Submission No 345

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

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

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Introduction

Thank you for the opportunity to make a submission to the parliamentary inquiry into health outcomes and access to health and hospital services in rural, regional and remote New South Wales.

Local Government NSW (LGNSW) is the peak body for local government in NSW, representing NSW general purpose councils and related entities. LGNSW facilitates the development of an effective community-based system of local government in the State.

This submission remains in draft form until endorsed by the LGNSW Board. Any revisions made by the Board will be forwarded as soon as possible.

Background

Access to health services in rural, regional and remote areas remains a significant issue for councils and their communities. While healthcare is a state and federal government responsibility, councils often find themselves with no choice but to take on additional responsibilities to support their communities.

The health outcomes for people living in rural, regional and remote areas are often far worse than their metropolitan counterparts[1]. Essentially, the more remote a person is, the worse the health outcomes they are likely to experience. While the general challenges and shortcomings of access to healthcare in rural and regional NSW are well-reported, this submission will focus on the experience of communities as expressed to and through their local governments.

Further, while this submission is made in response to a NSW Parliamentary inquiry, it will focus on healthcare responsibilities of all levels of government, in recognition that without an integrated approach to healthcare provision, outcomes will suffer. The submission also recognises that while the NSW Government has a direct role in health service provision, it also has an important role in advocating to the federal government for action on matters within the remit of the Commonwealth.

As the level of government closest to the community, councils play a key role in helping to maintain and improve the health and wellbeing of their residents. Rural, regional and remote councils provide a range of assistance to attract and retain medical practitioners to their areas including accommodation, travel incentives, private and commercial rental subsidies and funding of equipment, facilities and other infrastructure. These financial imposts adversely impact council budgets. One council reports spending the equivalent of four per cent of its total rate income to fund medical facilities, housing and vehicles, to ensure that its community has an opportunity to access health services.

Beyond upfront capital and foregone rent costs, councils are further burdened with costs for maintenance, property depreciation and eventual renewal. Where councils bear these costs, they also bear the opportunity costs having fewer funds to spend on other important services for their community, including revenue generating facilities such as sporting grounds, halls, gyms and swimming pools.

Financial assistance provided by councils to ensure access to healthcare places pressure on councils' discretionary budgets and ultimately their bottom line. Compounding this pressure,

[1] Australian Institute of Health and Welfare, 2019, *Rural & remote health*, available at: https://www.aihw.gov.au/reports/rural-remote-australians/rural-remote-health/contents/summary

council support for local healthcare provision is not factored into IPART's Local Government Cost Index for rate pegging. The abrogation of responsibility by other levels of government, and the reasonable expectation of communities that there should be equitable access to health care, places many councils in a challenging position, where already stretched budgets must be dedicated to a function that is not properly the role of local government.

As the peak body for local government in NSW, LGNSW has long recognised the need for urgent action from the NSW and Australian Governments to adequately and fairly fund the provision of healthcare across NSW, including in rural, regional and remote communities, and to end cost shifting onto local government. In May 2019 for instance, local government leaders gathered in Temora, NSW for an LGNSW forum focused on challenges and strategies for health care delivery in rural and regional areas.

LGNSW also publishes a Policy Platform[2], setting out the consolidated advocacy positions of the local government sector (including on health services), guided and amended by resolutions of the LGNSW Annual Conference. Relevant Conference resolutions are listed throughout this submission and also separately at Appendix 1.

LGNSW has received feedback from more than 20 councils in developing this submission, which builds on positions supported by councils across NSW through resolutions of the LGNSW Annual Conference. Collectively, councils have a wealth of knowledge and experience that can be used to guide and inform health policy and administration across rural, regional and remote NSW. The recommendations made throughout this submission vary from the broad to the specific. Importantly though, the first recommendation makes clear that it is critical that the NSW Government involve local government in finding locally relevant solutions to improving the provision of medical services in rural, regional and remote NSW.

[2] LGNSW Policy Platform available at: https://lgnsw.org.au/Public/Policy/Policy_Platform.aspx

1. Availability, access and quality of services

Terms of Reference (c).

Councils have long called for action to address concerns with the availability, access and quality of health and hospital services in rural, regional and remote NSW. As outlined below, there are serious issues with length of waiting times, access, cost and availability of services generally. Numerous reports and official data make clear the inequity in this regard, and this submission will not repeat sources that will be available to the Committee. Instead, the information below will emphasise the particular concerns raised by councils on behalf of their communities.

Councils resolved at the 2019 LGNSW Annual Conference to seek the NSW Government's support in establishing a joint task force representing local, state and federal governments to formulate a model to address these deficiencies in the provision of medical services and fund financial relocation packages for the engagement of doctors in regional and rural towns.

In line with a resolution of the 2020 LGNSW Annual Conference, councils also seek an expanded role for Local Health Advisory Committees (LHACs) to give local residents a greater say in the scope and delivery of health services in their local area. LHACs are established by the NSW Government's Local Health Districts to:

- Advocate for the local community
- Connect with local communities about health priorities
- Be a voice for planning and evaluation of services
- Provide support to local health services
- Promote health literacy and wellbeing in their local communities.

There is a concern among councils that the role of LHACs has diminished in recent years, and that their role is largely 'selling' health policies to the local community rather than having any meaningful input in developing these policies.

More broadly, councils would like to see better integration and cooperation amongst all levels of government. There is limited formal interagency cooperation between councils and NSW Health at the policy and decision-making level to ensure that the resources invested by councils and NSW Health are delivering the best health outcomes for regional communities. A further resolution of the 2020 LGNSW Annual Conference calls for a formal MOU between LGNSW, NSW Health and federal government Primary Health Networks to provide the basis for collaboration between the three levels of government.

Recommendation 1: The NSW Government should improve intergovernmental and community collaboration to promote better health outcomes by:

a) Preparing a formal MOU between NSW Health, Primary Health Networks and LGNSW to provide the basis for intergovernmental cooperation.

b) Establishing a joint task force representing local, state and federal governments to formulate a model for improving the provision of medical services in rural and regional areas, and developing strategies and funding financial relocation packages for the engagement of an essential health workforce in rural and regional NSW.

c) Revising the Local Health Advisory Committee model to give local residents a far greater say in the scope and delivery of health services in their local communities.

