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

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

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Overview

This individual submission is based on my experiences as a general practitioner during three decades of rural practice and, for the latter half of this period, as an addiction physician.

Rural people live with higher disease burdens and have shorter lives. Urban life expectancy is 82 years, falling by 3, 9 and 18 years respectively in outer regional, remote and very remote areas (1). It is even lower for Aboriginal or Torres Strait Islanders. Rates of premature deaths in rural areas are 40% higher than the cities (2). Hospitalisation rates for potentially preventable acute conditions are almost 2½ times higher in remote, as against urban, areas (1). Expenditure rates for community-based Federally funded Medical Benefit Services (MBS) and Pharmaceutical Benefit Services (PBS) items higher in the cities, decline with increasing rurality. This is the opposite of expenditure rates for state funded hospitalisations which increase with rurality (1). These figures demonstrate an under investment in rural health promotion and illness prevention and an over-reliance on advanced illness diagnosis and management.

Ideally, funders and regulators would seek to ensure the provision of proportionate health services. The "Law of Inverse Care," coined by Professor Julian Tudor Hart in 1971, describes the true relationship. It states that the availability of good medical or social care varies inversely with the need of the population served. This phenomenon has been described elsewhere as the Primary Care Paradox. On one hand, GPs usually provide poorer quality care of each specific disease than would the relevant specialists. On the other hand, population-level research shows strengthening of the GP sector improves many health outcomes, including mortality and health equity, and do so at a lower cost (3, 4). This may be because GPs offer greater geographical and financial accessibility along with opportunistic and longitudinal care.

So, the GP is pivotal to rural health care delivery and this submission mainly focuses on supporting this sector of the workforce.

One contributing factor is the decreasing role of the GP. GPs used to provide procedural care, offering a wide array of advanced skills, even in urban areas. Latterly, those entering general practice often do not seek procedural skills and politicians frequently can describe a GPs role as merely a "gatekeeper". Being a GP proceduralist, while professionally satisfying, does not increase earnings but does guarantee to disrupt both office-based private practice and after-hours life. GP procedural practice is very vulnerable to factors beyond the control of the doctor.

If a rural community loses nursing or medical staff with appropriate skills, funding for the relevant procedural unit may be shifted to a major centre, never to be returned. The loss of local maternity services contributes to the loss of young families from the bush. The Rural Doctors Association of Australia reported in its 2020 Budget submission that around the nation over the last decade, 50% of all rural maternity units have closed. Devalued GPs increasingly rely on specialist services and Allied Health providers. In rural areas, these may be located at a considerable distance or may have closed their books to new cases.

In my case, after completing two years of specialist overseas training and holding Diplomas in both anaesthetic and obstetrics, I ran a GP procedural and office-based practice for six years, mainly in Singleton and Condobolin. This abruptly ceased when I bought a practice in the Manning Valley. Prior to our committing to the purchase, the Manning Hospital medical superintendent confirmed to me that my dual procedural skills were welcome there. It was explained to me that the hospital frequently had no provide weekend or holiday cover and was forced to pay large sums to locums. However, on my arrival, the superintendent told me that the specialists had decided not to support the return of GP proceduralists. I was told if I wished to practice obstetrics, I would have to offer home birthing care.

It is important for the inquiry to comprehend how complex it is to recruit a GP workforce to a regional or rural area. Already over-stretched rural doctors find it near-impossible to recruit Australian-trained colleagues with appropriate skills. Attracting a workforce then becomes highly competitive for rural doctors. Recruits are sourced from two groups: GP registrars (trainees) or newly registered International Medical Graduates (IMGs), bound by the ten-year rural moratorium. Our failure to attract locally trained doctors means Australia has been stealing doctors from developing countries for years. This is the antithesis of foreign aid.

1 Workforce recruitment factors

a) General

Over my years as a rural GP, my major cause of headache has been medical recruitment and retention. Yet, many rural GPs are far worse off than me. Gunnedah, as I understand, currently has two GPs to cover a population of almost ten thousand. Recently the only private general practice in the Northern Territory town of Katherine, closed due to a failure to recruit and retain.

This requires the practices 8000 patients to travel three hours to Darwin for a GP consultation https://www1.racgp.org.au/newsgp/professional/closure-of-katherine-s-only-general-practice-hits.

