Submission No 391

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

Organisation: Office of the National Rural Health Commissioner

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Submission to the New South Wales Parliament

Portfolio Committee No. 2

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

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Acknowledgement of Country

The National Rural Health Commissioner (the Commissioner) and her Office acknowledges the Traditional Owners and Custodians of Country throughout Australia. The Commissioner recognises and deeply respects the strength and resilience of Aboriginal and Torres Strait Islander people and their continuing connections and relationships to community, rivers, land and sea.

The Commissioner and her Office pay respect to Elders past, present and emerging and extend that respect to all Traditional Custodians of this land and Aboriginal and Torres Strait Islander people reading this document.

The Office of National Rural Health Commissioner

The *Health Insurance Act 1973* (the Act) provides the legislative basis for the appointment and the functions of the National Rural Health Commissioner (the Commissioner) and the Office of the National Rural Health Commissioner.

In accordance with the Act, the functions of the Commissioner are to provide independent and objective advice in relation to rural heath to the Minister responsible for rural health.

This submission was prepared by Adjunct Professor Ruth Stewart, National Rural Health Commissioner.

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Terminology

Rural Generalist - A Rural Generalist is a medical practitioner who is trained to meet the specific current and future healthcare needs of Australian rural and remote communities, in a sustainable and cost-effective way by providing both comprehensive general practice and emergency care and required components of other medical specialist care in hospital and community settings as part of a rural healthcare team.[1]

[1] National Rural Generalist Pathway Taskforce. *Advice to the National Rural Health Commissioner on the Development of the National Rural Generalist Pathway.* Canberra; National Rural Health Commissioner; 2018 p. 5.

Executive Summary

The Commissioner acknowledges and recognises the importance of this Inquiry into health outcomes and hospital services in regional, rural and remote New South Wales (the Inquiry) and thanks the New South Wales (NSW) Parliament, Portfolio Committee No. 2 for the opportunity to contribute to this work.

This Commissioner's submission focuses primarily on the following items from the Inquiry's Terms of Reference.

> (a) health outcomes for people living in rural, regional and remote NSW;
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> (b) a comparison of outcomes for patients living in rural, regional and remote NSW compared to other local health districts across metropolitan NSW;
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> (c) access to health and hospital services in rural, regional and remote NSW including service availability, barriers to access and quality of services;
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> (e) an analysis of the planning systems and projections that are used by NSW Health in determining the provision of health services that are to be made available to meet the needs of residents living in rural, regional and remote NSW;
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> (g) an examination of the staffing challenges and allocations that exist in rural, regional and remote NSW hospitals and the current strategies and initiatives that NSW Health is undertaking to address them;

Referring to Terms of Reference (k) *an examination of the impact of health and hospital services in rural, regional and remote NSW on Indigenous and culturally and linguistically diverse (CALD) communities.* It is recommended that in order improve the appropriateness, cultural safety and cultural responsiveness of NSW health services, deep and ongoing consultation with Aboriginal peak health organisations be undertaken. It is recommended this engagement should include but not be limited to the National Aboriginal Community Controlled Health Organisation (NACCHO) and affiliates, Indigenous Allied Health Australia (AIHA), National Association of Aboriginal and Torres Strait Islander Health Workers and Practitioners (NAATSIHWP), Australian Indigenous Doctors Association (AIDA) and Culturally and Linguistically Diverse (CALD) peak bodies and representatives. The Commissioner also recommends ongoing consultation with health consumer representative peak organisations who have connections with CALD and Aboriginal and/or Torres Strait Islander communities and more broadly with health consumers.

The Commissioner would like to acknowledge the New South Wales rural and remote health workforce who continue to provide high quality health services to rural and remote communities in spite of often working in challenging environments, in health systems designed for high density metropolitan environments. 2020 has been a particularly challenging and distressing year for rural and remote communities in New South Wales with devastating droughts and bushfires followed by the COVID-19 pandemic. NSW rural health professionals have kept working throughout these compounding challenges. They have provided care while adapting themselves to new ways of delivering care safely, for example establishing general practice respiratory clinics; all of this while border restrictions affected

supply of equipment and staff. They deserve to be recognised, thanked, supported and importantly they deserve to be listened to in order to improve the systems of care they work in.