Availability and waiting periods for essential health services

There are long wait lists reported for primary health, specialist and allied health services in regional and rural areas. GPs in particular often have long wait periods once they have worked in an area for some time and have built up a regular patient base. One council highlighted the pressures on its healthcare services by noting it had directed a construction company due to commence operations in its area to bring the company's own healthcare services, so that the local healthcare system would not be overwhelmed.

Example: Access to GPs in Snowy Monaro Regional Council

On paper, the region is relatively well serviced by a general practitioner workforce of 153 FTE per 100,000 population. In reality, this figure does not reflect some of the challenges of accessing a GP, such as the large geographical area (11th largest in NSW), the transient and locum nature of many GPs working in regional areas, and seasonal fluctuations such as the winter tourism influx.

Access to GPs is also impacted by the diverse community expectations of a GP. Often in rural and regional communities, GPs are the first port of call for people experiencing everything from a cough to marriage difficulties. GPs are often seen as a soft entry point for people experiencing a variety of issues, especially those which are stigmatised or where accessing a specialist would quickly identify a person's condition (e.g. being seen walking into a mental health NGO). GPs who have remained in the area for a long period of time develop a regular patient load and can be difficult to get an appointment with, especially where a pattern of repeated visits should be developed e.g. pregnancy, ongoing or chronic condition.

Councils have also raised particular concerns that there are inadequate numbers of Visiting Medical Officers[3] funded to support the requirements of hospitals across regional and rural NSW. Where there are insufficient numbers of VMOs, it is often the case that patients have to be transferred to larger centres or held in an emergency department until care can be provided.

Recommendation 2: The NSW Government must provide adequate funding to support an increase in the numbers of Visiting Medical Officers at hospitals across NSW.

LGNSW also received feedback from one council that specifically noted that people are not provided with an estimated timeframe when placed on a waitlist to see a specialist. The effect of this is that where these timeframes extend into many months' duration, patients do not have the information to make an informed choice as to whether they should take the time to travel elsewhere to see a specialist. This can result in conditions worsening while a person is on the waitlist.

Recommendation 3: Where a person is placed on a waitlist to see a specialist, the person should be provided with an estimated duration of the waitlist so that the person is empowered to decide whether it would be prudent to travel and seek an alternative specialist.

[3] Visiting Medical Officers (VMOs) are medical practitioners in private practice who also provide medical services in a public hospital, contracted by the Local Health District.

LGNSW has received repeated feedback from councils advising that access to mental health and drug and alcohol support services is inadequate. This inadequacy has been exacerbated by years of drought followed by bushfires, other natural disasters and now COVID-19.

The Special Commission of Inquiry into the Drug 'Ice' report noted that the Commission heard:

> 'compelling evidence from Aboriginal people throughout NSW, not only about the profound impact of crystal methamphetamine in many of their communities, but also their immense frustration at the failure of successive governments to address the chronic lack of appropriate services for them.'[4]

While LGNSW welcomed in November 2020 the announcement of more than $10 million in state and federal funding for a new drug detox and rehabilitation facility in Dubbo, much more is needed. Notably, for many communities in rural and regional NSW it can be easier to travel to Sydney than Dubbo, highlighting the need for accessible facilities throughout NSW.

Recommendation 4: The NSW Government should significantly increase investment in drug detox and rehab services in regional NSW.

Mental health services

Access to mental health services in rural and regional areas is an ongoing matter of concern. This is particularly the case following emergency and disaster recovery situations, but many rural and regional areas struggle to fill vacant psychology and health and wellbeing positions even in the absence of these catalysts.

Young people in particular experience higher levels suicide in rural and regional communities, worsened by a lack of youth counselling services, programs and centres. Councils across NSW operate youth centres and services, but often cannot fund these for full time staff or hours of operation. Improved funding for services supporting youth and community wellbeing will improve the resilience of communities post disaster. There is a clear need for increased funding for specialised and appropriate youth services, counselling and support – particularly in bushfire, drought and disaster affected communities.

Targeted, long term funding is required to deliver resilience programs in various settings to children from pre-school up to high school. It is important that this funding is provided over a period of years (not just one to two years), in recognition that recovery from significant trauma takes years rather than months, and that children and young people are particularly sensitive to community upheaval.

This issue is at the forefront of many councils' concerns. Most recently, a resolution of the 2020 LGNSW Annual Conference calls for the NSW and federal governments to investigate and explore a partnership between local government and Headspace National Youth Mental Health Foundation to ensure young people in rural, remote, isolated and public transport-deprived areas gain access to appropriate and relevant youth mental health services.

Recommendation 5: The NSW Government should increase funding for specialised and appropriate youth and community mental health and wellbeing services to bolster resilience.

Recommendation 6: The NSW and federal governments should investigate and explore a partnership between councils and Headspace to ensure young people in rural, remote,

[4] Special Commission of Inquiry into the Drug 'Ice', 2019, Final Report, available at: https://www.dpc.nsw.gov.au/assets/dpc-nsw-gov-au/publications/The-Drug-ice-1546/02-Report-Volume-1a.pdf

isolated and public transport-deprived areas gain access to appropriate and relevant youth mental health services.

NDIS assistance

Accessing National Disability Insurance Scheme (NDIS) assistance can be a significant challenge in rural and regional NSW. Councils have reported that the market based NDIS system is at times unsuitable for rural and regional NSW, as there are often too few disability support providers available locally. One council noted that integrated care under the NDIS could be a challenge – exacerbated by the large distances patients in rural and regional NSW must often travel:

> *Under the NDIS families are being told to go to Dubbo to see separate specialists – not all of whom are available there either. There is no whole-of-child care and it will result in multiple 600km trips rather than one where all needs are addressed by a team of professionals working together.*

The lack of integration and high staff turnover can result in people needing to repeat their circumstances to multiple organisations and healthcare workers.