Single clinicians are reluctant to go to a rural area in case they cannot find a partner. This is particularly so if there is diversity regarding sexual preference, ethnicity or religion. Other barriers may involve language, culture or access to places of worship.

When advertising for recruits, I am inevitably flooded by overseas applicants who may or may not have passed one of the two parts of the Australian Medical Council (AMC) examinations. Not a single one of these will be recruitable within several years, if at all. I will be contacted b y many recruitment agents as well. These agents charge $14-25 thousand dollars for a successful GP placement. If the recruit then leaves within a couple of months, no credit is provided. Applicants often use numerous agents and talk to dozens of rural GPs to get the best guaranteed earnings and training with lowest after-hours workload so they can prepare for their Fellowship exams and guard their family life. The situation becomes dispiriting, akin perhaps to looking for true love at a speed dating function.

There is evidence that if the first job after graduation is in a rural setting, longer-term retention is more likely (5). However, apart from GP registrars, we rarely hear from Australian-trained GPs. I may have contact from one every 3-4 years of recruitment. Even then, it is usually only a preliminary chat due to the reasons covered below. The Rural Doctors Association of Australia recently estimated that fewer than 5% Australian-trained doctors choose to practice rurally.

b) IMG recruitment

IMGs who apply for vacancies are usually inexperienced and subject to a moratorium that requires them to work in hospital or outside most city areas for ten years. They account for much of the younger rural workforce, apart from registrars.

There is an urgent need for some communication between the different state and federal regulating bodies involved in this process. Kafka-esque is how processes unfold, rather than how the system works. Those who need to co-ordinate approaches include: Immigration, State and Federal Departments of Health, the Australian Health Practitioner Regulation Agency

(AHPRA), the GP Colleges and Revenue NSW. I have written to my local members previously about this in more detail and am happy to share these letters.

Four years ago, I engaged with two superb and experienced South African GPs interested in working over in NSW, each had Masters and Fellowship qualifications. The female GP, Dr DB, said a priority for her was to ensure her husband found a job in his area of expertise. So, I tracked down such a local sales position for him in his specialised area. I was disappointed that they eventually decided to go to a practice elsewhere to join a practice with several other South African medical ex-pats. I spoke to Dr DB two years after our initial contact, assuming they would be well established in NSW, or perhaps not settled and looking for an offer. She told me that due to the stress of the transition of the processes, their marriage had failed. She had never commenced work in NSW to ensure their children had access to both parents.

After DB told me that she had accepted a post elsewhere, I engaged with a male South African GP (RR), again requiring the Specialist Registration pathway. Due to bureaucratic delays, it took us 22 months for Dr RR to commence here. At least three times, when requirements were arbitrarily changed, we relied on our Federal member to negotiate the deadlines, and managed to salvage the process by a couple of days or weeks. An example of the inflexibility was how APHRA required Dr RR to fly to Australia to attend the APHRA office in person to present his identification documents. They refused to allow the Australian Embassy in South Africa to witness them. He flew to Perth and then had to either stay in Australia for a minimum of 6 weeks without working or return home, which he did. Because of the delays and the repeated near derailing of his progress, his wife accepted a position in an international pharmaceutical firm as their Chief Pharmacist for Africa and the Middle East. As Dr RR had no guarantee of Permanent Residency until he passed his Fellowship, she declined relocating the family until they knew they could stay. Dr RR was an excellent clinician, much loved by his patients and our practice staff. As Dr RR's wife's role required international travel, family pressures increased causing Dr RR to return to South Africa nine months after he had commenced with us.

Dr RR tells me that all of his colleagues looking to leave South Africa are now preferencing Canada. He explained that this is because when a doctor passes the Canadian entrance examination, they are guaranteed Permanent Residency.

An IMG may have passed only one of the two AMC exams and, subject to a PESCI assessment, may be granted limited registration (LR). These LR doctors require onerous levels

of support from their supervisor. This involves months where the supervisor has to review every single patient seen by the LR doctor before that patient leaves the surgery. Here, the supervisor is fully responsible for each patient's care.

