Submission No 354

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

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There are **three broad streams** of action, applying to both the Community-GP and the LHD-Hospital settings, to improve Health outcomes and access to health and hospital services in rural, regional and remote NSW, as follows:

	Increased personnel:	**Increased efficiency:**	**Diverting presentations:**
	General Practitioners (GPs), and other Primary Health Care Clinicians (PHCCs)	*of the work of GPs/PHCCs working in teams, with better Practice/ Administrative support*	*away from GPs/Primary Health Care Clinicians, and Hospitals, via improving baseline population health*
Community – Outpatient setting	Undergraduate Bachelor of GP degree course, undertaken solely in rural/remote General Practice, with clinician access to provision of hospital care, and specialist training on a modular, post graduate model	Improving public-private partnerships in health: developing models of local hospital-private primary health care integration	1. Better secondary prevention/ Chronic disease management via a 'Virtual Chronic disease hospital'
Community – Outpatient setting	Increase training of Nurse Practitioners to work in rural/remote Primary Health care clinics in teams alongside medical officers.	Improving practice support for the delivery of Primary Health care: - Practice Manager courses and training, and incentives - Receptionist and administrative staff courses, training and incentives	2. Better primary prevention via population health initiatives: improving Brain health, improving parenting, improving patient self-care, taking a whole of community life approach
Hospital setting	ED Directors in smaller hospitals Training pathway certification in ED for doctors in smaller hospitals	Better networking of doctors working in small hospitals to Specialist support: FACEMs/ FRACPs	Enhanced LHD – Primary care partnerships
Telehealth	Telehealth Specialist and Mental Health support. Clinically appropriate Telehealth in the ED	Telehealth administrative support and training for Admin staff. Networked practice management.	Telehealth primary and secondary disease prevention.

1. General commentary:

1. There is reduced access to GPs and specialists by patients living in Deniliquin.
2. There is an increased burden of acute and chronic disease of patients living in Deniliquin.
3. There is an increased burden of mental health problems of patients living in Deniliquin.
4. There is an increased rate of ICE/ crystal Methamphetamine use in Deniliquin, and problems of drug dealing, and crime.
5. There is an increased rate of social problems in Deniliquin, relative to times gone past, including family breakdown, domestic violence, unemployment and relative unemployment, and general reduced community cohesion and social capital.
6. There has been, and currently is, an influx of patients with Chronic disease into Deniliquin, and a relative efflux of health care delivery knowledge and expertise out of the community.
7. There are wider socio-economic factors driving the influx of high Chronic disease burden patients into Deniliquin, and the efflux of health care workers and expertise out of Deniliquin.
8. There is a lack of integration of primary health care services in Deniliquin.
9. There is a lack of recognition that the delivery of care environment has fundamentally changed, and that revered past models of service delivery by long term Deniliquin town doctors (Dr Ian Harper, Dr Middleton, Dr Gorman, Dr Noyes) are no longer sustainable.
10. The central role of the GP VMO (General Practitioner Visiting Medical Officer), working across the hospital and community setting, is increasingly unviable, and alternative models of medical service delivery will have to found.
11. The LHDs (Local Health Districts) and hospitals have a key role as the central institution in providing health care in the community. They need to acknowledge this role, and participate in all three streams of action: increased Primary Health Care Practitioner numbers, increased administrative support and team care, and better secondary and primary disease prevention.
12. The LHDs and hospitals can no longer rely on an external supply (Federal government funded GP training and placements) of medical workforce.
13. A collaborative framework for whole of government (Federal, State, and Local governments) engagement needs to be found. National Cabinet is a model for such inter-governmental collaboration.

2. Increased General Practitioners (GP)/ Primary Health Care Clinicians (PHCC) numbers working in Rural/ Remote Primary Health Care:

Increased numbers of clinicians, GPs and PHCCs in rural/ remote towns	**Commentary**
Increased General Practitioners (GPs)	Stop the current diversion of medical school undergraduates into speciality training and generalist hospital work with a standalone, full rural on-site training (Young, Leeton, Corowa, Deniliquin type larger country towns) **Bachelor of General Practice Degree.** To be administered by regional Universities (e.g: Charles Sturt University), with a hub and spoke model. Entry selection criteria based on rural background and primary care interest. Develop a modular career progress structure for these Bachelor of GP rural GPs, starting with progression to hospital care service delivery (Emergency Department and Inpatient Ward care), then on to entry into specialist training programs, if desired by the individual Bachelor GP doctor. Develop a more robust philosophy of medical primary health care generalism.
Increased Nurse Practitioners (NPs)	Remove the financial disincentives in the MBS towards employing NPs at current job market rates. Develop models of integration of NPs into the current GP led model of Australian primary health care. Develop training pathways for NPs to enter rural primary health care. Ensure rurality in the access of NPs to primary health care.
Increased Primary Health Care Clinicians	Make transition to a generalist style of primary health care possible for podiatrists, physiotherapists, Ambulance Officers, Pharmacists and other current specialist primary health care clinicians (PHCCs). Develop modular pathways for entry of other PHCCs into rural primary health care. Develop models for integration of other PHCCs into current rural primary health care service delivery models (GP clinics and Emergency Departments).