Councils have also expressed concern at the possibility of privatisation of government-run NDIS and aged care facilities. Many of these facilities/services are in small towns and their privatisation would likely add to the access-to-service issues already faced by regional and rural communities. Profit-driven providers are unlikely to be attracted to smaller communities and, as a result, some aged care and disability services may be lost completely from these communities. Further, some operators may not take on clients with high care needs, so it is likely that those clients would be lost to larger centres. Resolution 84 of the 2020 LGNSW Annual Conference calls for the NSW Government to retain ownership of its NDIS and state-owned aged care facilities.

Recommendation 7: The NSW and federal governments should intervene where the market based NDIS system is failing, to ensure disability support providers and health care is available to meet the needs of rural and regional communities.

Recommendation 8: The NSW Government must retain ownership of its NDIS and state-owned aged care facilities.

Preventative care

Council feedback suggests that in many ways the health system in rural and remote NSW is a system of crisis management, and is insufficiently resourced to focus on preventative practice. Inability to access annual check-ups can have an effect on the longer-term health outcomes for people living in rural and regional areas.

The window of opportunity for prevention or medical early intervention can often be narrow, not just for physical health concerns but also for drug rehabilitation, mental health, sexual health, or specific Aboriginal and Torres Strait Islander health programs.

There would be benefit in providing more regular annual screening checks (such as for breast cancer) to remote towns particularly, as well these opportunities being better promoted.

Recommendation 9: The NSW and federal governments should sufficiently resource proactive and preventative health measures including annual screening in remote, rural and regional NSW.

Measuring demand and quality
Some councils have raised concerns that data on use of health services may not be appropriately captured to accurately represent the location of the need for the service. Where residents of smaller towns travel into hospitals in larger centres, this may result in a hidden level of demand. That is, the data may show a reasonable level of need in the larger regional centres, and reduced need for outreach to smaller regional towns. This may result in services not visiting these smaller towns, and perpetuating this perception that the service there is not needed.

As an example, the Warialda Medical Centre in Gwydir Shire has over 6000 registered patients, which is far greater than Warialda's population of just over 1000. This signals that the medical centre services many patients from outside of its local area.

Related to this, councils have reported that at times there is a reluctance to make formal complaints about a service or its quality (where underperformance can potentially be signalling a system under pressure) as the complaint may result in a much-needed service being lost entirely from a rural, regional or remote community. This reluctance to report concerns may mask the degree of dissatisfaction experienced for underperforming health services.

Recommendation 10: Patient demand for health care services should be assessed with caution and a patient's usual place of residence (rather than the location of an accessed health service) should be recorded as the site of demand.

Transport options
Lack of public transport often impacts accessibility of healthcare. Some specific examples of the impacts of limited transport options include:

- Residents who require dialysis, oncology treatment, CT scans and rehabilitation services needing to travel long distances to access these.
- Teenagers from very remote parts of the state needing to travel long distances (being driven by family or friends, or spending two days on public transport)
- A teenager feeling unwell and the family needing to make a decision as to whether to watch the child overnight to see if symptoms improve, or travel 160km (one way) to get a second opinion.
- Natural disasters such as heavy flooding cutting communities off from accessing healthcare services owing to limited routes and transport options.

Example: Lack of treatment options in smaller hospitals and medical transport challenges (Warrumbungle Shire Council)

A mother took her child to the local Coonabarabran Hospital at 9pm. She lives out of town and has a husband at home with their other children. The doctor is sufficiently concerned about the child to want to observe the child overnight. As the hospital is not accredited to admit children, an expensive ambulance transfer is arranged to Dubbo. The next morning the paediatrician tells the mother that the child is safe for discharge. Somehow the mother has to find a way back to Coonabarabran with her child.

Councils have also noted that while they often provide community transport services to residents, this has been particularly challenging during COVID-19 restrictions as the drivers are often volunteers, many of whom may be older and more vulnerable to the virus.

Councils also often support their communities through grant funded bus services. While this grant funding is welcome, it would be advantageous to see the services better coordinated. Councils have provided feedback that some services are funded through the NDIS, and others

through Transport for NSW. The effect of these separate programs is that one bus may be permitted to transport a particular cohort of residents from one location, but is unable to collect residents with similar health issues from another location as the second cohort is not covered by the appropriate funding arrangement.

Recommendation 11: The NSW Government should review and address transport barriers to accessing healthcare and ensure better coordination, links and funding arrangements between different modes and providers of transport.

Locum GPs

Locum GPs provide a valuable lifeline for some communities where there would otherwise not be any medical practitioner. Many councils and their communities recognise the efforts of government in ensuring that GPs are available via this service.

However, it is important for health workforces servicing communities to have knowledge of the community when providing care, and it is beneficial for GPs to have had regional experience. Locum GPs, or services provided via telehealth, are less conducive to ongoing health provision relationships and continuity of care.

Councils have also provided examples of GPs receiving a much higher rate of pay if they operate as a locum, which appears to act as a disincentive to becoming a permanent GP in a region.

Recommendation 12: While recognising the importance of locum GPs, the federal and state governments should work together to further incentivise GPs establishing longer term or permanent services in rural and regional NSW.

Service system coordination

Councils report that services provided by agencies from outside regional areas are often poorly coordinated, duplicated and ad hoc. The healthcare system can be complicated to navigate and can lack consistency or continuity. Different services are funded by different levels of government, which is a challenge for people accessing services intra-regionally.

Policy procedures also differ across hospitals, whereby hospitals display different inter-hospital transfer processes and obligations of care to patients when they are discharged.

Councils have also highlighted that while they generally welcome the building of new hospitals, staffing allocation and services for these new hospitals (as well as existing health services and facilities) remains a critical need. One council has provided the example of a new hospital with an operating theatre that has not been used due to a lack of qualified staff.

Long term planning

Long term planning for facilities and services is essential to accommodate growth and change. The absence of adequate healthcare services can stall future growth and productivity. Councils have suggested that there is a need for long term health care priorities and strategies to be articulated for regional and rural NSW.

