Submission No 65

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: Royal Australasian College of Medical Administrators (RACMA)

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Mr Joe McGirr MP
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Portfolio Committee Number 2
Parliament House
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Dear Mr McGirr

Legislative Assembly Select Committee on Remote, Rural and Regional Health.

The Royal Australian College of Medical Administrators appreciates the opportunity to provide our expertise and advice to the inquiry into the implementation of Portfolio Committee No. 2 recommendations specifically relating to workforce issues, workplace culture and funding considerations for remote, rural and regional health.

We are also grateful for the extension provided to us, noting constrained resourcing at this time.

RACMA

RACMA is the only specialist medical college that trains doctors to become specialist medical leaders and managers. As demonstrated by the pandemic and the increasing complexity of health systems, leadership of organisations and systems change has never been more pivotal to health outcomes.

Our education programs, including our accredited flagship Fellowship Training Program, equip doctors with the leadership and management skills needed to influence and lead the Australasian health care systems with the clear aim of improving health outcomes of Australians and New Zealanders. RACMA Members fill diverse roles, including Chief Executives, Chief Medical Officers, Director of Medical Services, Heads of Departments, as well as working in the university and defence sectors. As such RACMA is a recognised and respected voice of medical leadership, management and clinical governance and a pre-eminent provider of medical leadership and management education and training.

In PC2 Report No 57 - Health outcomes and access to services in rural regional and remote NSW, there are 44 recommendations. RACMA wishes to address issues relating to the following recommendations:

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 12
That NSW Health review the working conditions, contracts and incentives of GPs working as Visiting Medical Officers in public health facilities in rural, regional and remote New South Wales, to ensure that the GP/VMO model remains viable while broader innovation and reform progresses.

The industrial instruments governing all elements of the medical workforce are limiting innovation, recruitment and retention in an ever-changing market and in roles where the breadth of delivery varies from service to service.

In professions experiencing chronic shortages, we now see state governments actively advertising and poaching staff from other states and overseas. This is particularly problematic when recruiting and retaining regional, rural and remote medical workforces and in and near cross-border towns. There is also increasing diversity in the funding and models of care, including fee for service, sessional Visiting Medical Officer (VMO) contracts, ongoing staff, agency staff and Fly-in-Fly-Out (FIFO) options – all of which are remunerated differently.

Models in primary and secondary education include tailored, locality-based and ongoing retention allowances based on a criteria of 'hard-to-staff'. These have demonstrated to be successful and ensure people don't come to communities for the length of the allowance and then return to a metropolitan service.

Most Service Registrars are working under the relevant State Award or the Medical Practitioners Award (under the Federal Fair Work Commission Modern Award). It is noted that pay scales and industrial instruments determining how and when they can work are quite different and Service Registrars are a very heterogeneous group, both in terms of pay and conditions but also professional development goals and pathways depending on the role and jurisdiction in which they are working.

Similarly, for non-specialist Career Medical Officers (CMOs), pay and conditions can vary widely. The NSW CMO Award describes progression of seniority and expected roles and responsibilities; this is also reflected to a lesser degree in the Modern Practitioners Award (under the Federal Fair Work Commission Modern Award) but neither articulate the diversity of CMO roles that are found across different health services and jurisdictions.

In summary, RACMA recommends a number of key areas of focus to address these issues including:

- Mechanisms to manage pay discrepancies due to Awards and cross border industrial instruments including recommendations for Award reform;
- Address out-of-Award arrangements whilst taking into consideration equitable incentivisation programs to address workforce shortages;

- Review contractual models of care – including Fee-for-Service (FFS) vs Sessional VMO contracts in metro/regional centres including dual appointments and reverse hub and spoke modeling for employment contracts.

Recommendation 13:
That NSW Health establish a state-wide system of GP/VMO accreditation, which is independent of the Local Health Districts. As part of this system, NSW Health should ideally look to establish an online GP/VMO availability system where GP/VMOs can nominate dates and locations they are available to work that can be accessed by the rural and regional Local Health Districts and general practices in filling vacancies.