3. **Increased efficiency of GPs/PHCCs through working in hierarchical structures/ teams:**

Initiative	**Commentary**
Develop innovative models of rural hospital- town General Practice integration	There is currently a market failure in the delivery of Primary Health Care (PHC) in rural and remote settings, particularly with regard to the provision of resource intensive Chronic Disease Management (CDM). There currently exists a patchwork of collaboration across the government (State and Federal initiatives) and the private sector. Aside from virtual partnerships and engagement, consideration needs to be given to actual physical co-location of services: GP clinics on hospital campus's, and other novel methods of approach to service delivery.
Increase the training and development of **Practice Managers**	Trained Practice Managers are key to improving service delivery in Primary Health Care clinics. Currently Practice Management training is in its early stages of development. The complexity of Practice Management, is such that part time, non degree selection and training is not adequate for equipping Practice Managers for their role.
Increase the training and development of **Practice Nurses**	The Australian Practice Nurse Association is providing much needed education for Practice Nurses, but there needs to be more recognition of the role of the Practice Nurse (as distinct from a Nurse Practitioner) in the Primary Health Care (PHC) service delivery environment.
Increase the training and development of **Receptionists** and Primary Health Care Admin staff	Receptionists and Administrative staff play a key role in service delivery. Their training is currently almost solely an on the job model, with ad hoc sessional supplementation. Current TAFE and VET courses do not equip Medical Receptionists for their role. Good Medical Receptionists relieve the workload of Practice Managers, and Primary Health Care Clinicians, and are an essential and undervalued part of the health care team (both in the community and hospital settings).
Develop robust models of team care, role delineation, and task allocation in a team comprised of GPs, NPs, other PHCCs, Practice Nurses, and Admin. staff	A working model of structure and robust role delineation needs to be developed for Primary Health Care (PHC) clinics service delivery. The current MBS funding model has developed out of an insurance rebate mechanism for doctors providing complete standalone primary health care. This insurance, fee for service model was appropriate for the style of limited episodes of acute care, seen in the mid 1970s, when the system was first designed. Now patients with very complex chronic disease are surviving longer. Unfortunately, the success of improved acute care, has created the unintended consequence of a chronic disease management crisis. CDM Care Plans, and the Federal government Health Care Homes initiatives are moves in this direction, but are structureless, at the moment.

4. **Diverting presentations away from GPs/Primary Health Care Clinicians via improving baseline population health:**

Initiative	Commentary
Better secondary prevention	There needs to be better integration of Chronic disease management (CDM) between service delivery partners. There are currently financial disincentives for GPs to practice resource intensive CDM case coordination.
'Virtual Chronic disease hospital'	There is a role for a central figure in CDM case coordination. Most of the time, this will be the town GP. But there is a role for a new body, an extension of the current Local Health District (LHD) led integrated care model, into something like the Chronic Disease version of a tertiary hospital, without an actual building. Flagship, large tertiary hospitals act like a complete community of care, providing all known care possibilities: advanced imaging, pathology, surgery, intensive care, in a coordinated, multi-disciplinary care setting. A community version of this complete, integrated, multi-disciplinary care approach to chronic disease management, is clearly lacking, more so in rural and remote communities. The 'Virtual Chronic Disease Hospital' would use the analogy of the flagship tertiary hospital coordinated, multi-disciplinary care setting, to address each individual patient's Chronic Disease Management needs. Something like this model is being attempted with the NDIS, and LHD Integrated Care, but it needs to be coordinated with GP chronic disease management, in a much more formal and operational manner.
Better primary prevention: acting on the **Socio-economic determinants of health**	We need to stop patients getting sick in the first instance. There is a huge difference in health service usage and health outcomes along the spectrum of Social Class 1. to Social Class 5. We need to recognise and act on what is already known about the socio-economic determinants of health. Healthy lifestyle habits start in infancy, with the help of authoritative parenting. The Canadian 'Early Years Study. 1999' has led the way in demonstrating the improvements possible in learning, behaviour, and health outcomes (=improved educational outcomes/ reduced criminal behaviour/ less chronic disease) by investments in the early years through the mechanism of targeting brain critical development windows.

4. Diverting presentations away from GPs/Primary Health Care Clinicians via improving baseline population health (continued):

Initiative	Commentary
Population health **lifestyle** initiatives	We need to develop whole of government, whole of community initiatives, targeting improved primary prevention through addressing issues outside of traditional health action. We need town infrastructure and an economy that gives incentives for healthy behaviour, and disincentives for unhealthy behaviour. For example, with regard to middle aged patients with low back pain on government transfer payments, we could for example use more subsidised gym and Pilates classes, amongst other initiatives. With regard to the PBS, we could prescribe health promotional books and videos, and group therapy classes, not just tablets.
Better researching of outcomes through qualitative **anthropological studies**, and a better understanding of the 'Levels of Evidence' concept	There is currently too much reliance on lower quality (Level 5 evidence grade) quantitative research (agglomerated government agency data) into population health and social status. Better quantitative research (e.g. using waste water to measure ICE/Methamphetamine community use) needs to be undertaken. There is also a need for targeted anthropological studies of population health and social status in rural and remote towns. Just as the phone company Nokia, engaged anthropological research into how phones were being used (New Scientist June 2008), so information about rural and remote population health and social status, not available through quantitative research, should be garnered through anthropological research. What the local Police Officers, the NSW Ambulance Officers, the Emergency Department Nurses, the town GPs, and the local employment agencies would tell you about a town like Deniliquin differs substantially from what seem like the official statistics.