Recommendation 13: The NSW Government should prepare long term plans for integrated health care provision in rural and regional NSW with a clear strategy and associated investment plans for how these will be achieved.

Service system literacy

Communities and their healthcare service structures differ across NSW, making it challenging to work across regions. Community members themselves can also often be unaware of the services available in their community (such as telehealth, travel and accommodation

assistance for isolated patients, community transport or outreach services) due to services being provided through different or inconsistent funding, resourcing or governance structures.

For those that travel to hospitals for appointments, information on the services that operate from the facility may not be obvious, or people may not know what questions to ask or look for. Clearly accessible information on the type of services available at that facility would allow people to plan for further trips and appointments.

Recommendation 14: The NSW Government should publish clear and accessible information on the services and procedures available at locations across regional and rural NSW to simplify navigating the healthcare system.

Cost

The cost for travel and accommodation for patients and their carers can be a barrier to accessing vital healthcare (particularly if travelling intra-regionally), and there are instances of residents being funded for fewer trips than the level of care required. Where travel distances are particularly great, cost pressures are compounded by loss of pay from not working. Some councils report that relatively minor procedures cannot be completed in smaller towns, and that the subsequent transfer to larger facilities can be expensive and appears inefficient and unnecessarily disruptive.

Example: Health travel challenges in Lachlan Shire Council

People in our community need to travel three times per week to Forbes for dialysis treatment, being a 200km roundtrip, with no public transport options available. However, these community members are only funded for one trip per week. This impacts the people themselves, as well as their family and carers. We have a community bus that operates within these towns, but it is only funded to operate once weekly, and so treatment needs to align to that particular day to access this service.

Recommendation 15: Where patients and their families are required to travel significant distances to access healthcare, the cost of this travel (and associated accommodation if necessary) should be met by the NSW Government.

Telehealth

While telehealth is a welcome service in communities where there would otherwise not be a service at all, councils report instances of people waiting long periods of time before being attended to via this medium. Feedback from councils also noted the challenge in accessing technology such as suitable camera equipment for videoconferencing.

Councils have generally welcomed increased funding for and availability of telehealth services, but caution that telehealth must supplement, and not replace, in-person services. Hay Shire Council has expressed concern that telehealth is being used to replace doctors in rural communities as a cost saving measure. However, even minor procedures of course cannot be performed via telehealth, meaning that lengthy transport to larger centres is required in these instances.

Recommendation 16: Telehealth services should continue to be rolled out but must supplement and not replace vital, in-person services.

Example: Impact of inadequate health services on Gunnedah Shire Council

Councils often pride themselves as being an employer of choice in attracting and retaining skilled staff. However, the lack of local health services remains a critical issue for the successful retention of staff. The productivity of councils can be impacted by the difficulty in accessing healthcare as people need to travel greater distances for workers compensation, rehabilitation or for return to work programs. This ultimately leads to increased costs in sick leave and other entitlements.

A recent survey undertaken by the Shire of Gunnedah illustrates the importance of local healthcare for their workforce:

- 94.12% of employees said that the availability of quality medical services is important to them and their family when choosing whether to live or continue living in Gunnedah.
- 82.35% of employees or members of their families have had to seek normal GP appointments outside of the Shire in the last 12 months. More than 50% have sought appointments outside of the area more than five times in the last 12 months. Just 17.65% of respondents said that they or members of their family had been able to secure all GP appointments within the Shire for the year.
- 100% of employees responded that they or members of their family have put off check-ups or medical appointments that normally would have occurred because services have not been available in Gunnedah. 55.88% of those respondents indicated that this had occurred three or more times in the last 12 months.

These statistics are likely replicated in communities across NSW.

2. Staffing challenges

Terms of Reference (g).

Councils acknowledge that healthcare staff often perform exceptional work, despite resourcing challenges. However, there are concerns that many healthcare professionals work under significant pressure and with long hours, potentially impacting the quality of care.

Staff attraction and retention remains a critical issue for communities. While there may be grant funding made available to construct facilities, or funding to offer a service, the benefits of this funding are at times not realised due to challenges attracting and retaining qualified staff to provide the services.

Councils have also reported challenges with high staff turnover and lack of continuity of care. One council described a resident being allocated seven speech therapists within a three and a half year time frame.

Geographical remoteness and needs classifications (and incentives)

The federal Department of Health uses the Modified Monash Model to determine if a location is defined as a city, rural, remote or very remote. Depending on the classification, the level of service delivered, training available and cost to deliver service based on classification changes drastically. There are instances of centres being reclassified, thereby impacting the delivery of health services to the region including through changes to:

- Bulk Billing Incentives
- Workforce Incentive Programs
- Bonded Medical Program (which aims to provide more Australian trained doctors in areas of workforce shortage, particularly in regional, rural and remote Australia).

Reclassification may also impact whether medical practices are available to Rural Pathway registrars.

Council feedback suggests that the Modified Monash Model may be inadequate in capturing the genuine relative isolation of some regions.

Recommendation 17: That the Modified Monash Model be reviewed to ensure that it genuinely captures isolation of an area and is appropriate in assessing relative health workforce need.

Councils have also reported that the current method for allocation of Medicare provider numbers for specialists (the District of Workforce Shortage classification) is flawed. The current system is largely based on areas covered by a particular postcode and does not adequately take into consideration the way specialist services are delivered in regional and rural areas. Regional centres provide services to a much broader catchment than that covered by their individual postcode.

As an example, ophthalmologists in Tamworth estimate that they cover a population of approximately 220,000 across the New England, North West Slopes, Upper Hunter and Upper Central West regions of NSW. The use of postcodes may be appropriate to achieve a spread of specialists across metropolitan areas, but in regional areas it results in a small number of specialists being required to work unreasonably long hours in order to service large geographical areas. The issue is evident in Tamworth where fully trained specialists would like to move to the town but are unable to do so because they cannot obtain a Medicare provider number without the federal Health Minister providing an exemption. Resolution 97 of the 2020 LGNSW Annual Conference called for the state and federal Health Ministers to ensure this is addressed.

