Submission No 34

THE IMPLEMENTATION OF PORTFOLIO COMMITTEE NO. 2 RECOMMENDATIONS RELATING TO THE DELIVERY OF SPECIFIC HEALTH SERVICES AND SPECIALIST CARE IN REMOTE, RURAL AND REGIONAL NSW

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

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College Submission

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The implementation of Portfolio Committee No. 2 recommendations relating to the delivery of specific health services and specialist care in remote, rural, and regional NSW

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, with approximately 24% of these being located in NSW. Our members live and work in rural, remote, and Aboriginal and Torres Strait Islander communities across Australia. They 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 the Royal Flying Doctor Service (RFDS) and Australian Antarctic Division.

Initial Comments

The overarching finding of the *Portfolio Committee No.2 Report* (PC2 Report) was that New South Wales'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. However, despite the findings of the PC2 report, our members report little or no progress particularly with regard the implementation of many of the recommendations.

ACRRM's Submission and testimony to the *New South Wales Parliamentary Inquiry into Health Outcomes and Access to Health and Hospital Services in Rural, Regional and Remote New South Wales* were quoted extensively throughout the PC2 Report. This included a detailed discussion of the role and potential contribution of Rural Generalists (RGs) across rural and remote New South Wales, together with acknowledgement of general stakeholder support for the rural generalist model of care.

The Rural Generalist is a clinician trained 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.

ACRRM contends that RGs provide is the most effective way that rural and remote communities can attain sustainable, cost-effective, high-quality health services. Rural Generalists are in a unique position to provide holistic care, crossing health care silos and providing care across the illness spectrum and the lifespan, and working with an extended scope of practice to meet community need. The College is dedicated to building a strong and sustainable rural and remote workforce with a rural generalist skill set.

With reference to training and retaining RGs in NSW, there has been a steady increase in Rural Generalist medicine and in the College fellowship program, with an increase of 11.8% over the past two years.

Further to this, ACRRM would welcome a discussion with the Minister and relevant representatives from NSW Health and local Health Districts regarding ways in which the RG workforce, including RG registrars, could be better utilised in regional, rural and remote areas of the state. The College has experienced situations where registrar placements have been delayed by relatively slow-paced, metro-centric processes which also lack flexibility. These delays may mean that prospective registrars may seek training posts in other states.

It is also important that current RGs who may be available to supervise and mentor registrars, are fully acknowledged and supported. Given that many of these doctors are ageing and considering retirement or significantly reducing their workloads, and increasing workforce pressure is likely to increase the possibility of this occurring, this should be given a high priority. If these doctors are no longer available to provide supervision, all work to attract and train registrars will potentially be compromised.

Response to Specific Recommendations

a) Maternity services, obstetrics, and paediatrics (including Recommendations 19, 20, 26 and 27)

Lack of obstetric services continues to cause severe issues outside the larger regional centres in NSW. With over 34,000 babies born each year in locations classified as outer regional, remote, and very remote, lack of access to appropriate services impacts women and their families. The College has received reports of instances where pregnant women in New South Wales have had to travel hundreds of kilometres to have babies delivered.

In addition to the impacts on women and their families, the loss of maternity services in rural towns also has wider flow-on impacts on the community. These can include a progressive de-skilling of the medical workforce more broadly; downgrading of facilities; and a progressive decline in the overall level of services. Access to a wider range of healthcare services becomes poorer as a result.[1]

Urgent action is required to address the lack of remote, rural, and regional maternity services. This should address a range of issues including the meeting the needs of women living in rural and remote areas; pre-and-post natal care; strategic planning for provision and ongoing support of a medical workforce and infrastructure, and alignment with the outcomes of the recent National Rural Maternity Forum and related documents.