Section 19AB of the Health Insurance Act (1973), which prevents payment of Medicare benefits to Overseas Trained Doctors for a minimum of ten years from the date of their first registration in Australia, and District of Workforce Shortage (DWS) classification for GPs have overall had a positive impact over the last decade in providing an improved distribution of workforce. However, rural, regional and remote (RRR) Australia still has a substantially smaller number of both GP specialists and non-GP specialists compared to metro areas, so there are still many challenges and opportunities to ensure ongoing sustainability. The provision of primary care in rural communities is particularly challenged, with issues also around the sustainability of general practices as small business entities in the current market, with small practices with less than five GPs struggling to survive leading to market failure.

It is important to note that there is currently a limited workforce willing and/or able to work outside of metropolitan centres in both general and specialist practice. Changes to 19AB exemptions alone will not address this issue. The recruitment of doctors into rural areas is more complex and measures adopted must ensure that we do not see any shift between rural and outer metropolitan areas and that there is strong encouragement for more locally trained doctors to work in underserviced communities. It is also important to note that the focus on bulk billing rates is a limiting factor to increasing the GP workforce. The costs of running a practice continue to outstrip the indexation of Medicare Benefits Schedule (MBS) rebates and GP earnings continue to significantly lag their non-GP specialist colleagues. This is detrimental to GP recruitment and, in the absence of further initiatives to improve GP remuneration, will continue to impact negatively on recruitment across the sector.

We strongly advocate for targeted support for health services based in Modified Monash Model (MMM) 4-7 communities, which is classed as 'Real Rural'. Large regional towns 1-2 hrs from the city that have access to all amenities are classed MMM2 and these regional towns being classified as rural within Government programs or initiatives targeted at rural and remote health services significantly disadvantages those services based in 'Real Rural' communities.

It is appropriate and necessary to design mechanisms to increase rural workforce. For those programs and levers intended to increase distribution to rural areas, there needs to be recognition of the differences between rural and regional areas, with preferential support for rural.

RACMA has also identified a potential issue with GP practices recruiting overseas practitioners when they have little experience of assessing work suitability, which results in the undesirable outcome of low-quality practitioners in remote settings. Our recommendation is to set up initial placements in hospitals for all overseas practitioners so that they can be assessed in better resourced settings to ensure they have the skills to work independently. Rural, regional and remote areas are not always the best place for supervision and assessment prior to working independently.

In rural and remote (MM4-7) areas there needs to be career pathways to ensure sustainability for both non-Fellowed GPs and non-vocationally registered GPs. The 3GA program provides access to a Medicare Provider number and billing whilst non-Fellowed GPs work towards Fellowship.

Whilst the successful completion of a Fellowship can provide for A1 billings, an A7 (Non-Specialist Practitioner) (80%) rate should be allowed for non-vocationally registered GPs to assist with current workforce shortages.

Other incentives that may be considered include Commonwealth/State reduction of university debt for any health professional who works in MM 4 – 7 areas for 5 years or more, for example, and consideration of higher Medicare rebates for doctors working in MM 4-7 areas.

Section 19AB was initially successful in attracting GP specialists and International Medical Graduates (IMGs) undergoing GP training to RRR areas and to a lesser extent non-GP specialists. There are many associations and alliances advocating for strategies to address the shortages of GPs in RRR areas but not many address the issue of shortages of non-GP specialists. The 2023 census shows that 29% of Australians live in RRR areas but only 12% of Royal Australasian College of Surgeons (RACS) Fellows work in RRR Australia. In addition, a large cohort of non-GP Specialist IMGs who entered Australia between 2002-2008 completed their mandatory 10-year moratorium and have now either relocated to metro areas, started entering the private hospital system and reduced their public appointments, or have exited the public system. In addition, a number of exemptions have also contributed to this drift from RRR to metro particularly of the non-GP specialists.

The solutions devised to counter the problems faced in the 1990s might need some modification to be relevant in years to come. This may include a review of the 10-year moratorium and a modified approach for newly trained specialists in specialities where there is oversupply or moderate supply with a reduced mortarium.

In summary, we require innovative thinking to find a balanced solution to distribution levers to address the supply and demand of the medical workforce in RRR areas, taking into consideration socioeconomic factors, evolving demographics and current workforce in establishing what is and isn't an area of genuine need.

Recommendation 15

That NSW Health review the current employment arrangements and remuneration structure for trainee doctors with a view to aligning rural trainees' remuneration and incentives with those provided to metropolitan students travelling for rural training.