An IMG may have passed both AMC exams plus had some Australian hospital experience, attaining General Registration (GR). IMGs with GR are sought out by agents who sell their services on the basis of assisting them to navigate the system and to shop around for the best deal. Naturally, IMGs with GR want a guaranteed income and offer of training support, the best percentage, and the best schools for their kids. They may see which location can assist with a job for their spouse. They all want to be sub-contractors. Any one of these factors will see their earnings captured by State payroll tax nets as discussed subsequently.

This year we recruited an IMG newly awarded GR. Dr DV had to have his Immigration sponsorship transferred to us from the Central Coast Local Health District. This took five months and during this time he was unable to work anywhere. We were very stretched at the time trying to construct and establish a GP Respiratory Clinic and it seemed bizarre that, due to bureaucratic delays, our community could not access his services and he could not earn a living.

Similar or higher barriers are faced by International Dental Graduates.

c) Registrars

The Rural Doctors Association of Australia estimates that registrars comprise approximately 12% of the rural and remote medical workforce.

For all these GPs (as well as IMGs), attaining a Fellowship within four years has become of critical importance or else they cannot access standard MBS payments and have to return to hospital work. For this reason, registrars must be totally exam focused. This means they want part-time work with little after hours and plenty of time off before exams. This is usually at the same time as any other registrars. They do not want to be located too remotely as there may be a lack of supervision or access to a medical educator.

The Australian Medical Association (AMA) has expressed concern that GP registrars often take a significant cut in pay and conditions when they leave the hospital system. In a recent newsletter, the AMA noted that this related to, "inferior sick leave, parental leave, annual leave, and long service leave arrangements."

For all these reasons, GP Synergy, who runs GP training for our entire state stated that in 2020 only 61% of rural positions were filled.

d) Locums

Many rural communities rely on locums or the equivalent of Fly-In-Fly-Out doctors. Issues involved include:

- if they are on a wage, they may not be motivated to work,
- if they are on a percentage, they may focus on throughput while claiming all the higher revenue items, thus disadvantaging the longer-term GPs,
- there is no continuity of care,
- reports of corruption due to the exorbitant locum agency fees involved. A colleague who locums in rural Aboriginal Medical Centres around Australia alleged kickbacks were not uncommon where centre managers prioritised one locum agency.

2 Workforce retention and development factors

a) General

Regulators need to consider longitudinal changes in the rural GP workforce.

- Most Australian-trained rural GPs are now quite senior with consequent morbidity or even mortality.
- The feminisation of the workforce has relevance regarding maternity leave or the traditional allocation of child-rearing to mothers.
- Many younger GPs preference lifestyle: they work to live and reject the traditional model perceived as living to work.

Our Manning Hospital now does not accept major trauma which is re-routed to Port Macquarie. This would cause many orthopaedic surgeons or registrars to choose to leave the area avoid coming here. Few would wish to work in a hospital that did not have a suitable caseload or equipment befitting their hard-earned and well-remunerated skills.

In my area of addiction medicine, there are few GPs providing opioid dependency treatment, particularly rurally. Because we cannot refer stable patients out to GPs, this places a burden on our hospital-based services. In consequence of this, we struggle with the intake of pregnant or chaotic patients, including those released from incarceration.

b) The professional experience for the rural doctor

Some of the barriers:

- To save time, it may be quicker to undertake requested tasks such as nursing home scripts without generating a MBS item. This may save time but makes one arrive home later without any payment.
- An over-stretched GP is unlikely to initiate quality care matters such as de-prescribing or preventative care. An over-stretched GP will be triaging the most important issues. Quality care takes time and if there is an overwhelming workload it is predictable that clinicians will tend to avoid prompting for time-consuming interventions or they will never see their family,
- Being on call every night for a hospital is destructive to doctors' physical, mental and family health.
- Rural GP earnings are the same as a metropolitan GPs: https://www.ausdoc.com.au/news/city-vs-bush-gp-income-figures-debunk-rural-gravy-train-myth
- It may be hard to access or cover the cost of a locum for holidays or personal/family illness. Locums may cherry-pick jobs with easier on-call demands.
- A higher turnover of GPs means more new GPs. For new GPs, every patient is new and the GP has to rely on clinical records which at times are of poor quality.
- Work doesn't go away when there is no time. Insurance companies still want reports and the Courts still issue subpoenas,
- Patients often must wait weeks to see a GP so will try and get as many problems covered as possible as well as seek services for their family members,
- Unhappy patients may complain or litigate, requiring time and emotional energy,
- Many rural communities have a large, aged population. The workload streaming from nursing homes is frankly relentless and much of it is unpaid. One local nursing home has a Clinical Nurse Practitioner. Much of her work attracts an MBS item, as long as the GP

does not consult on the same day. This does establish a conflict of interest. The Clinical Nurse Practitioner leaves un-billable chores such as scripts to the GPs.

