Submission No 31

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

Organisation: Inverell Health Forum

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Parliament of New South Wales

Made by: **Inverell Health Forum**
Inverell NSW 2360
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Improving the Quality of Healthcare for Inverell and Other Rural and Regional Communities

Inverell Health Forum:
The Forum is an Inverell community initiative, supported by Inverell Shire Council and chaired by Cr Wendy Wilks, comprised of councillors, general practitioners, medical practice managers, Aboriginal health service providers, representatives of business and industry, and community members that convenes for the purposes of furthering the aims and objectives described below.

Aim:
The purpose of this submission is to share practical recommendations and strategies to improve the quality of healthcare for Inverell and all rural and regional communities, resulting in timely health outcomes similar to those experienced in metropolitan areas.

Objectives:
- Improved health outcomes for Inverell, and rural and regional communities generally, through increased provision of both public (hospital) and private (general practice) medical services at a local level.
- Increased consultation on healthcare policymaking, so that practicing local rural health professionals and their communities have a say in decisions that directly impact them.
- To see members of rural and regional communities obtain primary healthcare equity within a reasonable distance of their residences, in line with metro area norms.

Background:
Inverell Shire is a vibrant community of around 18,000 people, which boasts a strong economy, thriving industry, and a growing population.[1]

The development of a new $60 million hospital completed in 2021 came with the promise of two equipped operating theatres and adequate staffing levels to ensure patient care for Inverell's residents and remove the need for frequent travel to larger centres.

[1] https://abs.gov.au/census/find-census-data/quickstats/2021/LGA14220

Unfortunately, this outcome has not eventuated, with the level of healthcare declining over many years through the reduction of services at the Inverell hospital, along with an increasing shortage of general practitioners.

The Inverell hospital is often without a doctor on duty, and ambulance resources and skills are wasted on transporting patients to other towns; an estimated 480 non-emergency patient transports from Inverell occur annually. Transporting a patient to Armidale removes an ambulance from Inverell for a minimum of four hours, and transport to Tamworth involves six hours of ambulance time. The community is at risk due to the lack of available ambulance services during these transports. Patients whose care is deemed non-urgent are expected to arrange their own transport for treatment, causing extra physical and emotional stress, as well as isolation from family and financial hardship. Travelling a three-hour return trip for treatment that should be available locally is an unreasonable expectation.

The critical shortage of general practitioners also means Inverell residents are unable to access basic healthcare services, such as an appointment with a doctor, causing great distress and adversely impacting their quality of life. This also affects the health and wellbeing of the few GPs we have, as they have taken on extra, unsustainable workloads. The very real risk of burnout will further reduce the number of GPs practicing in our community, and makes recruitment of new GPs highly challenging.

Inverell doctors are currently restricted by hospital rating policies on the procedures they are allowed to perform, even when they have the required qualifications and experience. Patients are routinely required to travel by road for three hours or more – often at great physical discomfort and/or real risk to their health (e.g., in late pregnancy and/or in early labour) – when a very capable doctor is available and willing to perform a procedure at the Inverell hospital.

Inverell residents need and deserve more than a referral hospital. The lack of reasonable access to basic healthcare is far more than an inconvenience for communities like Inverell. In reality, for many people it is a life-or-death matter. Because primary healthcare is often not locally available, many residents postpone seeking medical attention, knowing it will in all likelihood mean travel and isolation from family and familiar surrounds. Sadly, in some cases this delay means help comes too late. We have been given to understand that the DOA ("dead on arrival") rate at Inverell hospital is allegedly the highest in the state.

There is also a disconnection between the decision makers and the communities they are intended to serve. Policies based on external considerations and/or preconceived ideas of what rural and regional communities need – with little or no direct consultation – have serious implications for these communities.

Inverell residents conveyed their many concerns to members of the Inverell Shire Council, resulting in Cr Wendy Wilks forming the Inverell Health Forum to identify issues and try to find solutions for the healthcare crisis in our community.

