Submission No 261

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

Organisation: The Royal Australasian College of Medical Administrators

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The Hon. Gregory Donnelly, MLC
Chair, Portfolio Committee No.2 – Health
Parliament House
Macquarie Street
SYDNEY NSW 2000

Dear Mr Donnelly,

RE: Parliamentary Inquiry into health outcomes and access to health and hospital services in rural, regional and remote New South Wales

The Royal Australasian College of Medical Administrators (RACMA) is a specialist medical college accredited by the Australian Medical Council (AMC). RACMA is dedicated to the education, training, and professional development of medical practitioners in senior leadership and management roles, in clinical and non-clinical settings, throughout the world.

This constantly evolving specialty and the associated professional development program responds to and pre-empts the ever-changing landscape of medical leadership and management both in Australasia and beyond. RACMA's involvement in education, policy formulation, and decision-making enable it to contribute to Australian and New Zealand health systems.

The submission provided has been developed by RACMA Members having many years' experience in health practice settings relevant to the Terms of Reference for the *NSW Parliamentary Inquiry into health outcomes and access to health and hospital services in rural, regional and remote New South Wales*.

If you require any further assistance or information regarding this submission, please forward your query to my attention at advocacy@racma.edu.au. RACMA looks forward to the recommendations of the Inquiry's report.

Yours sincerely,

Professor Alan S C Sandford AM
President, RACMA

TITLE Ref: PAC08	**Parliamentary Inquiry into health outcomes and access to health and hospital services in rural, regional and remote New South Wales.**

RURAL, REGIONAL AND REMOTE NSW

Rural, regional and remote NSW has a population which differs demographically, socially and culturally. This diversity has been mapped by the Modified Monash Model[1], a system which defines a city, rural or remote classification, for resourcing and workforce distribution. Currently, the model classifies areas of "MM 2 to MM 7", as "people living in these areas can find it harder to get medical help and accessing doctors can take longer and cost more" (ibid). However, the Distribution Priority Area classification (DPA)[2] identifies the areas of "MM5 to MM7", as being where people do not have enough access to doctors based on the needs of the community.

Thus, areas such as Blackheath, Coffs Harbour and Broken Hill, classified as "MM3", are not considered as priority areas. RACMA suggests that the implications for state-wide resource and workforce distribution, places significant disadvantages on such misaligned priority areas and its communities. We therefore recommend that the Portfolio Committee, review the alignment of priority areas as defined by the Modified Monash Model's classification system.

Rural, regional and remote healthcare services are unique in the way that primary care interacts with secondary and tertiary levels of care. Primary care practitioners provide hospital care and population health services in addition to individual patient care in their practices. This care is provided by necessity, across a range of medical specialty areas.

RACMA strongly advocates that medical leadership, provided by appropriately trained and suitably resourced RACMA medical leaders and managers, is required to ensure a true integration of service delivery across the continuum of care at primary, secondary and tertiary levels. Our members are medical specialists trained in clinical governance and leadership to advise and provide input into health management structures and resource allocation. This tenet was reinforced in the Garling report[3] recommendations, strongly advising greater medical practitioner input into medical leadership structures. RACMA as a Specialist Medical Leadership College, welcomes future discussions on the Garling report recommendations for medical leadership.

MEDICAL WORKFORCE

Under-recognition of the demands on rural, regional and remote medical, nursing and allied health staff, a lack of formal ongoing staff training, and the challenges of implementing rigorous protocols for patient management, all contribute to staff dissatisfaction, high turnover and increased risk to patient safety.

An issue that RACMA has identified, is that not all Rural General Practitioners, have the training and background required to meet patient needs in rural, regional and remote country populations. This is often, more so with international medical graduates issued with visa's under section 19AB of the Health Insurance Act 1973[4], and its restrictions and requirements

[1] https://www.health.gov.au/health-workforce/health-workforce-classifications/modified-monash-model
[2] https://www.health.gov.au/health-workforce/health-workforce-classifications/distribution-priority-area
[3] https://www.dpc.nsw.gov.au/publications/special-commissions-of-inquiry/special-commission-of-inquiry-into-acute-care-services-in-new-south-wales-public-hospitals/
[4] https://www.health.gov.au/health-workforce/medicare-billing-restrictions/section-19ab

on where they can work. This is an Area of Need program[5] that does not fully address the issues of cultural safety, language barriers and differences in Australian medical practice for rural, regional and remote areas.