Recommendation 18: State and Federal Government Health Ministers must ensure the current review of the National Medical Workforce Strategy, and in particular how a 'District of Workforce Shortage' is determined when allocating Medicare provider numbers, provides flexibility and opportunities for medical practitioners and specialists to relocate to regional and rural communities.

Single employer arrangements for GP trainees

GP trainees are placed on multiple short contracts throughout their four-year training, because the GP trainees rotate between different hospitals (which are NSW Government funded) and private practices (which are Australian Government funded through the Medicare Benefits Scheme).

This acts as a disincentive to participating in GP training contracts, as trainees on short contracts are not eligible to accrue annual leave, long service leave, sick leave and access to paid parental leave.

It was a recommendation of the Australian Government's 2018 National Rural Generalist Taskforce that 'duration of training' contracts by a single employer be introduced as a mechanism to ensure preservation of employment benefits.

Feedback to LGNSW suggests that some Local Health Districts (LHDs) are agreeable to employing rural GP trainees as NSW Health employees for the four years that they work across various rural hospitals and general practices. This continuity of employment would mean that GP registrars training to become rural specialists could benefit from the above employment entitlements.

However, LHD employed GP trainees are prevented from Medicare Benefits Scheme (MBS) billing by federal legislation. Specifically, subsection 19(2) of the *Health Insurance Act 1973* (Cth) provides that medical benefits are not payable in respect of professional services rendered under an arrangement with a State, unless the Minister directs otherwise.

A single employer arrangement should not result in additional costs for the federal government, as GP trainees are already eligible for MBS billing when in private practice rotations of their training. It would just remove the legislative barrier to an overarching single employer arrangement so that rural GP trainees can benefit from employment entitlements.

On 6 March 2020 the federal Minister for Regional Health, Regional Communications and Local Government, the Hon. Mark Coulton MP, announced trainee rural generalist doctors in the Murrumbidgee LHD would have access to a single employer training model.

LGNSW welcomed this announcement and in mid-March 2020 wrote to the federal Minister for Health requesting that the Australian Government provide an exemption to s19(2) of the Health Insurance Act to enable single employer arrangements coordinated by NSW Health across NSW.

Recommendation 19: The NSW Government should work with the Australian Government to achieve exemptions under the *Health Insurance Act 1973* (Cth) to enable single employer arrangements coordinated by NSW Health for GP trainees in rural and regional NSW.

Work/life balance

Work/life balance of practitioners operating in regional areas is often challenging, with only a small pool of practitioners available, shouldering a heavy workload. With GP numbers

declining, many retiring, and fewer medical trainees choosing general practice[5], succession plans are needed. Retiring medical practitioners are often faced with a difficult decision between retiring at a time of their choosing or leaving their community with a gap in healthcare provision.

Examples of the challenging work/life balance provided by councils on behalf of their local communities include:

- A local healthcare practitioner being on call for 20 weeks in a row
- A local GP repeatedly extending their retirement plans as there was no replacement available
- A nurse needing to travel over 120km each way to work, as the accommodation in town is reserved for attracting a local GP only. Occupational health and safety concerns have been expressed for this nurse in needing to travel this distance, particularly after long shifts.

One council, aware of work/life balance pressures for its GPs, advocates for locum staff over the Christmas period to relieve its GPs.

Relevantly, recommendation 1 of this submission calls on the NSW Government to work with local and federal governments to formulate a model for attracting health workforces to regional areas. This model would ideally address many of the challenges set out above.

[5] Australian Doctor, Medical students shun general practice, 4 October 2019, available at: https://www.ausdoc.com.au/news/medical-students-shun-general-practice

3. Impact on different community groups

Terms of Reference (k).

Aboriginal communities

Many people from regional and remote communities have to travel far to access services. Councils report instances of people from Aboriginal communities not wishing to visit other towns due to excessive travel costs or not feeling welcome in that community.

Councils have reiterated the importance of building trust with the community, which can be impacted if Aboriginal health services are under-resourced, inconsistent, or undertaken by visiting/outreach services with high staff turnover.

Councils have also noted that the NSW Government has at times struggled to fill vacant Aboriginal Health Officer roles and that once filled, retention can be challenging. It is important that the NSW Government support the recruitment of people from Aboriginal communities into healthcare roles to help address barriers to healthcare.

Example: Aboriginal Environmental Health Officer Training Program

In April 1997 NSW Health launched the Aboriginal Environmental Health Officer Training Program to employ, educate, train and support Aboriginal people across NSW to qualify as graduate Environmental Health Officers.[6]

Trainees are employed full-time by councils or NSW Health as a Trainee Environmental Health Officer (EHO) and have a role in preventative and protective public health measures that focus on the interaction between the environment and community health.

A review of the program found that in its first decade the program trained 20 Aboriginal EHOs (there were no Aboriginal EHOs when the program began). The program continues, with the launch in 2019 of a revised training kit. While limited in scale, this program may be a useful model for successful and sustainable engagement of an Aboriginal health workforce.

A recent report from the Aboriginal health service Maari Ma '*Health, Development, and Wellbeing in Far Western NSW – Our Children and Youth*[7]' noted a number of alarming trends:

- smoking in pregnancy rates for young Aboriginal people in the far west of NSW is increasing and is nine times higher than for the rest of the NSW population
- there are increased rates of infant mortality and youth unemployment compared with the 2014 report.

Maari Ma notes the need for a smokers program, with a particular focus on pregnant women, as well as the need for comparable, state wide data across various health areas, including oral health, obesity, and mental health.

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[6] NSW Health, Aboriginal Environmental Health Officer Training Program, available at: https://www.health.nsw.gov.au/environment/aboriginal/Pages/aehotp.aspx

[7] Maari Ma Health Aboriginal Corporation, *Health, Development, and Wellbeing in Far Western NSW – Our Children and Youth*, 2019, available at: *https://maarima.com.au/uploads/documents/MM_CHP_Report_2019.pdf*

Recommendation 20: The NSW Government should further support the recruitment of people from Aboriginal communities into healthcare roles and improve resourcing and support for Aboriginal health services.

