Submission No 26

THE IMPLEMENTATION OF PORTFOLIO COMMITTEE NO. 2 RECOMMENDATIONS RELATING TO WORKFORCE ISSUES, WORKPLACE CULTURE AND FUNDING CONSIDERATIONS FOR REMOTE, RURAL AND REGIONAL HEALTH

Organisation: Australian College of Rural and Remote Medicine (ACRRM)

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College Submission

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NSW Senate 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

About the Australian College of Rural and Remote Medicine (ACRRM)

ACRRM's vision is **the right doctors, in the right places, with the right skills, providing rural and remote people with excellent health care**. It provides a quality Fellowship program including training, professional development, and clinical practice standards; and support and advocacy services for rural doctors and the communities they serve.

ACRRM is accredited by the Australian Medical Council to set standards for the specialty of general practice. The College's programs are specifically designed to provide Fellows with the extended skills required to deliver the highest quality Rural Generalist model of care in rural and remote communities, which often experience a shortage of local specialist and allied health services.

ACRRM has more than 5000 rural doctor members including 1000 registrars, who live and work in rural, remote, and Aboriginal and Torres Strait Islander communities across Australia. Our members provide expert front line medical care in a diverse range of settings including general practices, hospitals, emergency departments, Aboriginal Medical Services, and other remote settings such as RFDS and Australian Antarctic Division.

Initial comments

The *New South Wales Parliamentary Inquiry into Health Outcomes and Access to Health and Hospital Services in Rural, Regional and Remote New South Wales* was the first time a parliamentary committee had conducted an exercise in examination and assessment of the health system in New South Wales on this scale.

ACRRM's Submission and testimony to the Inquiry were quoted extensively throughout the *Portfolio Committee No.2 Report*. The role and contribution of Rural Generalists across rural and remote New South Wales was discussed at length and the Report recognised general stakeholder support for the rural generalist model of care.

The overarching finding was that the state's rural, regional, and remote residents have poorer health outcomes, inferior access to health and hospital services, and face significant financial challenges in accessing services compared to their metropolitan counterparts.

Of particular relevance and significance to ACRRM, were recommendations relating to:

- implementing the single employer model for General Practice and Rural Generalist trainees across rural, regional, and remote NSW[1]
- overhauling the Visiting Medical Officer (VMO) model to ensure viability[2]
- expanding rural and remote GP training positions and support[3] and
- reviewing maternity services in order to develop plans for midwifery, GP obstetrics, specialist Obstetrics and newborn services[4]

We have focused on the progress of these recommendations in our response. Disappointingly, our members report little or no progress has been made with any of these.

Response to Terms of Reference

1. Staffing numbers, recruitment and retention, and related workforce management and planning issues

The PC2 Report provides comprehensive evidence that rural and remote communities in NSW experience inequitable access to all medical care and especially to consultant specialist care and this access inequity is coinciding with these people recording significantly worse health outcomes than their urban counterparts.

A strong Rural Generalist (RG) workforce is a key solution to restoring sustainable health care services to remote, rural and regional areas. RGs can maximise the breadth of medical services available locally. They also record rural retention levels without parallel across medical specialties. This is evidenced by external studies of ACRRM Fellows[5], by the outcomes of RG programs in other jurisdictions[6], and by the 80% of ACRRM Fellows who are rurally based.

The College is pleased to see the expanding size and scale of the NSW Rural Generalist Training Program. However, despite the program's general expansion, it is beset with significant administrative impediments related to supervision, employment, and clinical credentialing decisions. These problems reflect the lack of representation or valuing of the program and its perspectives in many key decision-making forums both at local and whole-of-state levels. To successfully meet its potential, the program requires strong state-wide cross-system support. In the ideal this would come from a single point of coordination, directly answerable to the Minister.

Fellowship as a RG confers that a doctor has attained competency to practice across a broad range of healthcare settings as appropriate to meeting the breadth of healthcare service needs of their rural and remote communities. Thus, training to this scope of practice at minimum involves considerable training time in both hospital and primary care settings and in practice typically involves complex movements

[1] *Portfolio Committee No.2 Report* Recommendation 9
[2] *Ibid*, Recommendation 12
[3] *Ibid*, Recommendations 15 and 33
[4] *Ibid*, Recommendation 27
[5] McGrail M, O'Sullivan B (2020). Faculties to Support General Practitioners Working Rurally at Broader Scope: A National Cross-Sectional Study of Their Value. *International journal of environmental research and public health*, *17*(13), 4652. https://doi.org/10.3390/ jerph17134652
[6] Queensland Health (2022) *Queensland Rural Generalist Pathway 2020 Data Snapshot* Accessed at Jan 2021: https://ruralgeneralist.qld.gov.au/wp-content/uploads/2020/03/QRGP_data_summ_19Mar20_FINAL.pdf

between a range of settings in a range of locations to ensure all necessary skills and experience are attained.

