Bulgarr Ngaru Medical Aboriginal Corporation

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Response to supplementary questions from the Parliamentary Committee following evidence given on 27 November 2023 to the Select Committee on Remote, Rural and Regional Health inquiry into the implementation of Portfolio Committee No. 2 recommendations relating to workforce issues, workplace culture and funding considerations for remote, rural and regional health.

Question 1

" Is your workload currently divided between services you provide at Bulgarr Ngaru and work that you do for NSW Health? a. Is this workload currently sustainable? ?"

Answer from Dr Marion Tait, senior GP at the Casino clinic of the Bulgarr Ngaru Medical Aboriginal Corporation.

GPs are often asked to be part of working parties and committees within the LHD landscape which is a vital way to break down various silos and barriers to good health care across the primary, secondary and tertiary care sectors. GPs are very passionate about this work as it often directly enhances the care our patients receive.

These meetings are almost always during normal working hours for LHD staff, are considered a normal part of staff duties and do not have a financial impact on the LHD service. It needs to be understood that GPs usually need to take time off from their normal duties to participate in such processes and this is generally at the expense of their health service or practice which loses their time to see patients without any remuneration. Or, the GP may do it on their own, unpaid time. We do it for love most of the time, and there are possibly fewer GPs willing to do this now than when I started. It is so important in health service delivery design to have primary care at the table. We cannot do it forever without acknowledgement of our contribution, in a financial and other senses. No one else is asked to work for free, but GPs always are!

Perhaps the most common specific area of concern is that of the flow of patient related information from the hospital back to GPs. Our patients communicate with us that they assume their health information is competently and confidentially managed between the hospital and primary care sector, and are often as surprised, frustrated and eventually as angry as their GPs when important test results, discharge summaries or specialist letters do not make their way back to their GP for timely follow-up care.

When a doctor in the hospital ED orders a test for a patient, ideally, they should indicate on the request form that a copy of the report be sent to the GP. This is standard, expected practice for doctors when they order a test when the care of the patient is shared between more than one doctor. However, even if the

hospital doctor specifically requests this (and this is far from always), the hospital IT systems are unable to make it happen. This type of electronic transfer can work for discharge summaries, but not for any other type of clinical information such as pathology or Xray reports. So even if an ED doctor specifies that the GP should receive a copy, we don't get it. Frustrating for both ED doctor as well as the patient, and especially the GP who now has to spend quite a bit of time calling the pathology lab or radiology department to get the result faxed over. It wastes everyone's time, and is a barrier to good healthcare. There should be a simple fix, but neither I, nor many other doctors over many years, have been able to get the hospital to understand why this is crucial, and hence it is never actioned or changed.

While we sort out the complexities of the IT system, we could improve the flow of patient information by looking to a fabulous thing QLD health has done. They have a GP Liaison Officer at their major hospitals. This has been so very helpful to have a GP who understands what information is needed by GPs working within the hospital to provide the link in “lost” information. Such a person within a hospital could be vital for getting patient information to GPs reliably and quickly, but it is lacking in our region. And there is so much other scope for such a role. For example, in bringing a greater understanding of the local primary care landscape and how it works to hospital staff.

Another practical suggestion that could improve patient care would be to make a hospital or health department title identifiable when they call a patient for an appointment. Currently the number appears as a 'no caller ID' on a person’s phone which is not answered by many of us ever, so why keep using it? This results in patients not attending appointments and also results in patients being removed from appointment lists if they repeatedly don’t answer the call. We can only assume it is also a cause of frustration for hospital staff who are trying to arrange appointments.

I will continue to advocate for my patients within our healthcare landscape to try and help them access and receive the best care possible. For this advocacy to be sustainable, I think all hospitals need enhanced GP engagement that is respected, remunerated and acknowledged.

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Question 2

"What funding or workforce improvements could be developed to reduce the prevalence of treatable disease and illness in Aboriginal communities in your area?"