In identifying shortcomings in the healthcare available to Inverell residents, it was seen that many other rural communities face similar issues. This healthcare crisis requires action, not just at a local level, but also through state and federal government intervention.

SUMMARY: Recommendations and Strategies

The following short- and long-term recommendations and strategies have been identified by our Forum with respect to the specific needs of the Inverell community. We submit that they apply to other rural and regional communities as well.

Enhancement of essential hospital services

Strategies:

- Adopt a Single Employer Model
- Establish local independent health committees
- Local consultation on hospital policy and procedures performed
- Local consultation on hospital classification and level of service provided
- Partnerships among universities, metro hospitals, and rural and regional hospitals
- Recognition of Inverell hospital as a training hospital to enable continuous rotations of trainee doctors
- Continue incentives to attract healthcare professionals
- Policies to retain existing healthcare professionals
- Allow support staff to take on some administrative duties done by doctors

Addressing Medical Officer shortages

Strategies, Short Term:

- Adopt the Single Employer Model as in Murrumbidgee Local Health District
- Provide incentives for existing general practitioners to stay in rural and regional areas
- Increase Medicare rebate for rural and regional doctors
- Create more undergraduate placements
- Remove the current expensive agency agreements providing locums to the local hospital
- Increase overseas recruitment, prioritising the UK, Canada and New Zealand due to qualification similarities

- Assist private practices by streamlining the recruitment and accreditation processes for overseas practitioners, to reduce onerous time and cost burdens
- Assist private practices to train and supervise doctors recruited from overseas

Strategies, Long Term:

- Increase university intake for General Practitioner and Rural Generalist specialty programs
- Fund partnerships among universities, metro hospitals, and rural hospitals
- Provide and fund more placements in rural areas for medical students and registrars

FURTHER DETAILS: Recommendations and Strategies

<u>Enhancement of essential hospital services</u>

Strategies:

Adopt a Single Employer Model: The Single Employer Model (as operating in Murrumbidgee) is well suited for Inverell. It is our Forum's view that it should be implemented as a matter of urgency.[2] Other models for consideration include the model as implemented at Mudgee in conjunction with Hornsby Hospital, which features 12-week placements by registrars on rotation, and has similarities to the QLD Health model.

Establish local independent health committees: There is a disconnection between management, policy makers, and the communities they are to serve. More local community consultation is needed on health services. This could be coordinated through the establishment of local independent health committees.

Local consultation on hospital policy and procedures performed: Experienced and fully qualified clinicians need to be given the opportunity to perform procedures they are capable of, not restricted by hospital policies set without local consultation. Local clinicians need to be consulted on hospital policy. For instance, allowing more procedures to be performed in Inverell would achieve significant cost savings by reducing patient transports to Armidale and Tamworth, also helping to relieve the frequent bed-block status at those hospitals – while simultaneously realising quality patient care and consideration.

Local consultation on hospital classification and level of service provided: Rural hospitals such as Inverell's need to have input regarding their classification.

[2] https://www.nsw.gov.au/media-releases/expanding-single-employer-model

Partnerships among universities, metro hospitals, and rural and regional hospitals: Sharing of staff, information, and training opportunities.

Recognition of rural and regional hospitals as training hospitals: Introduces students to rural medicine and gives them a taste of living and working in a rural community. Provides increased opportunities for the community to showcase its benefits and attributes to students. Promotes careers as general practitioners / rural generalists by exposing students to the varied and rewarding aspects of these much-needed medical specialties.
Continue incentives to attract healthcare professionals: Consider tax breaks, HECS debt relief, cash incentives, additional training opportunities.

Policies to retain existing healthcare professionals: Allow healthcare professionals to perform tasks they are trained to do; cash bonuses, tax incentives, etc.; adequate relief staff so leave can be taken.

Allow support staff to take on some administrative duties done by doctors: Doctors currently attend to routine administrative duties in hospitals that could be managed by other allied health professionals, e.g., organising patient transport to other hospitals.