The National Rural Health Commissioner's response to Portfolio Committee No. 2 – Health: *Inquiry into health outcomes and hospital services in regional, rural and remote New South Wales*.

Terms of Reference:

a) Health outcomes for people living in rural, regional and remote NSW

b) Comparison of outcomes for patients living in rural, regional and remote NSW compared to other local health districts across metropolitan NSW;

Australians enjoy some of the best health outcomes in the world [i] and those benefits are concentrated in our urban centres. Approximately seven million (30% of) Australians live outside of urban centres in regional, rural and remote settings, nearly 2 million live in regional, rural and remote New South Wales. [ii] [iii]

Statistically Australians who live in rural and remote regions are more likely to experience poorer health outcomes than their urban peers. On average, the more remote your residence, the shorter your life span and the greater the burden of disease carried by your community.[iv] This is evident when observing median age at death rates in New South Wales; in urban areas (*Major cities)* it is 82 years, in *Regional and remote* areas 76 years and in *Very remote* areas median age at death is 14 years younger, 68 years.[v] New South Wales rates of premature deaths per 100 000 people show a similar pattern where in *Remote* (407.6) and *Very remote* NSW (475.6) rates are approximately double the rate of NSW *Major cities* (220.3) and higher than the averaged national rates in the same remoteness categories.[vi]

The rates of years of life lost in *Remote* and *Very remote* NSW are second only to Northern Territory, which has the highest rates in the country. [vii] These figures reveal the stark urban – rural health divide in New South Wales.

(c) Access to health and hospital services in rural, regional and remote NSW including service availability, barriers to access and quality of services;

It is important to acknowledge that geographically determined life expectancy and disease inequity at the urban- rural interface is seen internationally. This is largely a factor of the psychosocial determinants of health; that is the burden of disease relates to geographic, societal and system level factors. The challenge for health care policy makers is to address

these and overcome the twin tyrannies of distance and isolation which ultimately result in increased barriers to accessing care.

The ability to access appropriate care, when it is needed, is key in effective disease prevention, management of chronic disease and in improving health outcomes. The risk to patient health outcomes increases when access to the right care, at the right time, is compromised. Where there are access and system barriers, the risk unfairly shifts to the patient and adverse outcomes are more likely to occur.

Rural and remote Australians experience increased difficulty accessing care, 20% of people who live in *Remote and very remote areas* report not having a GP nearby as a barrier to seeing one, compared with 3% of those living in *Major cities*. Fifty- eight percent report not having a specialist nearby as a barrier to seeing one, compared with 6% in *Major cities*.[viii,ix] These factors contribute to the higher burden of chronic disease and shorter life expectancy seen in rural and remote communities.[x] In 2014, 5.1 per 100 people living in *Outer regional and remote* NSW reported experiencing barriers to accessing healthcare when needed in the previous 12 months. This rate is considerably poorer than the national rate of 1.9 per 100 people, in the same remoteness category. [xi]

An example of the impact of increased barriers to accessing health care can be seen in the participation rates in cancer screening. The National Bowel Cancer Screening Program participation rates in Remote (30.2%) and Very remote (26.7%) NSW are lower than the national rates of 27.8% and 35.8 % respectively. The incidence of bowel cancer in those areas are higher than national comparative rates, as are deaths from colorectal cancer. In Very remote NSW the rate of death from colorectal cancer is significantly higher with 22.3 deaths per 100 000, compared to the national rate of 7.3 deaths in the same remoteness category.[xii]

(g) an examination of the staffing challenges and allocations that exist in rural, regional and remote NSW hospitals and the current strategies and initiatives that NSW Health is undertaking to address them;

(e) an analysis of the planning systems and projections that are used by NSW Health in determining the provision of health services that are to be made available to meet the needs of residents living in rural, regional and remote NSW;