In preparing this response, we have consulted with the CEOs and staff of Bullinah Aboriginal Health Service in Ballina and Rekindling the Spirit Health Service in Lismore. The following therefore represents a shared view across all three services about ways to improve health care delivery and outcomes for Aboriginal people in this region.

As a preamble, it should be understood that the fundamental causes of the ill health Aboriginal people endure lie in their socio economic circumstances: poverty, unemployment, poorer levels of education, housing issues, systemic racism. Even though the focus of this committee is in a different direction, these issues must always be borne in mind. Indeed, there are two recommendations of the original NSW Legislative Council Inquiry into health outcomes and access to health and hospital services in rural, regional and remote New South Wales that are particularly pertinent to this:

Recommendation 8

That the NSW Government investigate ways to support the growth and development of the primary health sector in rural, regional and remote areas, and support the sector's critical role in addressing the social determinants of health and reducing avoidable hospitalisations for the citizens of New South Wales.

Recommendation 44

That the NSW Government adopt a Health in All Policies framework (similar to the policy in South Australia) to ensure that the health of people in New South Wales is central to government decision making, and which recognises that community physical and mental health is a responsibility of all Ministers and Departments of government. Further, such a framework should include a requirement that all decisions of government are assessed to determine the impact on human and environmental health to ensure a whole-of-government ownership of health outcomes for people living in New South Wales.

Recommendation 8 was supported by the NSW government while recommendation 44 was noted. However, in the supporting documentation provided to us for this parliamentary committee hearing, action was reported as ongoing in relation to both recommendations.

Invest in Primary Health Care, and Aboriginal Community Controlled Health Organisations in particular
To return to the focus of this particular supplementary question, the summary answer is to significantly invest in the primary health care sector and in particular in Aboriginal Community Controlled Health Organisations (ACCHOs); both in overall material capacity, but also in measures that enhance service and program development, and accountability abilities.

There has been much concern about the burden on the hospital system, the need to prevent hospitalisations and to transfer more care to the non-hospital sector. This can only be addressed by strengthening the primary health care sector and, for Aboriginal people, strengthening ACCHOs. This is the only setting where better health care across the whole domain of needs, delivered with a full understanding of the person's life circumstances and tailored to their needs, may prevent that person ending up in hospital.

The previous government flagged an investment of some $833 million for rural, regional and remote health services. However, the vast majority of this seems destined for the NSW health system and not primary health care.

Investing into the hospital system is investing at the end of the chain of events that has led to the person already being seriously ill. And when the person leaves hospital, they return to the same circumstances and health care system they were in before. Nothing changes.

Putting money into the non-hospital parts of the health department also misses the mark particularly for Aboriginal people. In spite of efforts to improve, health department services still lack the elements of cultural safety and connection to the community and are often not particularly well informed and adapted to the nature of Aboriginal community needs. All of which are essential to effective primary health care services.

So, in the context of this inquiry, the first step towards reducing treatable illness and disease in Aboriginal people would be to significantly invest in primary health care service delivery by ACCHOs so they can offer a broader range of sustainable services.

There has rightly been a strong focus in this inquiry process on mental health. This is an area of major concern to ACCHOs. Health department mental health units and programs are overburdened and not particularly responsive to the needs of Aboriginal people. There is far less access to psychologists and Aboriginal mental health workers and nurses than there needs to be. To look at psychologists as an example, ACCHOs need to rely heavily on the private practice sector for psychology services. But this fails to meet the need as there are significant wait times, few private psychologists will accept medicare rebates as full payment and few are well orientated towards the needs of Aboriginal people. There is a pressing need for ACCHOs to be funded to provide more in-house psychologist services. The same may be said for psychiatry services.

However, psychologists and psychiatrists are only part of the mental health picture. ACCHOs in our region envision a comprehensive approach to mental health issues within a **properly funded, culturally safe, community responsive, and sustainable** Social and Emotional Well Being framework.

Returning to the broader focus of the question, beyond the quantum and range of different services that need to be available, there are also important gains to be made in the way the workforce is developed and operates.