Refer to Recommendations 8 and 12 plus:

As detailed in the RACMA Medical Administration Scope of Practice, workforce is one of the eight core dimensions of practice for a Medical Leader. It is RACMA Members who lead the engagement, deployment, and accountability of the medical workforce, lead and advise on the most effective configuration and delivery of clinical services to meet the needs of the population served and bridge the interface between management and clinicians in complex health systems.

Service Registrars and Career Medical Officers

As such, the College believes a strong framework for Service Registrars and Career Medical Officers (CMOs) is crucial for establishing a clear and well-defined career pathway in the medical profession, and this framework and pathway is currently lacking. It would support professional development, quality patient care, and effective workforce succession planning, while also contributing to the overall success and stability of the healthcare system.

When reflecting on the Medical Workforce Reform Advisory Committee *Service Registrar and Career Medical Officer Framework Working Document,* at the very outset a re-evaluation of the perception of Service Registrars and CMOs and their integration into hospitals and health services is needed, as well as consideration of their identity within the workforce.

RACMA has identified the following areas which need consideration and development to ensure a sustainable workforce which addresses maldistribution and retention of this skilled workforce:

- Training, Education and Credentialing
- Continuing Professional Development (CPD) and accredited CPD Homes
- Valuable and rewarding Career Pathways
- Diversity of Conditions, including pay scales and professional development
- Accreditation of Career Pathways
- Cultural Change in the health system in relation to support and career development of this workforce.

Locum Workforce

RACMA also recommends that whilst the regional and rural workforce dependency on locums continues, consideration should be given to how NSW Health can influence the internal market to ensure a reliable and appropriately credentialed locum/casual workforce to provide safe and quality care to the communities they serve including:

- Creation of a statewide casual pool with rate-guided escalation points endorsed by Ministry of Health (MOH) policy;
- A Credentialing framework to ensure locums are working within their Scope of Clinical Practice (SoCP) and to avoid the morale hazard of locums employed beyond their designated SoCP for perceived continuity of safe service provision;
- Mandatory supervision and training competencies/expectations for the locum workforce;
- Pathways of integration of casual/locum workforce into training programs and/or substantive positions.

International medical graduates

International medical graduates remain an integral part of the rural, regional and remote workforce and for this reason, and it is clear that more investment is needed to ensure they are well supported and transitioned to the permanent workforce.

To ensure the employment of overseas health practitioners is successful and sustainable in helping solve some of our healthcare workforce shortages, while maintaining the delivery of quality and safe healthcare for all, there needs to be focus on:

- Improved cultural screening;
- Improved supervision frameworks;

- Impact on low and middle income countries;
- Retention and adjustment;
- Employment and professional development support; and
- Arrangement for MBS billings (see above)

RACMA has also identified a potential issue with GP practices recruiting overseas practitioners when they have little experience of assessing work suitability, which results in the undesirable outcome of low-quality practitioners in remote settings. Our recommendation is to set up initial placements in hospitals for all overseas practitioners first so they can be assessed in better resourced settings to ensure they have the skills to work independently. Rural, regional and remote areas are not always the best place for supervision and assessment prior to working independently.

Recommendation 17:
That NSW Health work to widely implement the Nurse Practitioner model of care in rural, regional and remote New South Wales, by:
• funding the recruitment and training of additional Nurse Practitioners to work in rural, regional and remote areas, particularly in facilities without 24/7 doctor coverage, or that utilise virtual medical coverage
• working with the Australian Government to address the practical barriers to creating and supporting these roles identified by the Australian College of Nurse Practitioners.

The current Australian Government Scope of Practice review is supported by RACMA and should consider all of the following. It is our view that strong clinical governance frameworks are needed for any expanded or changed scope of practice.

Despite the recommendation that rural, regional and remote areas require Nurse Practitioners (NPs) to be able to practice at the top of their clinical scope, supported by clinical experts in their fields, the implementation of this recommendation has been limited. Good examples are seen at regional base hospitals in WNSWLHD where NPs have a clearly defined and extended SoCP.

Rural areas are also ideal for piloting expanded scopes of practice to support community access to care, for example, the HEP C prescribing and fibroscan services provided by GPs and Nurse practitioners (NPs) in regional areas (WNSWLHD) supported by Hepatologists from tertiary centres.