RACMA advocates that the program has not been implemented correctly in providing these International Medical Graduates, the adequate support needed to meet quality patient care.

As an option to overcome these challenges, one of our members is the Chief Executive of the Rural Vocational Training Scheme (RVTS)[6], which is a Commonwealth Department of Health funded training program that has been set up to address common problems of rural and remote medical practitioners seeking to undertake formal training to attain GP specialist qualification. We strongly support such initiatives.

TRANSPORT AND ACCESS

Public transport services, such as buses and trains, in rural, regional and remote areas of Australia are often not available. This increases significant reliance on private transport modes from a peripheral site, to a regional or city hospital, which patients are required to fund and organise.

This lack of structure for patient repatriation often deters rural, regional and remote patients from seeking health care and acts as a barrier to access. The availability of complex tertiary level services (for example an Oncology service for cancer patients) demands liaison which includes transport for good patient care. Without this continuity of care, patient outcomes are seriously compromised. Supporting this narrative, are international medical journal publications documenting mortality due to cancer treatment delay[7].

TRAINING PATHWAYS FOR MEDICAL PRACTITIONERS

There are disruptions and inconsistencies in General Practitioner (GP) and Specialist training pipelines in New South Wales. Junior Medical Officers (JMO) who commit to full-time rural work by choice, are not offered the same financial or accommodation subsidies that are available to trainees on secondment to rural hospitals. This negatively impacts the likelihood of a JMO independently choosing a rural training post as an attractive career option.

RACMA believes that these barriers could be addressed by a single employer model during the training pathway for GPs and Rural Generalists in rural, regional and remote areas, having conditions of employment and service like other specialist trainees. Accordingly, we support programs such as the pilot Murrumbidgee Model[8] and encourage that this model is expanded to other regional and remote areas. At its launch, the Minister the Honourable Mark Coulton MP stated:

> …It (Murrumbidgee Model) aims to improve the availability of quality health services where people live and means trainee rural generalist doctors can work in private practices and local hospitals to provide a greater range of care…this model will be used to test how new employment models for rural doctors can make working in rural and regional Australia an even more attractive career option (ibid).

[5] https://www.health.nsw.gov.au/AoN/Pages/default.aspx

[6] https://www1.health.gov.au/internet/main/publishing.nsf/Content/work-pr-rvts

[7] BMJ 2020;371:m4087

[8] https://www.health.gov.au/ministers/the-hon-mark-coulton-mp/media/new-murrumbidgee-model-makes- rural-practice-more-appealing

As a long-term strategy, RACMA suggests there should be support for a salaried specialist, rather than the contracted Visiting Medical Officer (VMO) model of recruitment for rural health services. This strategy would assist developing a senior clinical workforce integrated into the rural, regional and remote health service clinical and management infrastructure, resulting in positive improvement of patient care and enhancement of health services.

FORMAL CO-ORDINATION STRUCTURES

Several of our members have noted an apparent lack of long-term inter-agency strategic health planning. There are examples in other Australian jurisdictions, such as the Kimberley in WA, where strengthened centralised governance (WA Country Health Service), funding and staffing has increased the availability of health care services.

RACMA recommends that community expectations would be well served by the development and implementation of an NSW formal hub and spoke model that clearly identifies (for local communities) all healthcare services available. The model consists of an anchor establishment (hub) offering a full array of services, complemented by secondary establishments (spokes) offering more limited-service arrays. As such, transferring patients needing more intensive services to the hub for treatment, greatly assists healthcare providers in meeting quality patient care.