The health profile and health service needs of Aboriginal people are complex and need to be developed and delivered in a well-researched, systematic and proactive way. Simply waiting for a person to come into the clinic with a problem, as is the case in much of mainstream primary care, is not good enough. There is a need to actively seek and address potential health issues both in clinic and in outreach settings.

The complexity of health issues means that the best response is often worked out over time and delivered in the context of agreed protocols and processes. Clinicians, particularly GPs, need to spend time developing these tools as well as ensuring that new practitioners are familiar with them, and all practitioners are following them.

Within a region, there is often considerable movement of Aboriginal people between ACCHO services. Most public health and particular service delivery issues are common to all the ACCHOs in the region. This points to the need for ACCHOs to work collaboratively towards common approaches to shared problems. Clinicians need to do this and need time and space to do so.

However a problem exists in the funding philosophy for clinician services within ACCHOs, which is almost solely premised on the delivery of specific *clinical* activity. For GPs, this relates to medicare billing. There is no understanding or inclusion of the need for clinicians to spend time developing, evaluating and refining the health service programs they are expected to deliver; or conducting transparent clinical quality improvement (QI) activities that would allow the community, via its health service management, to scrutinise the quality of care they are receiving.

Related to this as a workforce issue is the potential for burnout and reduced work satisfaction by limiting the role of clinicians to technical service provision and isolating them from other ways to contribute to service delivery. At a recent conference of ACCHO GPs in northern NSW, participants identified being limited to only seeing patients one after another in a relentless rhythm as a major burnout factor. Having the ability to do other types of work within the service, such as program development or dedicated QI activities etc was considered as an important means to address this burnout issue.

To summarise this point, we believe more can be done to get more benefit out of the workforce and to increase workforce satisfaction. But this needs to be specifically resourced. Until now the funding model for ACCHOs does not recognise this. ACCHOs have often relied on clinicians doing this type of work on their own time, or using resources cobbled together from elsewhere. This is not sustainable. NSW Health should consider providing funding for ACCHOs to support this activity as it is essential to ACCHOs being able to improve and demonstrate accountability for their service delivery.

More capacity and better primary health care service delivery by ACCHOs represent the best ways to prevent illness and disease in Aboriginal people and to reduce demand on the NSW Health system.

In Northern NSW, the three ACCHOs have over the past 2 years embarked upon a process of working together to share resources and approaches to address the issues mentioned above, and that we have outlined in a previous document we have provided to the parliamentary committee. For your convenience we repeat this information here.

A regional, collaborative approach by Aboriginal Medical Services in Northern NSW to improving health service delivery for Aboriginal people

Over the past 18 months, the Northern NSW Aboriginal Medical Services - Bulgarr Ngaru Medical Aboriginal Corporation (BNMAC), Bullinah Aboriginal Health Service (BAHS), and Rekindling The Spirit (RTS) – have been engaged in a regional, cooperative approach to enhance their health service delivery for Aboriginal people in the region. All three services believe this approach is already leading to appreciable benefits with the potential to increase more in a number of domains;

- Improving quality of clinical care in a measurable fashion with direct benefits for clients and potentially reduced demand for hospital care.
- Making fuller and better use of the expertise of AMS clinicians.
- Enhancing and broadening the work experience and support for AMS clinicians and so improving the ability of the AMS to attract and retain clinical staff.
- Providing public health leadership to the region.
- Providing greater partnership assistance to NSW health in matters relating to the health and health care of Aboriginal people.

We further believe the model could be more broadly emulated and supported by NSW Health and doing so would address a number of the challenges in remote, rural and regional health settings that the parliamentary committee is currently considering. Given the role of the Commonwealth in primary health care, the model could be considered by the Bilateral Regional Health Forum.