Extended scopes of practice and diversification of workforce roles for health practitioners in health care settings provide pathways for professional development and career progression and need to be considered more broadly than NPs and now include;

- Assistants in Medicine-to-Medicine Management Technicians.
- Clinical Pharmacist Prescribers working with medical practitioners to facilitate medication reconciliation on admission, discharge medication prescribing and medication management within given specialty frameworks.

However, any extended scopes of practice need to be considered under strict credentialing frameworks underpinned by the four key pillars of clinical practice, leadership, research and education for any advance practice domain.

Recommendation 27:

That the rural and regional Local Health Districts, and those metropolitan Local Health Districts that 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.

There are significant shortages of obstetric and gynecology services in rural, regional and remote New South Wales which is leading to lack of access to maternity services. Access to training in Obstetrics and Gynecology and (and the GP O&G) in regional and rural areas is limited which will continue to create pressure on any plan for these services in those areas.

Recommendation 29:
That NSW Health in conjunction with NSW Ambulance:
• undertake a community profiling program across rural, regional and remote New South Wales to identify the paramedic needs of communities
• ensure the equitable distribution of paramedics at all levels, including Extended Care and Intensive Care Paramedics and update ambulance deployment modelling to reflect present day demand, ensuring that ambulances are deployed as rostered
• expand the Intensive Care and Extended Care Paramedics program across rural, regional and remote New South Wales and allow paramedics outside metropolitan areas to undertake training, skills consolidation and skills maintenance locally
• explore innovative models of care utilising the skill sets of paramedics to better support communities that lack primary health care services, including consideration of embedding paramedics at facilities that do not have access to a doctor
• undertake a review of the efficacy of the current call triaging system and referral services.

Current projects in place with NSW Ambulance, under the remit of the Credentialing and Education Governance Committee (CEGC), are to establish and oversee a credentialing framework and education framework aligned to NSW Ambulance strategic priorities.

For this to be effective NSW Ambulance needs to provide assurance to stakeholders, particularly the community, that credentialing and education policy, procedures and practice are aligned to current best practice, relevant regulatory standards and NSW Ambulance strategic priorities whilst supporting the delivery of high-quality mobile health care by ensuring that services are provided by capable, appropriately qualified clinicians.

To ensure that all NSWAS practitioners can work at the top of their scope within a strong and robust governance, a framework for credentialing and education activities needs to be finalised and implemented throughout NSW Ambulance.

Recommendation 30:

That NSW Health:
• commit to providing continuity of quality care with the aim of a regular on-site doctor in rural, regional and remote communities
• commit to a model of care under which virtual care technology is used to supplement, rather than replace, face-to-face services
• where virtual models of medical care are operating, roster additional suitably trained nursing staff to assist in the provision of the physical care usually attended to by the medical officer

• provide staff members with training on how to effectively use telehealth and other virtual models of care
• create a public information campaign specifically targeted to rural, regional and remote communities in order to assist patients to effectively engage with virtual care, including factsheets and checklists to set expectations and support positive interactions
• ensure that the use of virtual care, if required, is undertaken in consultation with community members, health providers and local governments in rural, regional and remote areas
• investigate telehealth cancer care models to improve access to cancer treatment and care.

Telehealth and virtual health have become an integral part of the delivery of medicine in all location settings, accelerated by the pandemic. This mode of delivery and care is a useful augment to existing in-person health care. However, telehealth and virtual care has not been able to deliver a sustained comprehensive healthcare solution.

Therea are some excellent examples, e.g., Paediatric outreach consultation in WNSWLHD (Orange Base Hospital) and in Far West NSW Local Health District (FWNSWLHD), but government should resist the temptation to see tele- and virtual health as a possible solution to workforce and funding crises, particularly in regional and rural areas, but more of an enabler to help upskill and augment already existing services.

There are some other excellent but limited examples of this that could be broadened across other health services. An example would be the Westen NSWLHD remote critical care service delivered in conjunction with Emergency Department and Intensive Care specialists from the regional base hospitals in real-time with GPs and hospital clinicians across a number of smaller sites to facilitate early decision making and interventions for patients needing higher level care whilst waiting for retrieval. It also provides early decision making for patients who are not likely to survive and palliation or other measures to be put in place locally, avoiding resource intensive unnecessary transfers to regional or tertiary centres away for family carer and community. Not only does this provide rural and remote in-reach services, it provides clinicians in rural hospitals direct access to live specialist input and a platform for upskilling in complex decision making and emergent care.