- IT support and internet access in the bush can be problematic. Research provides evidence that provision of professional development supporting new recruits to rural life and private practice improves recruitment and retention (5).

Some facilitating factors:

- Many rural GPs appreciate the challenge of using their advance skills,
- Rural GPs appreciate community support and the clinical camaraderie required for hospital practice,
- An article about why three IMGs chose to stay as rural doctors can be read at https://www1.racgp.org.au/newsgp/professional/what-keeps-overseas-trained-gps-in-rural-areas-aft?

c) Dealing with Health Regulators/Funders/Authorities

- Although there may never have been a policy decision to do so, across the State there has been a steady decline in investment in rural hospital infrastructure.
- More rural services are lost when budgets are stretched and urban/tertiary hospital services are prioritised for funding. Clinicians committed to that service then either leave or de-skill. The same scenario eventuates when rural populations decline, and patient numbers drop.
- Rurality classifications regarding which areas are permitted to recruit IMGs are constantly changing. It is demoralising when State "Area of Need" or Federal "Modified Monash Model" boundaries change without notice or clear reason.
- Some rural GPs on social media describe "a toxic and adversarial attitude of the hospital…putting cost ahead of community…. where hospitals refuse to pay for complex emergency work such as car crashes or overseas tourists who are critically ill".
- Hospital systems may be developed without any collaboration with rural clinicians and so not integrate with private practice workflow or systems. It is vital that rural GPs and proceduralists can be involved in health service management decisions.

- Gaps in services add extra burden to the rural GPs. Our local community geriatric team does not have a social worker. This means local health services cannot deal with elder neglect or abuse and I have had to repeatedly involve the police or Guardianship Board.
- During the holiday season, many rural area face increased workloads. The population of our local tourist destinations such as Harrington or Forster may swell four-fold in the summer holidays, coinciding with the hospital's Christmas shutdowns. Many city-siders have weekenders in these areas as well. I suspect that these people's home addresses are used for determining health service funding as well as electoral vote weightings.
- Many rural people do not tend to swing their votes. Thus, they may miss out on marginal seats campaign funding offers (also known as rorts) as highlighted at both the latest State and Federal elections.
- There is some evidence indicating that financial incentives may enhance recruitment and retention. The evidence shows, however, that incentives alone are unlikely to provide any long-term solution (5).

d) The personal experience for the rural doctor

One GP wrote on social media that rural practice meant that they had "to choose between family/home/garden/interests and work. You cannot get to sporting clubs. You never finish jobs. As the tension with your non-work life grows so you postpone (jobs) hoping that there will be more time later." It is demoralising if, due to workforce/resource shortages, one continually either must curtail care or run late, losing personal time to ensure quality care. Doctors may start avoiding tasks such as responding to requests from pharmacists, nursing homes of concerned family of patients. Doctors who are over-stretched, demoralised and tired, may cut too many corners, increasingly reluctant to keep compromising personal or family time.

It is hard to make a business case for running a private GP clinic in lower socio-economic areas as commonly found rurally. Bulk-billing patients on the grounds of hardship does not generate income significantly above operating costs (unless there is focus only on throughput and not quality care). Regarding our own practice company, our profitability shrunk each year through the last decade to the point, two years ago, of failing to break even.

GPs fear colleagues' departure in case they become the "last person standing" in a small town. This would cause heavy workloads and exposure to financial obligations regardless of whether the practice continued or folded. Better succession support may prolong clinician retention.

One GP wrote on social media, 'It is crap to work in the rural area. You are on call nearly every weekend. You can't sleep, you can't take a day off if you are sick. It is all too difficult. Who likes to work in that environment? NO ONE!'