An essential element of much of this activity model is that it must directly involve working clinicians and be resourced. If a health service is to improve an area of its clinical service it needs its clinicians involved in planning, research, development of ideas via consultation, implementation and evaluation. This is work that does not involve seeing patients and billing Medicare. Clinicians need dedicated, paid time to perform this work and the health service must resource it from sources other than Medicare. NSW Health could resource PHC agencies in this domain.

The model the AMSs in northern NSW have adopted to implement this work involves:

- paid time for each individual GP to carry out clinical quality improvement activities,
- lead GP clinicians in each clinic with dedicated time to coordinate and support health service improvement activities and GP education at the clinic level, and
- a regional coordinator position to work across all three AMSs to provide coordination as well as strategic, public health and clinical technical support.

This model, and the activities we have undertaken, are pertinent to the funding, workforce issues and workplace culture foci of the parliamentary inquiry.

<u>Regional AMS clinician conferences</u>

In November 2022, May 2023 and November 2023, regional AMS conferences were held on Saturdays in Ballina. The aim of these conferences is to provide an opportunity for GPs and other clinical staff for networking, clinical education, and, more importantly, to raise and address public health and health service delivery issues across the region. All conferences were attended by between 30 and 35 people and

feedback has been extremely positive. Conferences are organised by a committee of GP representatives from each clinic who are allocated paid work hours by their AMS to organise the overall conference and individual sessions. The regional coordinator plays a major role in organisation. BNMAC provides the overall funding and logistic support for the conferences.

The focus on health service issues in these conferences is very important. They are attended by health service senior managers and clinic managers as well as clinicians. This allows for a more inclusive and engaged discussion of health service issues and improves the potential for finding, agreeing and actioning ways forward. As a direct result there have been major new health service initiatives implemented across all services and an enhancement of the cooperation and coordination between the services and adoption of common approaches to common issues. The conferences provide a mechanism by which clinicians can not only gain education, but also directly contribute to health service policy, initiatives and overall direction both of which enhance their technical capacity and work satisfaction. Specific examples more fully described below include the Quality Improvement / Continuing Professional Development (QI / CPD) program and the Opiate Replacement Therapy (ORT) initiative.

<u>Quality Improvement / Continuing Professional Development program</u>

This concept was canvassed in the lead up to the first clinicians conference when it was discussed and agreed to by participants and has been implemented since.

In this program all GPs are given quarantined work time (usually 2 hrs per month) during normal hours to do clinical quality improvement work. This consists of initial education and discussion, case note audits (if necessary initiating follow up for individual patients to ensure they are receiving the required standard of care), collation and feedback of results and discussion of implications and areas for improvement. Quantifiable indicators are generated to be re-measured in future to assess whether there has been a practice wide improvement.

Some of this work is coordinated at local clinic level by the lead clinicians. Much of the technical work, for example extracting data, generating patient lists and developing the conceptual and practical framework for the audit is done by the regional coordinator and shared across all services.

A very important element of this program is its direct focus by the clinicians themselves on actual clinical management and outcomes with a direct link to the care of individual patients.

This is in contrast to other QI concepts, for example, the national or NSW Key Performance Indicators for Aboriginal health services, which mostly reflect activities rather than clinical outcomes. The few that do reflect clinical outcomes, for example birthweight result, HbA1C result, and renal function result, are population level measures which reflect the full range of environmental, behavioural and clinical management influences and are of limited use at clinic level in ensuring people with diabetes, chronic kidney disease or hypertension are receiving appropriate medication and monitoring. It also contrasts with other QI programs that are generally conducted by outsiders, either without or with very little involvement of the clinicians providing the actual care.

The northern NSW AMS program focusses on how GPs are assessing and managing individual patients with reference to an agreed standard of care with education, technical support, performance measures and accountability built into a system, which also allows for immediate improvement for the care of individuals.

In addition to providing the health service with a QI program directly relating to improving clinical care, the system provides a mechanism for GPs to gain the necessary Continuing Professional Development hours in the "performance review" and "outcome measurement" categories now required by the Australian Health Practitioners Regulatory Authority.

