalism – A proposed model

The recommended option for Portland District Health is a critical mass of rural practitioners that is supported by regional specialists providing services across South West Victoria. The intent is to improve services for the community of Portland and Glenelg and also to optimise the use of the infrastructure available at PDH.

Implementing and sustaining the national rural generalist pathway is a substantial multi-year commitment (5-10 years) and it is important that a comprehensive range of stakeholders remains committed over this time. The program needs to build on the four pillars regarded as essential to the Queensland Rural Generalist Program (21, 22) and also the recommendations of the taskforce established by the National Rural Commissioner on the pathway (6). In this implementation model the key success factors and negative influences have been identified and addressed.

Looking at the four pillars strong support for Workforce redesign, recognition of rural generalist medicine, valuing of the practice of rural generalism for its true worth and the creation of a supply line / pathway to vocation practice is required.

In providing strong support of workforce redesign it will be important to have ownership by the Stakeholders over the five to ten year period.

1. Commonwealth Government and Victorian Governance establish a stakeholder group to oversight the implementation of the National Rural Generalist Model in Victoria. This includes the funding bodies (Commonwealth DOH and Victorian DHS), Universities, College of Rural and Remote Medicine, College of General Practitioners – Rural Faculty, Australian College of Nurse Practitioners, GP Supervisors Australia, GP Registrars Australia, Regional representatives responsible for program, Primary Health Networks and Regional Training Organisations. The role of the group is to ensure the creation and maintenance of the training program to support viable rural generalism across Victoria.

2. Five (5) DHHS regions establish their regional oversight committee of appropriate membership, preferably based close to the principal Rural Generalist training hub. Ensure representation is committed to issues of rural generalism in key clinical areas (medicine, nursing and allied health) and also facilitating technology such as telehealth.

3. In each of five regions an appropriate health facility in an outer regional area is selected where the rural generalist training program will be supported. This facility will have close links and alignment with the Rural Clinical Schools and ACRRM / RACGP-Rural training program.

   With reference to this report, Portland needs to be considered as a demonstration site for the development of a Rural Generalist Training Hub

4. If a critical mass of rural generalists to sustain 1:4 rosters is not achievable in the chosen health facility, then a 5 - 10 year program be created to establish a critical mass of 4 rural generalists in each of the areas of additional skills.

There needs to be strong recognition of rural generalists across the programs and ensure there is a culture of learning and education to support the ongoing training and professional development.

5. Appoint a Rural Generalist as the Clinical Lead of the program with appropriate administrative / coordinating support. Ensure there are appropriate co-appointments of key individuals with the Rural Health School of the University. Key linkages with ACCRM and the Rural Faculty of RACGP need to be achieved to ensure close alignment with the training pipeline requirements.

6. Establish additional teaching practices in conjunction with Universities.

7. Identify Rural Generalists who can provide teaching in the enhanced skills areas of emergency medicine, anaesthesia, obstetrics, aged care, drug and alcohol. Also identify additional specialists in these areas who are supporters of rural generalism and are willing to teach in the generalist program.

8. Identify with the Colleges the ongoing delivery requirements of training for rural generalists and Nurse Practitioners.

9. Identify educational programs from Colleges for Educators and mentors in the programs and ensure funding is available for those involved with teaching to be appropriately trained.

10. Identify and champion appropriate telehealth modalities in Victoria.

Recognising the value of rural generalists for their true worth is multi-faceted.

11. Some of this will be industrial in pay-rates through Victorian EBA conditions. However, it has been shown in Queensland that having pay and conditions matching those of other specialists is critical for the ongoing viability of rural generalism. The funding currently being spent on locum payments can hopefully be utilised to more appropriate pay rural generalists.

12. Ensure funding is available through the Commonwealth and State department for the required posts, training, mentoring and support for the national generalist training pathway.

There are a number of areas that are critical to run smoothly and with substantial support for the trainees to ensure a supply line / pathway to a vocational practice. These are highlighted in the QRGP success factors.

13. Confirm the number of rural generalists required to graduate from the program each year in Victoria. (Approximately 25% of the 350 annual national graduate pool)

14. Confirm the number of teaching posts PGY 1 to PGY4) required for dedicated rural generalist teaching (approximately 350 in total). This will include the core clinical training, the primary rural and remote training and advanced specialist training over four years. Determine how these can be prioritised for trainees on the rural generalist pathway.

15. Allocate the number of graduates and teaching posts across the 5 Regions to whom DHHS is delegating rural generalist training, recognising that areas with more health requirements in Outer Regional classified areas will need a greater number of posts.

16. Undertake an audit of posts available in each region and pathways that are already identifiable. Determine pathways for trainees that will provide ongoing connection and coherence whilst providing distinct career opportunities.

17. Identify a communication channel through Universities with the cohort of students who are undertaking terms in rural areas to enable contact about ongoing training opportunities and potential mentoring.

18. Identify with Universities how to actively interact with the rural training schools to gain mutual support. Actively market to all University medical students with priority of those with one year of training in rural areas. Provide ongoing career progression advice on a regular basis.

19. Administrative and collegiate support and coordination should be provided so that applying for the rural generalist training options is achieved easily and without confusion.

Additional areas to address

20. Recommendations in the Taskforce advice to the National Rural Commissioner

21. Determine measures of success, such as number of students being selected from the local geographical areas and number of graduates of the rural training program. Report on these annually and the number of students being selected from rural areas returning to train and practice there. The

12. Conclusion

Given the realities of health workforce sustainability in South West Victoria, although the status quo could continue, only substantial development of a regional approach to clinical services will provide significant improvement in sustainability. Given the failure of earlier discussions and models, this report proposes two alternatives being outsourcing of clinical services or conversion to a rural generalist model within a more regionalised specialist set of clinical services. The preferred and recommended alternative is to progress to a rural generalist model with a comprehensive, multi-year approach.

For the rural generalist model to succeed, not only in Portland but also in other regional areas of Victoria, the most substantial issue is the agreed and joint recognition of the seriousness of the challenge at multiple levels and bringing together of the stakeholders required for a comprehensive solution. The answer requires a compelling narrative that includes cultural change, sensible regionalisation of services, introduction of a critical mass of rural generalists in a framework of education, training and mentoring that is focused not only on the workforce issues of Portland District Health but also the health services of the region.

If Portland District Health wishes to positively embrace a substantial and effective rural generalist workforce at a Board, Executive and clinician level, there is a real possibility of becoming a prominent demonstration site for the Victorian roll-out of the National Rural Generalist training program. Although there will be significant challenges there is enough good will from the various stakeholders and key changes in strategy at Commonwealth and State level as well as Medical College training program level that could benefit such a program in South West Victoria.

Portland could strongly contribute to bringing the many regional workforce initiatives of the Commonwealth and State government that have involved health services, health care providers, Universities and Medical Colleges together in a cohesive manner. It is a most substantial challenge to change the culture and address more fully the issues of patient safety and quality. The Board members and Executive of PDH are aware of their broader responsibilities to the community of the region rather than the more limited service profile of their own organisation. The solutions will require a timeframe of at least 5 to 10 years but with the increased recognition of the rural generalist specialty, training programs, and more committed and direct medical college oversight there is a coherent option in outer regional Victoria and Australia. In an effective consortium with Universities and Medical Colleges and funded appropriately by government the current sustainability crisis can change.

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