RG registrars commonly report facing difficulties in completing their Advanced Specialised Training in regional and rural hospitals. The reported barriers include rural and regional hospitals losing their accreditation as training facilities due to lack of staff or resources, they also arise due to the limited pool of rural training places being prioritised for trainees with other specialist colleges. These problems reflect the scarcity of funding and ongoing workforce shortages but are compounded by a lack of strong sponsorship for Rural Generalist training and practice scope in wider decision forums.

In addition to these difficulties, the *National Rural Generalist Taskforce Advice Paper* recognised that the complexity of RG training represented a barrier to doctors training to this career. A key disincentive was that RG registrars forewent the opportunity to accrue workplace benefits. Consequently, it included a recommendation to facilitate the subsequent exploration of single employer mechanisms.

- **Recommendation 9 -** NSW health to work with Australian govt and PHNs to expedite the implementation of a single employer model for GP trainees across rural, regional, and remote NSW
- **Recommendation 15** - Increase rural GP and specialist training positions and integrate these with the recommended employment service delivery models
- **Recommendation 33 -** Review current employment and remuneration structures for trainee doctors

Single Employer Models (SEMs), when appropriately designed, are a positive development toward building a strong Rural Generalist workforce. ACRRM is committed to progressing initiatives to implement appropriately designed SEMs and to contribute to their development and delivery at all stages, noting that they are not the only or whole solution to addressing workforce issues.

Rural Generalist registrars in particular, face challenges in attaining Fellowship which require bespoke solutions, given that RGs provide broad scope services to meet the needs of people without easy access to the specialised services available in cities. To attain this scope involves training in multiple workplaces and a longer and more complex training journey than that requisite for general practice Fellowship.

To incentivise the growth of this critical workforce, Rural Generalist registrars must have access to pay and conditions that recognise these circumstances and fairly reward their services. The SEM approach provides a mechanism for addressing a key disincentive to attaining the Rural Generalist scope of practice, namely the inability to accumulate job entitlements for the duration of training. It potentially has broader benefits such as streamlining training and contributing to better integrated patient care.

Under single employer models (SEMs), registrars maintain one employer for the duration of Fellowship training usually a jurisdictional health service. The Single Employer provides the participating registrars' salary and work entitlements, and secondment arrangements are established with the additional workplaces in which the registrar may train. In the ideal under these arrangements, training toward a Fellowship qualification as a specialist General Practitioner and RG would provide a seamless movement between hospitals, general practices and other work settings such as Aboriginal and Torres Strait Islander Medical Services or Retrieval Services.

To be effective, SEM models must:

Consider the longer-term imperatives for workforce development, which will be best achieved where registrars have a positive experience of rural training

Include strong cooperation between participating doctors, practices, and health services in design and delivery

- Build in sufficient flexibility to be compatible with Rural Generalist training needs
- Involve ACRRM as part of the planning and roll out as the leading arbiter of professional standards for Rural Generalist training and practice.

In addition, for the rollout of SEM in NSW to be successful, it is essential that it is overseen directly by the Department, enabling Local Health Districts to develop local solutions, while establishing state-wide structures and frameworks which will allow NSW to work cooperatively across LHDs towards shared workforce goals. The rollout must be managed centrally to ensure the implementation of a robust and predictable model which will apply wherever a registrar chooses to train in NSW.

The College supports SEMs as part of a range of employment options available to Rural Generalist registrars. However, there must be a range of options which are fit for purpose for the diversity of contexts in which Rural Generalist training occurs and the varied training journeys that Rural Generalists pursue**.**

To be effective, employment models for the training workforce must then be transferred to complementary frameworks in which careers in rural practice beyond Fellowship can also be appropriately remunerated and incentivised.

2. Staff accreditation and training

- **Recommendation 12 -** Working conditions, contracts and incentives of GPs working as VMOs should be reviewed to ensure the GP/VMO model remain viable while broader innovation and reform progresses
- **Recommendation 13 -** A state-wide system of GP/VMO accreditation should be established, independent of local health districts, and that an online availability system should be established as part of this process

The College supports appropriately remunerated and supportive contractual and employment arrangements for the GP VMOs providing services to rural and remote hospitals and health care facilities. VMO arrangements should not rely on MBS billing to fund a heath service which the state is required to provide.

In the view of the College, the employment arrangements for RGs working in small rural and remote health services requires a nationally coordinated review. This is particularly relevant given the current application to the MBA for the national recognition of Rural Generalism as a specialised field of general practice.

3. Challenges relating to the implementation of recommendations relating to funding for remote, rural and regional health services and programs – Maternity and Obstetrics

- **Recommendation 27** – Rural and regional Local Health Districts and those LHDs which take in regional areas of the state, review their maternity services in order to develop plans for midwifery, GP obstetrics, specialist Obstetrics and newborn services

Our members report little or no progress with regard to Recommendation 27, with lack of obstetric services continuing to cause severe issues outside the larger regional centres. RGs are integral to delivering safe, high quality maternity care to women in rural and remote communities in a cost-effective manner. In addition to the important role of the rural GP, RG proceduralists perform key roles in providing maternity services to many regional, rural and remote communities.

ACRRM is dedicated to building a national rural and remote workforce with a 'Rural Generalist' skill set. ACRRM believes that provision of a national network of Rural Generalists is the only way that rural and remote communities can attain sustainable, high-quality health services, including maternity services.