People from culturally and linguistically diverse backgrounds

Navigating the health system and support programs can at times be challenging. Councils provide community services that assist in reducing social isolation, which can be an issue for new migrants and people from culturally and linguistically diverse backgrounds.

While translated pamphlets and written information can be an important resource, the COVID-19 pandemic has demonstrated to councils that the most effective health messaging uses a variety of media, including audio-visual resources, ensuring the widest possible understanding of health messaging. The sheer quantity of translated health communications for multicultural communities during the pandemic provides a substantial resource for evaluation and further refinement of approach.

Recommendation 21: The NSW Government should ensure health messaging – particularly to those from culturally and linguistically diverse backgrounds – uses a variety of media to ensure the widest possible understanding.

4. Council actions to address healthcare deficiencies

While regional centres may be growing, many smaller communities face a range of economic, demographic and environmental challenges, such as structural change (e.g. farm consolidation and increasing capital intensity of farming and mining), ageing populations (with increasingly complex health care needs), skills shortages and population decline, and water insecurity, that together undermine long term sustainability.

These challenges have been worsened by the abrogation of responsibility for service delivery in a range of areas by state and federal governments. Councils often have no choice other than to take on additional responsibilities such as support for medical services and aged care.

Despite not being a local government responsibility, councils in rural and regional areas will often take steps to secure healthcare for their communities and attract and retain a health workforce to the area. These initiatives include:

- Providing subsidised accommodation and transport for healthcare employees;
- Financially supporting new healthcare infrastructure; and
- Adopting policies and incentives that aim to attract and retain medical practitioners and their families.

The financial commitment from councils to retain existing medical services and secure new medical services is considerable. This financial burden is a particular challenge for rural and remote councils which often have smaller rate bases and budgets that are already stretched as a result of rate pegging, cost shifting and state and federal funding arrangements that are no longer fit for purpose.

Hay Shire Council, for example, estimates that it costs the equivalent of four per cent of that council's total rate income to fund medical facilities, housing and vehicles, to ensure that its community has an opportunity to access health services.

These incentives councils provide are often critical to attracting and retaining the health workforce. Members of the community may not necessarily know the full extent of councils' support to ensure healthcare is available in the community. As such, councils are at times left in a tenuous position of trying to budget for something for which they are not funded, while also facing criticism should financial pressures result in some of these healthcare incentives being withdrawn (particularly as council budgets are under severe strain as a result of COVID-19, drought, bushfire and other natural disasters). One rural council has advised LGNSW:

> *Council has had to reduce our operating budget and so reduce the incentives normally provided to attract and retain local healthcare services. The general practitioner left as a result and we have not been able to replace [the GP] since.*

Another council noted that a local (non-government) community welfare group had paid 12 months of rent for a house for a GP, with council then asked to cover the costs once the funding from this community group had run out.

Accommodation

In recognition that housing support is critical to the successful recruitment and retention of the healthcare workforce, councils will often provide accommodation for GPs, visiting medical officers or nursing practitioners.

In feedback to LGNSW, councils have highlighted that there is an expectation by the NSW Government that councils will provide accommodation at a subsidised rate to attract medical practitioners. One council has reported that its town hospital has requested that the council build short term accommodation to combat difficulty in attracting nursing staff.

The financial impact on councils providing accommodation is considerable and includes forgone rent, depreciation, as well as maintenance and eventual renewal.

Example: Forbes Shire Council furnished residences at reduced rental rate

Forbes Shire Council received a grant to part-fund the build of four 2-bedroom units for the purpose of providing accommodation to medical practitioners at a reduced rental rate. Two of the units were sold to offset the cost of the build and Forbes Shire Council has retained two units. For the past 10 years or so the units have been exclusively rented to registrar doctors participating in programs with one of Forbes medical practices where the registrar undertakes a 12-month placement leading to full certification. Part of the intent of this program is that the registrar experiences living in a rural/regional setting and may seek permanent employment in Forbes or another rural area.

Councils reasonably believe that accommodation needs should be factored into the conditions and costs of employment from the organisation delivering the health care service which in most cases is the state and federal governments.

However, many councils ultimately do provide subsidised accommodation for their healthcare workforces in recognition that if they do not, their communities are likely to suffer worsened access to health services.

Example: Properties owned by Lachlan Shire Council for the purposes of health care provision, demonstrating the annual costs incurred for 2019/20 in attracting health services to the region.

Item	Melrose St Medical Centre, Condobolin	Doctor's Residence, Tottenham
Income		
Rent (Income)	$20,000	$2,600
Expenses		
Electricity	$13,479	$239
Rates	$4,887	$1,997
Water	$405	$772
Insurance	$1,359	$1,123
Security	$1,400	$0
Cleaning	$40	$0
Buildings maintenance and repair	$10,916	$2,047
Grounds maintenance and repair	$10,252	$717
Furniture & Fittings Maintenance	$0	$3,055
Balance	**-$22,738**	**-$7,350**

The rental figures are lower than could be expected if the property was listed on the open market. Further, these figures do not include depreciation expenses. The doctor's residence figures represent 6 months occupation.

Transportation
Councils often provide private transportation to GPs at a subsidised rate to incentivise relocation to their town. This can include motor vehicles or car allowances.

Councils also operate a community transport service for vulnerable members of the community (such as aged, people with disability) which can be used for people to attend medical appointments out of town.

In the most remote parts of the NSW, councils maintain airstrips to ensure the Royal Flying Doctor Service can urgently access communities when needed. Central Darling Shire for example maintains six airstrips across a vast area, at Emmdale, Ivanhoe, Menindee, Tilpa, White Cliffs and Wilcannia.

