Submission No 35

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

Organisation: University Centre for Rural Health, Northern Rivers

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13th October 2023

Thank you for the opportunity to submit to the inquiry into the implementation of recommendations relating to workforce issues, workplace culture and funding considerations for remote, rural, and regional health.

I am writing on behalf of the University Centre for Rural Health (UCRH), Northern Rivers, based in Lismore and Grafton and surrounds, Northern NSW. We work closely with many university partners, Northern NSW Local Health District, primary health, and community partners, to support education, research, and workforce development for the next generation of health professionals. We train approximately 50 long-stay medical students (12-month placements), and 700-800 allied health professionals (average length of stay ~6 weeks) in rural locations of Northern NSW each year.

We have several observations to make relating to the terms of the inquiry:

Investment: We particularly support Recommendation 11, and there is much work needed to see this progress.

Attracting and retaining healthcare workers has been made more difficult by the recent floods in northern NSW and has especially impacted staffing levels at Lismore Base Hospital. Health must work with other sectors to ensure affordable housing especially for lower paid workers.

Furthermore, while pay discrepancies exist between states, the northern rivers will continue to struggle to attract and maintain staff who can easily travel across the border to access better pay and conditions.

We are aware that students who stay longer, and who have a deeply embedded health experience are more likely to stay and work in the regions post the training. We were disappointed recently when a missed opportunity occurred with insufficient commitment to support **Assistants in Medicine program**. We had approximately twenty enthusiastic students ready to commit to that program from three cohorts of medical students, but we were unable to progress this with insufficient commitment to the program in a timely manner. These students commit to future intern positions, and it is a missed opportunity for building the next generation of medical interns.
We are pleased to report that of six final year medical students who were able to stay a second year in the region, five have committed to become interns at Lismore Base Hospital and the sixth at Coffs Harbour. This is the type of program that needs more support.

If we had the commitment for a program of new graduates from other health professionals, such as in **allied heath,** working in hospital and primary sector, that would boost that program of building workforce and supporting renewal in the systems. Attention should be made to evaluating and supporting new models of care, with attention to primary prevention and rehabilitation. For this to work well, **Regional Training Hubs** for new graduates should be investigated. We currently have RTH for new medical graduates, and a similar program is required for allied health, and nursing and midwifery.

Workforce will only be attracted and maintained if pay and conditions are competitive and offer a financial viability – especially in areas of high house prices and rents.

Assist local regions to provide training, including scholarships, housing, and transport, to students choosing to train in a rural area. In this region, **allied health, dentistry, nursing, and midwifery**, need to be supported. Especially prioritising Indigenous students in areas of high populations of Indigenous communities should be a priority.

Ensure inclusion of University Departments of Rural Health (UDRHs) and Rural Clinical Schools in the discussions about development and implementation of workforce recruitment and retention. We serve an important role to support training and development in rural and remote locations throughout the state.

Palliative Care (Recommendation 23)

Palliative care services are not robust in the northern rivers. A GP registrar model was piloted in the Richmond area several years ago and was successful. The funding was discontinued. As well as solutions proposed in the recommendations, innovative models such as the one mentioned described by van de Mortel et al, 2017 should be explored.

General Practitioners (Recommendation 8 and others)

Payroll tax continues to be a looming menace for many general practices and threatens their viability. (AMA). Again, health needs to work with other sectors to find a solution to ensure access to quality care for all patients. And especially those in rural areas.
Ensuring one model of pay for GP trainees across hospital and community will attract more doctors to GP training. Many older GPs might be prepared to work part-time but the costs of remaining a doctor – CPD system and registration, plus medical defence, make it nonviable financially. There could be solutions found to this.

Aboriginal Health Workers (Recommendation 33)
At UCRH we have an active Aboriginal health workforce (19% of UCRH staff), who lead education and research training at the Centre. We collaborate closely with many community partners, and this is an important model for development of Aboriginal health staff. We also find engagement with schools is essential so we model throughout the lifecycle, a career in health and provide that vision for what that could look like. I suggest working closely with University Departments of Rural Health and Rural Clinical Schools, throughout the state, as an important way to support Aboriginal health workforce. And note the prior recommendation to provide scholarship support.

Virtual Care (Recommendation 30)
As stated, virtual care can be an extremely efficient and workable, and currently an underutilised way to conduct some aspects of health care – e.g., mental health support. Remote communities and individuals with lower socio-economic resources, may however lack consistent access to devices required for this model of care. While acknowledging that face to face encounters are often preferred, providing access, training, and expertise in telehealth, in a sustainable manner, could potentially make a major difference in outcomes.

Low health literacy is an issue in many rural and remote communities. In addition, in this region several schools are in the lowest 3% for socio-educational advantage. Running groups for adults and working with education to address this inequality could be a low-cost way to improve health literacy. We also run very successful service-learning placements of allied health students in local schools and aged care facilities, and this is well received by schools and the aged care sites. This is an innovative model of addressing peoples' needs throughout their life cycle. In the case of school placements, we see this work as critical early in their life to support engagement in the education systems and eventual better health outcomes. Future workforce opportunities exist for this cross-sector approach in rural

settings (often where there are high needs, and little access to services to support otherwise).

Research and evaluation:
Ensure that adequate research funding and resources are made available to fund robust research into the health needs of individual regions, and innovative models of delivering this care. E.g., working with groups may be a more cost-effective way to deliver preventive health messages, as well as key health messages. In areas of high need and low resources, this includes ensuring access to the basics of life: e.g., heathy food is both accessible and affordable.

A career pathway that includes opportunity for research and education can be an important attraction to support professional development and engagement throughout life, and I suggest we could have more joint funding opportunities for positions in health and education, working together to support health sector and investigate innovative models of care that are locally relevant and applicable, and that simultaneously support people living in the region, including the health workforce, and build up the next generation.

References:

van de Mortel TF, Marr K, Burmeister E, Koppe H, Ahern C, Walsh R, Tyler-Freer S, Ewald D. Reducing avoidable admissions in rural community palliative care: a pilot study of care coordination by General Practice registrars. Aust J Rural Health. 2017 Jun;25(3):141-147. doi: 10.1111/ajr.12309. Epub 2016 Jul 6. PMID: 27380901.
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