[1] ACRRM Position Statement Rural Maternity Services, November 2019

RGs are integral to delivering safe, high-quality continuity of maternity care in rural and remote communities in a woman-centred and cost-effective manner. This includes both general practice-based pre and post-natal care as well as more advanced obstetric care delivered by RG Obstetricians and Anaesthetists within a team-based setting. RG-based care allows 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.

b) Patient transport and paramedicine (including Recommendations 3, 28 and 29)

ACRRM views with concern, an increasing trend to rely on telehealth services, particularly with respect to dealing with emergency situations and complex retrieval cases. Although telehealth has a role to play in supporting local practitioners and services, it should not be viewed as a replacement for in-person services and a competent and adequate local workforce and level of facilities. The RG can play a key role in supporting patient transfer and emergency response.

Patient transfers - Timely patient transfer to tertiary hospital care is essential for rural and remote and Aboriginal and Torres Strait Islander communities, however this can be limited by a range of factors, including weather conditions, and lack of available vehicles or aircraft and pilot hours. This is especially an issue with an increase in bariatric cases who cannot be treated locally due to intra-operative and post-operative risk and lack of ICU services.

Rural facilities and medical staff need to be appropriately equipped and skilled to be able to deal with situations where patient transfer is delayed. Once again, RGs, with their ability to work across both the hospital and primary care settings, are integral to this process.

Retrieval Protocols - Retrieval services are also essential to rural and remote communities, particularly in terms of emergency response. Early patient assessment and care with possible retrieval saves lives.

Unfortunately, it is increasingly common for the local GP or RG to be sidelined as part of the emergency response and retrieval system, so that rather than involving local staff in transporting patients from the scene of an accident to hospital for initial assessment and stabilisation, metropolitan-based retrieval services are ordering that patients remain at the scene of the accident or emergency and await aerial or other transport to a tertiary centre. This can delay patient assessment and initial management and lead to worse outcomes for patients; a potentially unnecessary activations of retrieval services and a waste of the skillset that is often present in a nearby town. Not only are these available skilled services being withheld from rural patients, but local RGs and other skilled support staff are demoralised, and future staff disincentivised from basing themselves in rural communities where their skills will not be employed or respected.

Lifting the retrieval silo is imperative to improve outcomes for rural and remote patients. This would involve recognition of the RG services that are available locally, together with the skills and training that underpin them. RGs should also be involved in disaster and emergency response planning at both the regional and state-wide level.

c) Indigenous health services (including Recommendations 23, 31, 32, 33, 34, 35 and 43)

ACRRM is committed to improving health outcomes for Aboriginal and Torres Strait Islander people. We acknowledge the importance of building the indigenous workforce and have established training and support initiatives to increase the number of Aboriginal and Torres Strait Islander registrars and Fellows within the College.

Aboriginal and Torres Strait Islander health is incorporated into all areas of the College curriculum. The College also recognises the importance of cultural safety and provides comprehensive training to registrars. In acknowledgement of the importance of self-determination for First Nations practitioners and communities in all areas of decision making regarding Indigenous healthcare policy and service delivery, ACRRM aims to foster and support its First Nations Fellows and registrars to be leaders and to be actively involved in these activities.

d) Mental health services, and drug and alcohol services (including Recommendation 11)

Funding - Further investment in mental health is required. In the view of the College, current funding models do not reflect the important role played by GPs and RGs in providing mental health services. These doctors may experience layers of financial disadvantage: they have limited access to subsidised courses (noting that mental health emergency training has now been approved under the Rural General Practice Procedural Grants Program); they earn less per hour, and the patients they manage generally experience high levels of disadvantage so GPs tend to bulk-bill these patients in order that they can access care. Despite this, GPs continue to provide mental health care in some of the most disadvantaged areas of Australia.

Feedback from College members indicates that the current Medicare Benefits Schedule (MBS) rebate structure for GP mental health consultations is completely inadequate and does not reflect either the degree of skill involved or remunerate effectively for the time taken for these consultations, which are often of a long and complex nature. This poor rebate structure does not recognise the level of mental health services provided by rural and remote GPs, nor the circumstances under which they are delivered. It also means that they are less able to afford additional training and upskilling.

Given the disparity in access and the greater demand for services in rural and remote areas, ACRRM would like to see more weight be given to allocating funding for these communities, with a priority given to supporting local services and training and supporting a local health workforce wherever possible.

