INQUIRY INTO HEALTH OUTCOMES AND ACCESS TO HEALTH AND HOSPITAL SERVICES IN RURAL, REGIONAL AND REMOTE NEW SOUTH WALES

HEARING – Wednesday 16 June 2021

RESPONSE TO SUPPLEMENTARY QUESTIONS

1. *In addition to what is contained in your submission and evidence provided at the public hearing, do you have any further comments regarding the current provision of palliative medicine, nursing and care in Gunnedah and the region?*

   The provision of palliative care is not separate to the provision of other health care, it is a core part of quality health services. The membership of the Gunnedah Community Roundtable shared insights into the current provision of palliative medicine, nursing and care in Gunnedah and the region through a facilitated workshop and supplementary contributions.
   It was agreed that the Roundtable does not have the expertise to comment on the provision of medicine or nursing practice, and our submission is limited to the experiences of and access to palliative care. A clear theme emerged through the various contributions; the barriers to accessing quality palliative care are identical to those associated with access to other areas of health care:
   - a critical shortage of General Practitioners (GPs)
   - inadequate physical access
   - inadequate transport options
   - limitations to telehealth
   - incentive to opt out of or delay medical interventions due to these barriers.

   Roundtable members who interacted with palliative services in personal or professional contexts reported that when palliative care was accessible at the Gunnedah Hospital or in the home, the palliative care staff and GPs were compassionate, dedicated, and professional. These experiences were limited to end-of-life care where pain management had become the priority. It was

noted that due to the acute staff shortage and limited facilities, the quality of care and communication between staff and the family members of a palliative patient was inconsistent.

Anecdotal evidence indicates that members of the Gunnedah community are requiring palliative care for diseases which are treatable in their early stages, such as types of cancer and kidney disease. There is a perception that this a result of delayed diagnosis, due to the inaccessibility of health checks, preventative screenings, and investigation of persistent complaints. This is attributed to the lack of GP services, resulting in Gunnedah residents being denied basic diagnostic testing and intervention. Due to the excessive cost, time and burden on family, friends and services, many people opt out of receiving oncology and renal services, and such require palliative care much earlier than they otherwise would have and, in some cases, had treatment continued palliative care would not be required at all.

Community members indicated a severe lack of choice in how palliative care is delivered, with families simply making the best of what is available, instead of being able to prioritise the wishes and dignity of the palliative patient. People shared their experiences of feeling pressured to admit a palliative family member into hospital in Tamworth, despite the person stating their desire to remain in Gunnedah. This resulted in the palliative patient experiencing isolation and loneliness during their final opportunity to say goodbye to friends and family.

It was noted that the community have expectations of aged care staff to have a level of competency regarding palliative care provision, especially when it is being provided in the home. Aged care is a low skill, heavily casualised industry. It is not realistic to expect palliative care competencies as an industry norm, however, many aged care workers have a high frequency of contact with palliative patients who remain in the home and develop positive relationships. They are perhaps an unrecognised resource in providing a level of emotional support and comfort.

The Roundtable reached out a local GP, Dr Chris Gittoes, who has interacted with the Gunnedah Community Roundtable through involvement with collective community initiatives and invited him to provide feedback. Dr Gittoes contributed his thoughts, which are attached in Appendix 1.

2. *In addition to what is contained in your submission and evidence provided at the public hearing, do you have any further comments regarding ways to*

improve both the access and availability of palliative medicine, nursing and care in Gunnedah and the region?

The staff shortages experienced in Gunnedah, and elsewhere across the state, directly impact the provision of quality care. To improve access and availability of palliative medicine, nursing and care in Gunnedah and the region, there must be a commitment to improving the access and availability of all primary medical services.

There are many ways in which the current systems shaping and providing palliative care can be improved. These include:

- Improved outreach services to enable people to avoid hospitalisation and remain in their home
- Confidence that a doctor will be available in needed
- Support of family members throughout the process
- Support to develop and implement advanced directives
- Transport when required

Maintaining the dignity of the patient and avoiding unnecessary suffering are two core tenets of effective palliative care. It is for this reason, the Gunnedah Community Roundtable supports the introduction of assisted dying as an aspect of effective, person-centred palliative care.

The population modelling completed by Hunter New England Health for their recent Clinical Services Plan indicates that the aged population of Gunnedah is expected to grow. This is consistent with current trends. Demand for palliative services is likely to rise as the population ages, and Gunnedah must be suitably equipped. Like oncology and renal services, palliative care provision must be adequate to support the changes in community demographics, and if HNE Health are to continue with the “hub and spoke” model of care they are currently committed to, then HNE Health must directly address the access barriers our community currently faces.