The NSW Health department Multipurpose Service Program (MSP)[9] quotes the following:

> …Regional and rural communities have accessibility to more flexible and sustainable services…the Hub and spoke model incorporates facilities which generally provide 24-hour drop-in or urgent care, inpatient beds, palliative and respite care, residential aged care, a range of primary, community and ambulatory care services, and provision for visiting specialists (or telehealth via video) …
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> …When access to additional services is required, people living in regional and remote NSW may travel or be transported to a District Hospital, to access additional services…these hospitals include: a 24-hour emergency department, general medical ward, medical imaging, drug health services, rehabilitation, renal and chemotherapy units, and some surgical services...
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> …People living in regional and remote NSW may sometimes travel to major Metropolitan Hospitals (statewide or tertiary teaching hospitals) for highly specialised surgery or treatment, such as neurosurgery or cardiac surgery, or severe burns treatment…

Whilst appropriate and high-quality tele-health support is to be encouraged, guaranteed access from the “spoke” to the appropriate specialist services and assured transport to higher level facilities (Hub) is also essential.

Furthermore, the model of the Neonatal Emergency Transport Service (NETS) has no adult equivalent. In the majority of adult cases, the complexities of referral to higher level facilities has depended on personal relationships to co-ordinate time consuming back and forth debate and communication, for a patient’s acceptance to a tertiary site. Further exacerbating challenges in referral process for a medical practitioner, are problems with the tertiary site’s staffing rosters, duty hours, timing and availability of transport. RACMA recommends that having an adult NETS equivalent that is a centralised service, would ensure a smooth coordination of bed availability and transport, and reduce the current onerous and stressful co-ordination.

[9] http://www.mps.health.nsw.gov.au/about-us/about-the-program

RECRUITMENT, RETENTION AND REPLACEMENT

In rural, regional and remote areas, the public health system and services depend heavily on General Practitioners and Rural Generalists. Whilst in metropolitan areas the funding of General Practice is considered the primary interest for the Commonwealth, in rural NSW it is only the State Health Department who funds care delivered in its hospitals, yet care is often provided by General Practitioners.

There are issues of an ageing General Practitioner population and supply shortages for many rural, regional and remote areas. These barriers could be addressed through a single employer model such as the Murrumbidgee model during trainee pathways, providing conditions of employment and service, similar to other specialist trainees in public hospitals. Choice of employment arrangements following completion of specialist training, such as full time or permanent part time employment as salaried specialists, would also be beneficial to recruitment and retention.

RACMA members indicate that General Practitioners and Rural Generalists, do not always feel valued as team members within NSW Local Health Districts. As such, we recommend that specialist recognition with commensurate remuneration, e.g., Queensland Health Rural Generalist Model[10], would assist greatly their value proposition and in encouraging graduating doctors to consider practicing in rural, regional and remote centres.

RACMA supports the Commonwealth Government's development of Regional Training Hubs[11] in New South Wales. We advocate strongly that Regional Training Hubs must remain aligned to University Medical School training and the local health services. This model provides strong support for medical students and graduates to pursue rural and regional specialist training pathways, providing a positive outcome for increasing the numbers of rural, regional and remote medical graduates in Australia.

In summary, RACMA provides the following recommendations:

- Rural medical leadership must be resourced and provided by appropriately trained specialist medical leaders, such as our members, to ensure a true integration of service delivery across the continuum of health care in NSW.
- Continuing education and training funding and support for rural medical practitioners and administration must be a strategic priority for the NSW government.
- The NSW "Area of Need" program for International Medical Graduates, needs to support cultural safety and language support for practice in rural, regional and remote areas through programs such as RVTS.
- In light of the increase of Australian medical graduates, the "Area of Need" program should be assessed in terms of its effectiveness and outcomes.
- Transport structures to and from higher level health care centres needs to be reviewed and assessed for alignment with rural, regional and remote community needs.
- A centralised adult NETS equivalent to co-ordinate patient bed availability and transport is critical for quality patient care.
- Regional Training Hubs aligned to University Medical Schools must continue to be a priority for the NSW government, to ensure recruitment, training, retention and workforce replacement.
- Discussions with RACMA, continue outside the terms of this submission, for rural medical administration and leadership.

[10] https://ruralgeneralist.qld.gov.au/

[11] https://www1.health.gov.au/internet/main/publishing.nsf/Content/regional-training-hubs

- RACMA Specialist Medical Administrators are considered as an essential NSW rural workforce solution and resource.