One ex-rural GP wrote on social media, 'the things that don't attract me- grew up in the city, all family and friends in the city, husband has job in tertiary centre, I want kids to go to particular schools, I feel supported by specialists and have easy access to hospitals, radiology and pathology. There are plenty of other GPs so I can take as much time off as I like. I don't need to do any after-hours work. Not sure how to solve those problems. Throwing money at the issue wouldn't change how I feel about it.'

e) The personal experience for the rural doctor's family

Racist comments can be a problem. After an Islamic terrorist attack, one of our Islamic doctor's children was so vilified at school that he told his parents that he wanted to die. She tendered her resignation that month and moved to Sydney with two weeks' notice.

In rural areas, IMGs of diverse cultural or linguistic background may have no-one else there sharing these features. Isolation from friends or kin is a burden. Country towns often are suspicious of non-locals. It may take decades (or generations) to become a local.

A married doctor's spouse is likely to be highly educated and in a senior position. Such positions would be rare in small rural communities. Separating family for work reasons increases the tendency for doctors to return to the city. The husband of one registrar, whose marriage was so divided, blamed being forced to live in Sydney without his family as the trigger for seeking a divorce.

Many doctors feel that there is little entertainment for their children in the bush and that rural schools are not at the level of the elite city schools. Doctors with disabled children will be aware that there is rarely specialised support available in country towns. Some small country towns may even lack child-care facilities.

Many doctors' families may resent the loss of access to a city level range of shopping or the arts.

3 Regulatory factors

a) Research

GP research predominantly originates in the cities. There is a paucity of funding for research by rurally based clinicians (1). However, the payoff for both health policy and clinical care may be worthwhile. With others, I had three successful applications to the then NSW Health Drug and Alcohol Research Grants Program. Our published papers identified and explored how GPs provided opioid analgesics and benzodiazepines at increasing rates to more rurally or remotely-based patients, to those in lower socio-economic areas and to Aboriginal or Torres Strait Islanders (6, 7). These findings informed the Australian Atlas of Healthcare Variation (8). Another project was able to document and explore the non-compliance of NSW GPs with the then analgesia prescription guidelines as well as quantitate the barriers and enablers for GPs regarding the provision of safer, dependency-style opioid prescribing (9, 10). We were able to develop and deliver brief non-commercially funded chronic pain education to GP registrars with our subjective and objective evaluations giving disparate results (11, 12).

Unfortunately, the Mental Health, Drugs and Alcohol Office of the NSW Ministry of Health cancelled the clinician grants programme ten years ago. This de-railed our continued exploration of how to understand and address escalating iatrogenic harm from opioid analgesic prescribing and the non-provision of opioid dependency-style care.

b) Payroll tax

About five years ago, NSW Revenue levied me a six-figure sum based on our standard arrangements with IMGs described above. This was done retrospectively on the earnings of IMGS who had departed many years since. I protested to our local MP, who passed my letter to the Treasurer, but no-one would engage on the issues raised. They claimed this was because it was under dispute. I was told repeatedly that the policy committee of NSW Revenue would consider the matter, but as far as I know, they never did. Finally, I took the matter to the NSW

Civil & Administrative Tribunal. In 2018, NSW Revenue was told they could not charge payroll tax on services that were bulk-billed and so about 90% of the claim was put aside. This process was highly stressful and costly. It does seem perverse that one arm of government has been punishing quality rural health delivery and bulk-billing while another arm has been trying to support it.

If an IMG receives supervision, parole tax may be levied, if no supervision is provided, the community suffers from inferior health care. The Health Care Complaints Commission has requested that I become an Expert Reviewer for cases of alleged mis-prescribing. I have already been a witness to one mis-prescribing hearing of a local GP who owned a practice. This practice had numerous IMGs working as sub-contractors with several of these deregistered for mis-prescribing. The barrister for the NSW Health Care Complaints Commission (HCCC) asked me whether the owner should have supervised and counselled the IMGs on their prescribing practices. I advised if the owner had indeed done so, this would pull the trigger for another state department, NSW Revenue, to seek from the owner 5.75% of all the IMG's earnings in tax. The practice of NSW Revenue to levy payroll tax on GP registrars and any IMGs where clinical supervision is required is a barrier to workforce development and a threat to the health of the public.

c) A lack of collaborative planning and leadership.