Recommendation 31 160
That NSW Health acknowledge the significant cultural barriers that telehealth poses for First Nations communities and work to ensure face-to-face consultations are prioritised.

Telehealth for regular management of chronic health conditions can be preferred and many programs that support regular telehealth following the downloading of remote recording of health data has been successful in First Nations communities. The mix of face-to-face and telehealth needs to be driven by the needs of the communities and not a stop-gap to manage workforces shortages. Inappropriate or not culturally supported provision impacts on health outcomes and decisions around face-to-face vs telehealth access need to be worked through in consultation with community.

Other Comments:

Remote, rural and regional health care services require a medical workforce that is, wherever practicable, locally resident and provides genuine continuity of clinical care and cultural safety to patients and population health services to Australian communities.

Strategic medical workforce development and deployment for remote, rural and regional health services is a complex problem and should be led by RACMA members who are specialty-trained in medical leadership and management who will:

RACMA recommends consideration of some key areas of focus in addressing the workforce issues in remote rural and regional and rural health services including:

a) The role of the general practitioners in hospital and community care
b) Generalist medical and surgical workforce in the hospital setting
c) The impact of a locum workforce and the FIFO model
d) The role of International Medical Graduates (IMGs)
e) Consideration of Scopes of Clinical Practice
f) Models of care including telehealth and hub and spoke models
g) Award arrangements and Industrial Relations
h) Federated Model of Care

a) General Practice in Hospitals

The role of the general practitioner is central to the adequate provision of both primary care in the community and population health services in addition to hospital care and individual patient care across a range of specialty areas including procedural services in Anaesthetics, Obstetrics and General Surgery.

We are facing the significant issue of medical graduates training in primary care but fewer training as GP proceduralists who are able to contribute to hospital-based care. Another challenge for hospital-based GPs in rural and regional settings include the volume of work in their community general practice which means they have no financial incentive or time to also work in their local hospital. Their skills and experience often mean that they may not have equitable relationships with hospital managers and issues of professional isolation and lack of onsite specialists means they are concerned about risk with complex patients and feel underprepared for the breadth of practice in what is often the only hospital for many hundreds of kilometres.

b) Generalist medical and surgical workforce:

The importance of a generalist medical and surgical specialist workforce cannot be understated. In regional and rural settings, the relatively low number of resident specialists combined with the breadth and depth of clinical presentations requiring emergent care requires an expansion of the generalist workforce. This include general surgeons and general physicians and RACMA encourages RACP and RACS to enhance training position focusing on building and developing a broad generalist skill set for their trainees and Fellows.

Although some of this is currently provided by community GPs who work in the hospital setting as above, current College training programs are increasingly focused on subspecialisation resulting in pipeline issues for the generalist speciality workforce, further impacting the ability to deliver adequate hospital services outside the metro or large regional hospital setting.

The development of a local specialty generalist workforce supplemented by upskilling GP proceduralists with advanced scopes of practice in Obstetrics, Anaesthetics, General Surgery and

other medical subspecialties is critical to ensuing ongoing equitable access to care in regional and rural communities.

c) Locums and FIFO

Specialist Workforce:

Whilst essential for short-term crisis workforce solutions and for providing much needed leave cover, we are now seeing a rural, regional, and remote workforce increasingly dependent on locum medical professionals. This may be regarded as positive or helpful in the very short term whilst government works to find more sustainable solutions. However, as those more sustainable solutions have not been forthcoming over the last decade, we are now left with a two-tiered rural workforce. Due to the inconsistent nature of the work, locums earn significantly more than resident doctors, without the responsibility for providing continuity of care.

As this has become entrenched as the ongoing model, instead of the short term or leave relief option, it becomes less and less attractive for a medical practitioner to make any ongoing commitment to either an ongoing role or building a practice in a rural or regional area.

Although FIFO specialist models have been a key part of rural and regional health care, especially for healthcare that requires advanced specialty training (such as Intensive Care and some surgical and medical specialties), and will continue to be needed, there are increasing issues in the disparity between pay, working conditions and professional isolation that makes the FIFO model increasingly attractive, discouraging specialists to establish a more permanent practice in regional rural settings.