The Rural Generalist practitioner is a clinician able to meet the health care needs of his/her community through a broad scope of practice which includes comprehensive primary care, public health, and advanced skills as appropriate for community need, delivered within the unique circumstances and context of rural and remote medical practice. Maternity services form an important component of this broad scope of practice, allowing women and their families to access a high standard of care close to home and minimising the economic and social imposts associated with travel to larger regional centres to access appropriate care.

Social and economic benefits of rural generalism include:

- Local access to procedural and emergency skills, including obstetric skills, which are most needed by the highest needs members of our rural/remote communities,
- Reduced health care costs for both governments and patients,
- A range of advantages for rural and remote patients, their families and caregivers, including reducing the need to travel and its associated costs and risks; reduced social dislocation; and enabling patients to access social and other support from their families and communities,
- Maintaining social capital and a range of medical and other skills within the community,
- Increasing retention of a skilled medical workforce and the associated infrastructure and support services within the communities where they are needed,
- Reducing the risk of a spiralling loss of services which results from a declining work Reducing the risk of a spiralling loss of services which results from a declining workforce; reduced skill sets; and consequent loss of workforce and infrastructure.

The College recommends an urgent review of remote, rural and regional maternity services in NSW, covering a range of issues including the needs of women living in rural and remote areas; pre-and-post natal care; development of a medical workforce and infrastructure strategy, and alignment with the outcomes of the recent National Rural Maternity Forum.

4. Challenges relating to the implementation of recommendations relating to funding for remote, rural and regional health services and programs – Emergency Medicine

There are numerous references in the PC2 Report to emergency departments under pressure, however, the Report was short of recommendations despite these findings:

"*We heard stories of emergency departments with no doctors; of patients being looked after by cooks and cleaners; of excessive wait times for treatment; and of misdiagnoses and medical errors*.[7]"

Whilst we appreciate the issues faced by emergency department are inextricably linked to significant and longstanding workforce challenges across remote, rural and regional NSW, nonetheless, current models of emergency care must be reviewed. This is particularly relevant in the context of RG recognition and ongoing Australia-wide discussions around Urgent Care Centres (UCCs).

In order to facilitate the best possible emergency care for people in rural and remote locations, the special skillset associated with the ACRRM Fellowship and particularly that of FACRRM's with Emergency Medicine Advance Specialised Training (AST) should be leveraged. The ACRRM Rural Generalist Fellowship Program is an AMC accredited specialist training program. It includes mandatory training terms and summative assessment at the Core Generalist level in Emergency Medicine as well an option to complete an additional twelve months of Advanced Specialised Training (AST) with an associated education and assessment program in Rural Generalist Emergency Medicine. Both the training and assessment are specifically designed to assure competency for practice in a low-resource, clinically/geographically isolated context.

Our members in NSW are increasingly concerned about the trend towards replacing vital face to face emergency services with virtual FACEM consultations. As one member succinctly puts it "the camera cannot cannulate". It is important to recognise that the UCC workforce is likely to require the same skills and scope as the RG workforce, and RGs therefore present a logical solution to the workforce crisis in EDs. FACRRMs are already trained to operate in EDs and UCCs, and are arguably better equipped to assess, treat and manage patients across the full range from Category 1 immediately life-threatening conditions, though to Category 5 chronic or minor conditions requiring assessment and treatment.

The College would caution against the approach adopted in New Zealand, where a separate college and curriculum are being developed, unless there is clear evidence to support that need.

The College would also caution against UCCs being deliberately built on workforce planning which utilises unsupervised non-VR IMGs or even by Fellows of other specialties who are not also FACRRMs/FRACGPs. That would indicate a lower standard of care than general practices or most hospitals where senior supervision would provide a safety net for patient care.

- If UCCs are to be classified as primary care settings then their staff and facilities should be expected to meet the same minimum standards as general practices do.
- If they are classified as equivalent to small hospital settings then they should meet those standards.
- If they are to establish a new classification that integrates both then that requires new standards and it should reflect the scope of practice that is RG - and ACRRM should have a pivotal role in the formulation of those standards.

Managing rural emergency departments involves a unique and complex set of competencies and the College Fellowship has been specifically designed to reflect these. Rural management involves capacity for service delivery in an isolated, low-resource environment, it requires broad scope generalist care, strong skills in patient stabilisation and transport, capacity to manage undifferentiated patient presentations, and often also, the capacity to manage in-patient and follow-up care.

[7] *Portfolio Committee No.2 Report* page 11

Many Rural Generalist doctors managing rural emergency departments have decades of experience which has been included in the training and assessment standards for all ACRRM Fellows. It is also important to consider the requirement for Junior Medical Officers on the Rural Generalist pathway to undertake ED rotations. This consideration will need to be factored into workforce planning and staffing arrangements.

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ACRRM acknowledges Australian Aboriginal People and Torres Strait Islander People as the first inhabitants of the nation. We respect the Traditional Owners of lands across Australia in which our members and staff work and live and pay respect to their Elders past present and future.