Too often, planning seems to focus on electoral strategies rather than need. In the Manning Valley, we have the Federal electorate with the oldest population and yet only have one part-time community geriatrician and one full-time geriatrician who additionally has to take up a general physician on-call rotation at Manning Hospital.

Funding decisions too often seem to reflect ideology. For example, in Tony Abbott’s new Federal government, the assistant health minister Fiona Nash immediately dismantled both peak Drug and Alcohol infrastructure organisations without even consulting with their boards or executive.

Currently NSW Health is setting up a real time prescription monitoring programme and I am on the guidance committee for this. One concern I have is that more attention is required to strengthen the workforce which will be required to deal with the many higher prescription consuming patients and liberal prescribing doctors so identified.

Poor planning was revealed during the bushfires of a year ago. There was no GP involvement in any co-ordinated response to the emergency. On November 11, 2019, at the height of our disaster our practice workforce was reduced to one GP Registrar and myself along with three nurses. As most or all of the other practices were closed, we were kept busy. We still rang the Emergency Department and offered to take any patients presenting there who could be seen by in a GP office but never received a response.

In early December 2020, we did finally meet for collaboration between local GPs, the public and private hospitals and the Primary Healthcare Network. A couple of week-ends later, these connections became invaluable when two cases from the Northern Beaches COVID-19 cluster were revealed to have visited the area. Those at the meeting were able to coordinate and mobilise services on a Saturday evening to start the next day. This facilitated testing for over a thousand patients during the following few days.

Over the decades that I have been a rural doctor, I have noted governments tend to propose and fund workforce projects designed to reassure voters that things will get better. Failed projects include the rural bursary scheme where doctors who accepted monies to support them during training years, as the doctors simply paid back the debt while continuing to work in city tertiary centres. These workforce projects suffer from a neglect of evaluation, probably as they take decades to make a difference and the political cycle focuses on the election-cycles every few years. This means subsequent politicians can continually announce brand new approaches while there is no-one left to be responsible for on-going failures.

Having been a GP proceduralist working in public hospitals in Singleton and Condobolin, it is my belief that a well-trained GP proceduralist can provide most emergency, inpatient and maternity care for their communities and do it in a highly cost-effective manner. As it is an increasingly niche role, leadership from policy makers is required to support and expand such services.

Ready to take over the better-paid and less time-consuming aspects of general practice are the Pharmacy Guild and Clinical Nurse Practitioners. It is important our state does not sleep-walk into changes that will undermine quality GP care.

Rural GPs have not been well served by the bitter division between their two Colleges: the Australian College of Rural and Remote Medicine (ACRRM) and the Royal Australian College of General Practitioners (RACGP). This division originated from the NSW Rural Doctors' Dispute of 1987 and the diverging roles of the urban GP and rural procedural GP. Support for a rapprochement would strengthen the profession.

4 Community/patient factors

Rural communities rarely speak as one rural voice. They have lost further clout following the local council amalgamations. Amalgamations were introduced without consensus. In many city areas, they were de-railed by communities with the wealth and advocacy skills to challenge them. Rural people lacked these factors to oppose these amalgamations, in the same way as they have been able to ensure equitable health care policy and funding.

Rural communities may not be aware, or capable of, supporting IMGs, GP's families, and their social or school needs. These new doctors keep being asked how long they will stay, which in itself is a deterrent from doing so. It is traumatising for patients to have to repeatedly describe their stories to transient doctors. Often, I am asked, "Why do we keep losing our doctors" or "Why can't you keep your doctors". Patients don't want to see new doctors. This means doctors who have been there longer remain overburdened and newcomers may not get the immediate clientele they expected. If the practice owner underwrites their income initially, the criteria for the imposition of payroll tax is reached.

Rural media is struggling to survive due to reduced advertising along with mergers and takeovers. This means media increasingly relies on click bait rather than the education of the community regarding the complex reasons for their healthcare disadvantage.

Waiting times are a disincentive for non-acute care. The other day, I asked someone to have some skin cancer treatments. "But I can never get in" was the response. Here in Australia's oldest electorate, the waiting time to see a local geriatrician (triaged) is seven months.