5. Hospital setting changes:

Initiative	Commentary
Re-think the GP VMO role in smaller rural hospitals.	The GP VMO, working across community and hospital sectors, is the classic 'country doctor' figure. The role was better suited to hospital presentations of limited episodes of acute disease. The role provides wonderful continuity of care, but is becoming harder to deliver, with workforce shortages and increased burden of chronic disease. Alternative models of hospital doctor staffing need to be considered; roles which will not have the unintended consequence of de-skilling rural community GPs and making that role less attractive.
Create ED Director positions in smaller rural hospitals.	ACEM is starting an EDAD (Emergency Department Advanced Diploma) qualification and training pathway, designed to equip doctors as directors of smaller EDs.
Create Hospital Generalist positions in smaller rural hospitals	Fly in – Fly out (FIFO) ED locum Medical Officer positions frequently do not include adult inpatient ward cover. Consideration needs to be given to hospital generalist positions, with the caveat, that creating these positions do not de-skill, and downgrade the local community GPs role.
Create training pathways for ACEM and RACP for doctors working in smaller rural hospitals	Along with new qualifications, there needs to be training positions for doctors in training in smaller rural hospitals. Training positions for GP streaming doctors, for trainee Physicians/ Internists, and for ACEM trainees. GP streamed doctors would benefit from mid-level training positions with support from the Australian College for Emergency Medicine and from the Royal Australian College of Physicians.
Support current serving GP VMOs with a more robust specialist support network	Currently, there is minimal formal dedicated specialist support and mentoring for the GP VMOs working in smaller rural LHD hospitals. GP VMOs need regular dedicated mentoring with regional FACEMs and General Physicians as part of dedicated support plan.
Support current serving GP VMOs with a more robust framework of training	GP VMOs arrange their own training, according to their needs. But there are problems with locum provision whilst training, and course selection, and the whole program is piecemeal, and probably not fit for purpose. (City GPs DO have a fit for purpose QI&CPD program).
Hospital clinicians craft group clinical training background	There is a fundamental question about the staffing of senior clinical roles in smaller hospitals. This has traditionally been with GP VMOs/ generalist doctors. Should this change to a much wider use of Nurse Practitioners, or to involvement of specialists in some roles. For example, in smaller rural hospitals, should FACEMs staff the EDs and Specialist Physicians staff the adult inpatient wards?
Involve ACEM and RACP in discussions about change	Both the Australian College for Emergency Medicine and the Royal Australian College of Physicians, need to be involved in discussions, along with the many current stakeholders (the RACGP, ACRRM, LHDs, Primary Health Networks, the AMA, the National Rural Health Alliance, the Rural Doctors Network, the Rural Doctors of Australia Association, the three levels of Australian government, and other stakeholders).

6. Roadmap for change:

Here	**Roadmap**	**There**
Current status of population health care and service delivery	Pathways to improvement	Agreed goal of improvement in status of population health care and service delivery
Measure	**Design**	**Implement**
Robust quantitative and qualitative measure of current status of population health care and service delivery	Engage stakeholders to use Edward de-Bono lateral thinking, and Harvard Mediation Program and Conflict Resolution Network (https://www.crnhq.org) style conflict resolution techniques, to produce an agreed pathway for improvement	Through a Federal-State 'Garling' style Special Commission of Enquiry with powers of implementation: - Set goals - Set a framework for change - Deal with resistance from interest groups - Empower change

7. Summary commentary:

Fundamentally, in all aspects, a more collectivist, corporate (public and private, and public-private partnerships) approach needs to be found. Individual private practitioners delivering isolated episodic fee-for-service acute care is no longer a viable workforce or service delivery model. The wider socio-economic factors as well as the changing chronic disease context need to be taken into account.

There have been over 25 years of government initiatives operating at the margins to nudge change in service delivery models in rural and remote Primary Health Care.

These initiatives (other than the 'moratorium', known as section 19AB) have not worked for rural and remote communities (albeit doctor numbers in regional centres like Albury have benefited from the presence of the University of NSW Medical School Campus), and the system is clearly more in crisis than ever.

A more radical and more fundamental departure from this style of government intervention, in an arena of market failure, is now needed. We have to think differently about change, and leave behind a piecemeal, gradualist style of change.

As well as thinking differently we need to act differently. A body needs to be empowered to bring about change, in the way that changes occurred in response to the NSW Government 2008 'Garling Special Commission of Inquiry'. Something along these lines will be needed to empower change.

Yours faithfully

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