Regards

Kate McGrath

Gunnedah Community Roundtable
Member

APPENDIX 1:

Gunnedah GP Shortage

There exists a wide range of variables limiting the availability and thus the attraction and retention of GP trainees (registrars) or trained GPs to Gunnedah and to many NSW rural towns with similar challenges around their GP workforces.

Those variables include:

1. the gross numbers of Australian medical students graduating, the number of these Australian medical graduates electing to pursue GP training and most importantly, the subset of these GP trainees who choose to become rural GPs.

2. the age of graduation of Australian trained Doctors. Australian Medical degree programs are now mostly post graduate university programs meaning that prior to commencing a four- year medical degree, students have already completed a 3 or 4 year undergraduate degree and thus, by the time they graduate from a Post graduate Medical degree and complete their intern years and commence GP training, they are in their mid to late twenty's and likely have established social, family and economic roots adding to the difficulty of making the transition to a rural community to train and practice as a GP. GP training programs need to have inherent flexibility to recognize and adapt such a demographic cohort.

3. the availability of Overseas trained doctors (OMGs): largely an immigration issue however it needs to be recognized that OMGs have played a vital role in provision of GP services to Australian rural communities over many years and will likely continue to do so.

4. The capacity to attract qualified non-rural GPs to relocate to a rural setting.

So what can be done politically to attract Australian medical students to become rural GPs and to attract existing non-rural GPs to become rural GPs? The answer lies in appropriate, targeted, and effective incentivization of careers in Rural General Practice throughout the whole medical training pathway from first year medical student through to final year GP registrar trainee and they beyond through the career as a rural GP.

Financial incentives are of course critical however, with some imagination and long term thinking, social incentives may also prove to be vital.
The following are some suggestions to attract and retain GPs to rural NSW as they would apply chronologically in throughout the training and career of a Rural GP (the key objective being to create a positive experience for the student/GP registrar and ultimately the GP to attract and retain them to a career as a Rural GP):

1. Give additional priority to students from rural backgrounds when allocating university medical student places. There is some evidence that this factor (a medical student having a rural background) is the most predictive factor of medical graduates returning to rural communities to work.

2. Bonded Medical scholarships for medical students who agree to pursue a career in rural medicine. Such scholarships could be similar to those currently offered by the Australian Defence Forces and would need to pay a reasonable remuneration during the whole of a Medical Student's training in return for four or five years placement as rural GP registrar/GP. It would be important that within such a scholarship program that the student was linked to and had training placements in a SINGLE rural town throughout their university training placements and continuing throughout their GP training years. This continuity of training location over potentially 6-7 years would facilitate the student forming social and professional bonds with the community in which they have been training and would thus maximise the student's likelihood of remaining in that community in the long term. Such an approach would be far more attractive to a student/GP trainee than the current training model which requires Rural GP trainees to move between practices and towns throughout their training time which creates enormous disruption and results in a negative experience for the GP trainee rather than a positive one. This current requirement to move practices/towns during GP training is incredibly disruptive in particular, for GP trainees with young families.

3. Provision of low-cost accommodation in the rural community during the training period for the student/GP trainee.

4. Funded training placements for Rural Medical Bonded Scholarship holders to attend Rural GP conferences and training programs throughout their university training to facilitate the trainee developing professional bonds to the Rural GP professional community.

5. Taxation incentives linked to the degree of rurality where the Rural GP Registrar/GP is located. For example, when a GP bulk bills a patient (due to a

perception of financial hardship of the patient), the GP is foregoing income which they would earn on a non-bulk billed appointment. This loss of income could be viewed as a virtual donation and made tax-deductible on that basis. The degree of tax deductibility could be linked to the degree of rurality of a GP's location. (say nil deduction in the cities then scaled-up to 100% deduction in remote regions). Alternatively, bulk-billed income could be treated as tax-free with a similar sliding scale of rurality.

6. Financial incentives to relocate existing GPs to rural regions such as moving expenses, stamp duty exemptions on purchasing a home their chosen rural town, concessional finance to buy into existing Rural GP practices (if available) in their chosen rural town or to establish their own practice if buying into an existing practice was not an option.

7. Funded advanced skills training options for GP registrars such as the current Rural Generalist Pathway.

8. Funded GP locum services so that existing Rural GPs are able to get away for training activities, conferences, health issues, holidays and other reasons without having to close their practices or reduce their practice capacity to service their community when the GP is absent.

9. Funded counselling/supervision services for Rural GPs.

10. Infrastructure grants for Rural GPs to expand existing practices or build new practices

11. Realistic training incentives for existing rural GPs to train medical students and supervise GP registrars and OMGs.