Provision of infrastructure, facilities and equipment
Some councils will build, own and maintain buildings such as a local medical centre or a GP surgery for the purposes of housing medical services. Councils may also provide the facility fully furnished including fixtures and fittings, or provide funding for this purpose. In the instance of Gwydir Shire Council, a donation of $20,000 was made to the Rural and Remote Medical Services to replace and purchase equipment for patient care use.

Councils may also be responsible for the local aged care facility or retirement village, to support community members ageing in place.

In the same way councils are often expected to provide accommodation for the purposes of attracting a healthcare workforce, councils have also been compelled to fund state government owned facilities and infrastructure in the absence of any alternative. One council has advised LGNSW that it provided the capital for an extension to a NSW Government multipurpose service (combined hospital, aged care and accident and emergency facility) as well as the land for the extension, for which it does not charge rent.

LGNSW received feedback from one council noting it was asked to contribute funding and resources to contribute towards equipment and other fees to meet accreditation requirements for a GP clinic. The council contributed resources to the value of $19,000 to ensure residents have access to a GP locally, however council had not budgeted for this expense as funding healthcare is and should be the responsibility of state and federal governments.

Example: 'Walk in – walk out' medical facility at Forbes Shire Council

In 2009, Forbes Shire Council developed a 'walk in – walk out' medical facility that meets GP accreditation standards. (The 'walk in – walk out' model refers to the GP, not the patient.)

The model is based on the council building and owning the medical facility (building, fixtures and fittings). GPs pay an annual lease fee to council based on the number of doctors in the practice.

Part of the intention of this model is to remove the barrier of an upfront cash requirement for a doctor to buy in as an equity partner to the medical practice. The Forbes facility was funded through a $1.7 million commitment from Forbes Shire Council, and a $500,000 grant from the Australian Government.

Benefits of the facility include:

i. attracting GPs, allied health and visiting specialist services.
ii. providing capacity for the expansion of services required by the community such as mental health services.
iii. providing proximity to other medical professionals for the sharing of information, skills and resources
iv. increasing clinical capacity through:
    a. removal of travel time between practices and the hospital
    b. removal of business responsibilities
v. improving co-ordination between services to meet local needs
vi. improving recruitment and retention of qualified staff and opportunities for medical professionals to work as part of a multi-disciplinary team
vii. generating continuity and surety for the Forbes community through practice infrastructure and practice management skills benefiting the patient and resulting in more productive, less stressed clinicians
viii. improving response times to major emergencies on account of co-location with the emergency department of hospital
ix. providing a permanent helipad with night landing capabilities

Since opening the facility, Forbes has increased the number of GPs and registrars serving the region and further has reduced the need for community members to travel out of town to access specialist services by enabling visiting specialists and allied health professionals to consult from the facility.

Programs and incentives

Councils will also provide free membership to community facilities such as gyms, golf clubs and swimming pools as an incentive to health practitioners, as well as to encourage the health practitioners to build connections within the community.

Examples of council programs and incentive contributions:

- Gwydir Shire Council supports the Dr William Hunter Scholarship, which was introduced to address the challenge of retaining health professionals in rural communities and to provide help with their medical studies

- One council provides monthly return flights to Sydney for the local GP, as an incentive to staying in the region

- Coolamon Shire Council provides immigration support for prospective doctors, and has also donated land and $100,000 in funding to build an ambulance station in Coolamon.

- Forbes Shire Council partnered with the University of Wollongong to establish a regional hub for medical students to address a shortage of medical practitioners outside of major cities

- Glen Innes Severn Council has a Business Incentive Fund that may be used to provide financial support to businesses and medical practitioners moving and servicing the local area.

Creating liveable neighbourhoods to attract healthcare professionals
Councils work hard to develop and implement strategies that create liveable communities that benefits members of the community including residents and visitors alike. These strategies also act to attract health professionals and their families seeking to relocate to the bush, and build strong connections to keep them there.

However, the availability and quality of local health services is often a key consideration when choosing where to live. Smaller regional communities may not be able to accommodate the full spectrum of needs of a GP and their family relocating, such as education, childcare, employment for other members of the family, housing, social activities, or transport. In turn, the absence of a GP or adequate health services often means that professionals in other fields are reluctant to relocate to a region, contributing to a cycle of communities under-served by services essential to quality of life.

Public campaigns
Councils have at times created or contributed to public campaigns and marketing to attract healthcare professionals to their regions.

- The Gwydir Health Alliance (including council representatives) created a promotional video to assist in attracting medical professionals to Gwydir Shire.[8]

- Temora Shire Council partnered with the Temora Medical Complex to develop the 'Great Quack Quest' campaign and music video in a light-hearted drive to attract GPs to the region.[9]

Recommendation 22: The NSW and federal governments should consult with and learn from the local experiences of councils in addressing healthcare deficiencies, and reverse the significant cost shifting of state and federal responsibilities onto local government.

[8] Gwydir Shire promotion video available at: https://vimeo.com/232470942
[9] Great Quack Quest video (Temora Shire) available at: https://www.temoramedical.com.au/great-quack-quest

Summary of recommendations

Recommendation 1: The NSW Government should improve intergovernmental and community collaboration to promote better health outcomes by:

a) Preparing a formal MOU between NSW Health, Primary Health Networks and LGNSW to provide the basis for intergovernmental cooperation.

b) Establishing a joint task force representing local, state and federal governments to formulate a model for improving the provision of medical services in rural and regional areas, and developing strategies and funding financial relocation packages for the engagement of an essential health workforce in rural and regional NSW.

c) Revising the Local Health Advisory Committee model to give local residents a far greater say in the scope and delivery of health services in their local communities.

Recommendation 2: The NSW Government must provide adequate funding to support an increase in the numbers of Visiting Medical Officers at hospitals across NSW.

Recommendation 3: Where a person is placed on a waitlist to see a specialist, the person should be provided with an estimated duration of the waitlist so that the person is empowered to decide whether it would be prudent to travel and seek an alternative specialist.

Recommendation 4: The NSW Government should significantly increase investment in drug detox and rehab services in regional NSW.

Recommendation 5: The NSW Government should increase funding for specialised and appropriate youth and community mental health and wellbeing services to bolster resilience.