5 Proposed solutions

a) Facilitate research for better practice and policy:

- Over the last decade or so, I have enjoyed collaboration with a range of brilliant clinicians to research health problems and solutions. Much chronic and complex illness now is considered to be best managed by tertiary multidisciplinary teams. However, it seems to me that city-based solutions cannot simply be transposed rurally. After the GP

Respiratory Clinic project is completed, I would like our practice to host private generalist Allied Health Practitioners co-located with GPs in order to facilitate collaboration on chronic, complex cases in a similar fashion to that seen in tertiary centres. A similar proposal has been floated by the Rural Doctors Association of Australia (13). There has not been an evaluation of health outcomes from such a collaborative primary care service as against tertiary multidisciplinary teams (14). If we could access funding to evaluate cost-effectiveness, we may have identified an innovative and inexpensive approach to providing rural quality health care. However, the lack of clinician-based research funding will preclude an evaluation and make any outcomes invisible and so transitory. Please reinstate rural clinical research grants.

- We need to carefully evaluate all policies designed to enhance the rural workforce over the short and long term (5). Policy and funding should be evidence-based and should be protected from corruption by ideological or marginal seat strategies.
- While it may not be politically appealing, we need state and federal agreement to reform the funding of addiction treatments. This would improve rural health especially for disadvantaged groups such as Aboriginal or Torres Strait Islanders. We must support those requiring opioid dependency treatments such as methadone to access PBS subsidies as well as the "Closing the Gap" discounting. While this has happened with the latest formulation, depot buprenorphine, it is not so for the majority of those on dependency programmes. There is a strong evidence base to show how cost-effective this is with a $5 saving in costs of criminal justice and in health and social care for every $1 so spent (15). Higher rates of alcohol dependency are found in rural areas. Essential alcohol dependency treatments also should be made accessible to disadvantaged groups. This inquiry should call for thiamine and disulfiram (Antabuse®) to receive unrestricted PBS subsidies.

b) Facilitate recruitment.

- We need to address the drivers of workforce maldistribution. Failure to do so means over-stretched clinicians will be constantly choosing between providing better care or having time and energy for their family. Their extra earnings will not cover their divorce costs.

- It is essential that there is coordination between the various Federal and State Departments that currently make recruitment to rural areas a kaleidoscope of barriers. This may be an important role for new National Rural Health Commissioner, Associate Professor Ruth Stewart.
- There is evidential support that case managing the transition to rural life and practice improves recruitment, retention and succession.
- We need to insist Australian-trained doctors spend time rurally. One politician explained to me that no government could do this because the AMA would oppose medical conscription. However, as this is currently being done with IMGs, this argument is fallacious. The taxes of rural communities contribute to finance the undergraduate and postgraduate training of Australian-trained doctors and rural communities should derive direct benefit from these graduates.
- GP registrar training providers should prioritise rural/remote placements before urban placements are allocated.

c) Facilitate retention:

- We need to be creative in how we fund rural general practice. The fee-for-service payments to GPs provide an income identical to those in the city making it relatively unattractive. Consideration needs to be given to reducing administrative burdens for private rural GPs, creating salary packages reflecting their disproportionate hospital, nursing home or public health obligations. Perhaps private rural medical practice could be allocated specific administrative or IT support.
- Registrars and IMGs working rurally should be granted additional time to attain their Fellowship.
- There should be more support for rural GPs to access locums, particularly for family or personal illness.
- We need to encourage rural communities to look past parochialism and embrace their multi-cultural community, especially as an increasing proportion of our health workforce has trained overseas.

d) Facilitate Public benefit from strengthened primary care services

- We need to see better connections between primary care and the hospital sector as well as with health regulators, and not only for disasters. Our rural hospitals need to be supported by clinical and political leadership who will effectively advocate for us. Because it is paid by the state government, the ability of the NSW Rural Doctors Network provide robust advocacy is limited. This organisation should receive sanction to become an effective communication link between government and rural doctors.
- We need to encourage GP supervisors who are training registrars and IMGs. Training the rural workforce of the future is a community service. The policy committee of Revenue NSW needs to be instructed to ensure payroll tax exemptions are given where they benefit the public.
- Funding of rural health services should reflect the additional service burden required due to tourist inflows during holidays. It should also reflect the use of week-ender accommodation by city-siders who often are choosing to work from there during the COVID pandemic.