Addressing Medical Officer shortage

Strategies, Short Term:
Provide incentives for existing general practitioners to stay in rural and regional areas: E.g., tax breaks, HECS debt relief, cash incentives. This could be a coordinated effort among local, state, and federal government. For instance, Inverell Shire Council has committed to a one-off relocation incentive of $30,000 to each general practitioner moving to Inverell.

Increase Medicare rebate for rural and regional doctors: Make private practice more attractive and profitable.

Adopt a Single Employer Model: As detailed above.

Remove the current agency agreements providing locums to the Inverell hospital: The current system is extremely expensive and is at best a stop-gap measure for rural communities. Locum placement is similar to an auction system, with the highest bidder awarded a locum. Locum doctors often lack experience but are paid exorbitant fees for their "fly in, fly out" services, in comparison to local, community-based doctors who provide continuity of care for their patients.

More undergraduate placements: Bringing registrars to rural and regional centres provides healthcare staffing benefits while giving undergraduates the varied experience of rural medicine and lifestyle.

Increase overseas recruitment: Prioritise the UK, Canada, and New Zealand as these countries have similar training programs to Australia, meaning doctors require less preparation to practice here. Designate a Government agency to provide direct assistance to overseas doctors wishing to relocate to Australia and/or their sponsoring local practice. Obviously, the required medical standards need to be retained, but the current visa and registration processes are extremely complex, costly, and time-consuming, and involve multiple forms, agencies, and governmental departments. The burden should not fall on the applicant and/or the sponsoring local practice.

Assist private practice to train and supervise doctors recruited from overseas: one-on-one supervision is costly and greatly reduces productivity, especially for small medical practices, whose resources are typically already overstretched.

Suggested Pilot Program:

1. Local medical practice finds and contracts an overseas doctor for 5 years.
2. GP training providers (ACCRM, RACGP, NSW Rural Doctors Network, or another dedicated organisation funded by Government with specialist staff) complete all necessary processes to bring a doctor to Australia, including visas, examinations, qualification checks, language, etc.
3. GP training providers (see 2) funded by Government supervise the overseas doctor until they are approved for practice without supervision within the rural town. Remote models of supervision could be incorporated into this model.

Strategies, Long Term:

Increase university intake for General Practitioner and Rural Generalist specialty programs: Enrolment at Australian medical schools needs to be significantly increased to meet current and future needs. At present, the number of students wishing to study medicine, and with the required scholastic ability to do so, exceeds the available university places. More government-funded and corporate-supported university places must be made available.

Fund partnerships among universities, metro hospitals, and rural hospitals: Create opportunities for increased sharing of staff, information, and training. Provide partner hospitals so that metro hospitals can rotate training doctors to rural, regional, and remote hospitals. Expanded training facilities may potentially lead to greater university intake capacity.

Provide and fund more placements in rural areas for medical students and registrars: Participants gain the experience of living and working in a rural environment and community.

Conclusion

All Australians have the right to access safe, competent, and modern healthcare, regardless of their postcode. Rural and regional communities contribute to the economic prosperity of the nation through the provision of food, fibre, resources and tourism, but there is an alarming disparity between the health outcomes of people living in rural and regional areas compared to those in metro areas.

Inverell, like many other rural and regional communities, has witnessed the dramatic decline of its health services over several decades. Community residents are all too often the victims of high-level policies presumably designed to mitigate institutional risk and liability but which have the effect of eliminating vital local services. This consequently places patients in harm's way, as many are forced to travel long distances to receive needed care that previously would have been available locally. Such travel is often itself potentially harmful or risky to patients.

In this submission, the Inverell Health Forum has presented practical strategies and recommendations toward halting and reversing the decline in healthcare services in our community. Key concerns addressed include the reduction of services in rural and regional hospitals, the shortage of general practitioners, and the lack of meaningful community consultation.

We call on the Committee to use its platform to highlight the serious disparity between health services in rural and regional communities compared to metro areas and to promote action and solutions across governments and agencies to make primary healthcare equity a reality for all Australians.

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This submission is made on behalf of the following members and entities participating in the Inverell Health Forum:

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