Opiate Replacement Therapy (methadone and buprenorphine programs) initiative

As a result of a session in an AMS conference for clinicians concerning access to services for clients with Alcohol and Other Drug (AOD) problems, it was agreed that the AMSs would work towards providing improved access to ORT for Aboriginal people. Until this time there were only a handful of people receiving this therapy via an AMS in the region, but large numbers of Aboriginal people within the NSW Health program. A weekend training day was organised with the support of the NSW Health AOD program and AMS GPs and nurses were paid by their AMSs to attend. Over 20 GPs attended as well as several nurses. Several GPs have attended the LHD specialist clinics for follow up clinical training time. An MOU has been signed between the AMSs and the LHD to regulate and oversee a process whereby stable Aboriginal clients of the LHD system can be transferred to the care of the AMSs and back again if necessary. The process of transferring patients is beginning now, albeit at a very slow pace.

Acute Rheumatic Fever and Rheumatic Heart Disease in Northern NSW

AMS clinicians in Casino became concerned about the number of cases of Acute Rheumatic Fever (ARF) in the area and also by the poor quality of care they were receiving within the hospital system. ARF and the long term damage it can cause, Rheumatic Heart Disease (RHD) are now relatively rare in the general population, but much more common in Aboriginal people. Generally speaking most clinicians have little to no experience or awareness of it.

As a result, the three AMSs agreed to do a comprehensive audit of medical records across all their clinics to explore the matter. It revealed a much greater incidence of ARF and prevalence of RHD in the region than was appreciated and a significant need for improvement at both AMS and hospital level in the management of people with ARF/RHD. Within the AMSs a major education process was put in place to improve ARF/RHD management and prevention within the AMSs, new systems involving local cardiologists developed to ensure timely access to echocardiograms, and active follow up of all patients with possible RHD was instituted to clarify their situation and ensure they are receiving appropriate care.

The AMSs also approached clinicians within Lismore Base Hospital in order to raise awareness and improve management. A working group established between AMS and hospital clinicians developed an agreed standard of care and referral pathway. AMS clinicians began to notice an improvement in the care of these clients and communication about them from the hospital. Also as a result of the AMS work, a significant number of new and older cases of ARF and RHD were able to be notified to NSW Health to give disease control authorities a better appreciation of the situation in northern NSW. This was received very positively by the disease control authorities.

Key concepts and benefits of the regional, collaborative approach

The program provides the resourcing and technical expertise to allow for a more systematic, informed and coordinated process for the improvement of health service delivery. It provides a mechanism to be more proactive in addressing health issues. This applies within an individual service and across all the services and so reduces the fragmentation of service delivery in the region.

By having a united approach and increased technical ability the capacity for AMS leadership is enhanced in relation to both Government and Non Government agencies regarding public health and health service issues.

It enables GPs to enhance and expand their role and focus within the AMS in a way which builds in commitment. The regional conference concept provides a mechanism for GPs and other clinicians to have greater input into models of care, potentially fostering innovative, community responsive models. This should increase the contribution they make to the health service, increase their accountability and, hopefully, increase their job satisfaction and perception of AMSs as a place to work.

This model requires resourcing and coordination and cooperation across services.

To meet their needs, AMSs cannot rely upon GPs to do meaningful QI or service development activity on their own time. They must give GPs paid time to do this work and some of it at least needs to be done within normal work hours.

The need for a common, coordinated approach by AMSs to public health or health service delivery issues requires coordination, technical expertise and dedicated time resource within the AMSs. A resource to do this can be shared efficiently between services in the form of a regional coordinator. This position and its role needs to be recognised by each of the AMSs. This is enhanced if the coordinator is formally employed as a doctor by each service with a similar or the same job description in each. The coordinator therefore has accountability to all services, legitimate access to clinical records and is bound by the privacy codes of each service. This allows the coordinator to provide individual support within clinics and work across all clinics to facilitate the regional approach. It also enhances the capacity of the coordinator to represent the three AMSs in their dealings with other organisations and agencies such as the LHD.