While these are largely issues within the remit of the Commonwealth rather than the State, NSW advocacy would be useful.

Training and the Role of the RG- The ACRRM primary curriculum is designed to equip registrars to deal with a wide range of patient presentations, including acute, non-acute, occupational, and preventative mental health presentations, and in rural and remote setting where limited resources and referral supports are available.

Registrars also have the option of undertaking Advanced Specialist Training (AST) in mental health. Following completion of this AST, registrars will have developed higher level diagnostic skills and greater competency in management of complex and chronic mental health conditions.

As previously outlined, Rural Generalist practitioners and especially those with advanced skills in mental health, will be in the best position to deliver and coordinate a range of services, especially in those communities which lack the critical mass to employ a full health care team, including psychiatrists and mental health workers.

e) Aged care and palliative care (including Recommendations 18, 23 and 24)

The PC2 Report tasked NSW Health, in conjunction with The Australian and New Zealand Society of Palliative Medicine, the Royal Australian College of General Practitioners, the Royal Australasian College

of Physicians and the Aboriginal Health and Medical Research Council of NSW to urgently establish a palliative care taskforce to:

- plan palliative care access and services of equivalence to those living in metropolitan areas
- map who is currently providing palliative care services and their level of training, as well as where these services are offered
- establish an agreed, uniform state-wide platform for the collection of palliative care and end of life care data to allow for clinical benchmarking of regional palliative care services
- investigate and promote innovative models of palliative care services
- ensure culturally appropriate palliative care services are available to First Nations peoples.

Following the release of the report, ACRRM asked to be included as a member of the Taskforce, but while we note that there is an End of Life and Palliative Care Network within the NSW Agency for Clinical Innovation, the College has received no further information regarding the membership of activities of a Palliative Care Taskforce.

It should be noted that the PC2 Report included the testimony of the Australian and New Zealand Society of Palliative Medicine, (see page 109) which explicitly recognised the role, skills and training of ACRRM Rural Generalists and the needs for these doctors and their services to be incorporated into planning of Palliative Care services.

f) Cancer care and oncology (including Recommendation 21 and 30)

Recommendation 30 contained a commitment to providing continuity of quality care with the aim of a regular on-site doctor in rural, regional and remote communities. The College fully agrees that rural and remote cancer treatment and care should be person-centred while being cognisant of the needs and circumstances of families, carers, and the wider community, however again, little or no progress has been made.

ACRRM views the optimum model of care as enabling patients to continue to live within their community where they can be supported by family and their wider networks and receive ongoing, coordinated and collaborative care from a well-trained, skilled and supported health care team led by their local medical practitioner. Patients benefit the most from a lifelong relationship with a “usual GP”.

In recognition of the desire of most people to remain in their homes and communities, service models should be based on meeting as many of the needs of clients as close to home as possible. This will require flexibility in service delivery models, utilising team-based care and providing additional support for facilities and carers. Innovative service delivery models such as the National Ambulance Service model in New South Wales, which utilises paramedics to treat patients in their own homes (with medications per doctors prescribed plans) should be explored as a rural and remote home treatment option.

Funding models should recognise the important leadership role RGs and GPs can play in providing not only in treating direct clinical needs, but in assisting with strategies to improve overall health and wellbeing.

Summary

We note that the NSW Government has either supported, or supported in principle, the majority of the recommendations from the Inquiry into health outcomes and access to health and hospital services in rural, regional and remote NSW.

The College recommends that, in order to monitor implementation progress and ensure that all stakeholders remain informed regarding this progress, a regular 'report card' or similar reporting mechanism be introduced. This document should provide a short summary of the Government's actions in response to each recommendation, and any outcomes as available.

As previously outlined, ACRRM recommends that the NSW Government consult with the College to discuss addressing barriers to Rural Generalist training in NSW, and ways in which these barriers could be addressed and RG practice better integrated, supported and recognised at the Health Service District and state level.

Given the importance and urgent need to address a range of Inquiry recommendations, ACRRM would also strongly support the appointment of a Minister for Regional Health who would be able to focus on this important component of the broader health portfolio.

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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.