Conclusions

This inquiry needs to protect our rural communities from the inertia described by the Law of Inverse Care. Based on the evidence described by the Primary Care Paradox, the inquiry should recommend the need to expand and support rural generalist medical services. We need to follow and develop further evidence-based policies regarding improving the maldistribution of the healthcare workforce and how to deliver quality care in regional and remote areas. For their taking on of these challenges, acknowledgment should be given to rural doctors, nurses and dentists and, of course, their families. Given the multitude of factors undermining the delivery of quality health care in the bush described above, rural nurses, dentists and doctors should be commended that our present health outcomes are not far worse.

It is important that this inquiry has canvassed these complex matters. While many inquiry or Royal Commission findings are shelved as politically unpalatable, it is my hope that this inquiry's recommendations are actioned respectfully and effectively by our politicians and regulators.

References

1. Stewart R. Enough seagulls! Rural and remote communities need local researchers living, walking and talking with locals. Medical Journal of Australia. 2020;213(11):514-5.
2. Adair T, Lopez A. Widening inequalities in premature mortality in Australia, 2006-16. Australian Population Studies. 2020;4(1):37-56.
3. Stange KC, Ferrer RL. The Paradox of Primary Care. The Annals of Family Medicine. 2009;7(4):293-9.
4. Basu S, Berkowitz SA, Phillips RL, Bitton A, Landon BE, Phillips RS. Association of Primary Care Physician Supply With Population Mortality in the United States, 2005-2015. JAMA Internal Medicine. 2019;179(4):506-14.
5. Osborne SR, Alston LV, Bolton KA, Whelan J, Reeve E, Wong Shee A, et al. Beyond the black stump: rapid reviews of health research issues affecting regional, rural and remote Australia. Med J Aust. 2020;213 Suppl 11:S3-S32.e1.
6. Holliday S, Morgan S, Tapley A, Dunlop A, Henderson K, van Driel M, et al. The Pattern of Opioid Management by Australian General Practice Trainees. Pain Medicine. 2015;16(9):1720-31.
7. Holliday S, Morgan S, Tapley A, Henderson K, Dunlop A, van Driel M, et al. The pattern of anxiolytic and hypnotic management by Australian General Practice trainees. Drug and Alcohol Review. 2017;36(2):261-9
8. Australian Commission on Safety and Quality in Health Care. The Australian Atlas of Healthcare Variation, Chapter 5: Opioids. Sydney: ACSQHC; 2015.
9. Holliday S, Magin P, Dunbabin J, Oldmeadow C, Attia J, Henry J, et al. An evaluation of the prescription of opioids for chronic non malignant pain by Australian General Practitioners. Pain Medicine. 2013;14(1):62-74.
10. Holliday S, Magin P, Oldmeadow C, Dunbabin J, Henry J, Attia J, et al. An examination of the influences on New South Wales general practitioners regarding the provision of Opioid Substitution Therapy. Drug and Alcohol Review. 2013;32(5):495-503.
11. Holliday S, Hayes C, Dunlop A, Morgan S, Tapley A, Henderson K, et al. Protecting pain patients. The evaluation of a chronic pain educational intervention. Pain Medicine. 2017;18(12):2306–15.
12. Holliday S, Hayes C, Dunlop AJ, Morgan S, Tapley A, Henderson KM, et al. Does brief chronic pain management education change opioid prescribing rates? A pragmatic trial in Australian early-career general practitioners. Pain. 2017;158(2):278-88.
13. Rural patients dying to see a doctor [press release]. 5 June, 2020. https://www.rdaa.com.au/news/rural-patients-dying-to-see-a-doctor
14. Holliday SM, Hayes C, Jones LE, Gordon J, Fraser C, et al. Prescribers or Multidisciplinarians? An Evaluation of Brief Education for General Practitioners on Chronic Pain Management. Health Education in Practice: Journal of Research for Professional Learning. 2020;3(1):5-25.
15. Farrell M, Wodak A, Gowing L. Maintenance drugs to treat opioid dependence. BMJ. 2012;344.