Recommendation 6: The NSW and federal governments should investigate and explore a partnership between councils and Headspace to ensure young people in rural, remote, isolated and public transport-deprived areas gain access to appropriate and relevant youth mental health services.

Recommendation 7: The NSW and federal governments should intervene where the market based NDIS system is failing, to ensure disability support providers and health care is available to meet the needs of rural and regional communities.

Recommendation 8: The NSW Government must retain ownership of its NDIS and state-owned aged care facilities.

Recommendation 9: The NSW and federal governments should sufficiently resource proactive and preventative health measures including annual screening in remote, rural and regional NSW.

Recommendation 10: Patient demand for health care services should be assessed with caution and a patient's usual place of residence (rather than the location of an accessed health service) should be recorded as the site of demand.

Recommendation 11: The NSW Government should review and address transport barriers to accessing healthcare and ensure better coordination, links and funding arrangements between different modes and providers of transport.

Recommendation 12: While recognising the importance of locum GPs, the federal and state governments should work together to further incentivise GPs establishing longer term or permanent services in rural and regional NSW.

Recommendation 13: The NSW Government should prepare long term plans for integrated health care provision in rural and regional NSW with a clear strategy and associated investment plans for how these will be achieved.

Recommendation 14: The NSW Government should publish clear and accessible information on the services and procedures available at locations across regional and rural NSW to simplify navigating the healthcare system.

Recommendation 15: Where patients and their families are required to travel significant distances to access healthcare, the cost of this travel (and associated accommodation if necessary) should be met by the NSW Government.

Recommendation 16: Telehealth should continue to be rolled out but must supplement and not replace vital, in-person services.

Recommendation 17: That the Modified Monash Model be reviewed to ensure that it genuinely captures isolation of an area and is appropriate in assessing relative health workforce need.

Recommendation 18: State and Federal Government Health Ministers must ensure the current review of the National Medical Workforce Strategy, and in particular how a 'District of Workforce Shortage' is determined when allocating Medicare provider numbers, provides flexibility and opportunities for medical practitioners and specialists to relocate to regional and rural communities.

Recommendation 19: The NSW Government should work with the Australian Government to achieve exemptions under the *Health Insurance Act 1973* (Cth) to enable single employer arrangements coordinated by NSW Health for GP trainees in rural and regional NSW.

Recommendation 20: The NSW Government should further support the recruitment of people from Aboriginal communities into healthcare roles and resource and support Aboriginal health services.

Recommendation 21: The NSW Government should ensure health messaging – particularly to those from culturally and linguistically diverse backgrounds, uses a variety of media to ensure the widest possible understanding.

Recommendation 22: The NSW and federal governments should consult with and learn from the local experiences of councils in addressing healthcare deficiencies, and reverse the significant cost shifting of state and federal responsibilities onto local government.

* * *

LGNSW would welcome the opportunity to assist with further information during this review to ensure the views of local government are considered. To discuss this submission further, please contact LGNSW Policy Officer Elle Brunsdon at elle.brunsdon@lgnsw.org.au or on 02 9242 4082.

Appendix 1: Local Government NSW Annual Conference Resolutions

2020 resolutions

- **83 – Health services in rural, regional and remote NSW**
  That Local Government NSW:
  1. Advocates for the Local Health Advisory Committee (LHAC) model to be revised to give local residents a far greater say in the scope and delivery of health services in their local communities.
  2. Pursues a formal MOU with NSW Health and Primary Health Networks which provides the basis for collaboration between councils and NSW Health and Primary Health Networks.
  3. Makes a submission to the Inquiry into health outcomes and access to health and hospital services in rural, regional and remote NSW

- **84 – NSW Health to retain public ownership of aged care facilities**
  That Local Government NSW calls for NSW Health to retain ownership of its National Disability Insurance Scheme (NDIS) and State owned aged care facilities.

- **96 – Partnership with Headspace**
  That Local Government NSW calls on the State and Federal Governments to investigate and explore a partnership between local government and Headspace National Youth Mental Health Foundation to ensure young people in rural, remote, isolated and public transport-deprived areas gain access to appropriate and relevant youth mental health services.

- **97 – Medicare provider numbers**
  That Local Government NSW makes appropriate representations to the State and Federal Government Health Ministers to ensure the current review of the National Medical Workforce Strategy, and in particular how a “District of Workforce Shortage” is determined when allocating Medicare provider numbers, provides flexibility and opportunities for medical practitioners and specialists to relocate to regional and rural communities so that they are not disadvantaged in the delivery of adequate and essential medical services.

2019 resolutions

- **85 – Rural doctor incentives**
  That a joint task force representing local, State and Federal governments be formed to formulate a model for improving the provision of medical services in rural and regional areas, and funding financial relocation packages for the engagement of doctors in rural towns.

- **92 – To establish social justice committees across all councils**
  That Local Government NSW:
  1. Recognises and supports social justice committees across all councils with a specific outcome of meeting the demand for residential rehabilitation services, regional Drug Courts, Youth & Adult Koori Courts and Justice Reinvestment Initiatives.
  2. Requests that the NSW Government establish funding across regional NSW for youth detox services and expansion of the Magistrates Early Referral into Treatment (MERIT) program.

2018 resolution

- **67 – Health in rural areas**
  That Local Government NSW calls for the NSW Minister for Health to:
  1. Urgently form a joint task force representing local, State and Federal spheres of government, to formulate model funding packages for the engagement of doctors in rural towns, and contribute to those financial packages.
  2. Advocate to the Federal Health Minister to ensure that safeguards are in place to prevent GP practices from appropriating patients' medical records and making a profit out of transferring them to incoming practitioners, and to advise councils on best practice legal agreements to secure the services needed and secure the patients' records. A similar motion was passed by a large majority by the National General Assembly calling on the Federal Health Minister.

Further information on LGNSW annual conference resolutions are available on the LGNSW website at https://lgnsw.org.au/Public/Events/Annual-Conferences/Annual-Conference-2020.aspx.