Supporting a Rural Health Workforce

While Australia has one of the highest ratios of doctors per head of population in the world this workforce is not distributed proportionately across the country. It is concentrated in the urban centres. Data collected in 2015 and published by the Australian Institute of Health and Welfare indicate that the overall supply of employed medical practitioners varied from

442 full-time equivalent (FTE) per 100,000 population in *Major cities* to 263 in *Remote* and *Very remote* areas.[xiii] The rate of specialists also substantially declines with increasing remoteness from 143 per 100,000 people in *Major cities* to 22 per 100,000 population in *Very remote* areas.[xiv]

One of the reasons for the disparity of workforce distribution is the economics of health service provision. Health care professionals are expensive to employ and of this workforce doctors are the most expensive. For it to be viable to employ a doctor it requires that they are seeing enough patients and providing enough services to draw in sufficient funds to sustain their employment in a public system, or to satisfy expectations in a private system. There must be enough people in a given community who the doctor can treat to support that doctor's employment in that community. If a doctor's activity is focussed on one sector of the community either by age or disease profile (eg. A paediatrician who attends only children or a rheumatologist who attends only those patients with joint conditions) that doctor will need a larger population to support their activity than would a generalist doctor (such as a GP or Rural Generalist). This is the economics reality that sees towns of 15,000 people or less serviced by the latter and towns with 50,000 or more residents serviced by the former. The risk is that when the supply of doctors is dominated by consultant specialists there will be too few doctors to work in the towns of less than 50,000 people.

This simple equation is complicated by another factor. General Practitioners can be trained for a concentrated range of office and community care or they can be trained to deliver comprehensive general practice, emergency care and required components of other medical specialist care in hospitals and community settings (Rural Generalist).

The setting for the Rural Generalist is primarily in smaller towns without the critical mass to support larger medical specialist teams, where they provide additional skills but are still part of regional networks of providers. It is in such towns of less than 20,000 people where the supply of health services is most under pressure. In communities where there are no consultant specialists, Rural Generalists can attend to the common and emergent health issues and are vital to delivering high quality care across Australia.

At present only one in ten General Practitioner registrars complete training to become Rural Generalists. This does not match the proportion of the Australian population who lives in rural, remote or very remote locations. It certainly is not enough to fill the existing employment vacancies in these areas and it will not replace the ageing cohort of existing rural doctors as they retire. The NSW Health Department could increase support for the training of Rural Generalists and thus increase the proportion of the workforce that is suitably trained for rural practice. Experience elsewhere in Australia indicates that such investment when added to the impact of the Murray Darling Basin Medical School Program[2] significantly improves the numbers of doctors ready and willing to work in rural NSW.

[2] In May 2018 the Australian Government announced funding for the Murray Darling Medical School Network Program to expand end-to-end training for medical students in a number of rural locations by increasing the number of Commonwealth Supported Student placements in medical schools. This program is part of a suite of

The National Rural Generalist Pathway

The Australian Government recognises the importance of generalist skills in rural health settings and has invested in the development of a national training pathway for Rural Generalists, that is, General Practitioners working to their broadest scope across primary and secondary care with emergency care and at least one additional skill.

The National Rural Generalist Pathway (the Pathway) will provide end-to-end medical school education followed by five to six years of postgraduate training delivered through integrated teaching and training health service networks across regional, rural and remote Australia.

The Pathway will see increased numbers of rural and remote students enrolled in medical schools and studying in rural and remote communities at rural clinical schools. There is strong evidence that rural primary schooling teamed with rural clinical school training results in a greater proportion of medical graduates choosing to work in rural locations. This positive rural and remote orientation is compounded when vocational training can be provided in the rural or remote context by skilled and supportive supervisors.

Rural Generalists are currently delivering services to rural and remote communities. Commonwealth investment will see a further 350 Rural Generalists per year completing their fellowship training with the Australian College of Rural and Remote Medicine (FACRRM) or with the Royal Australian College of General Practitioners (FARGP). Any workforce planning that occurs in rural and remote health service provision needs to incorporate this highly skilled and rapidly growing workforce.

Sub-regionally Based Integrated Service Models of Care

While the Australian health system is recognised for providing cost-effective, high quality care, the benefits of this system are experienced to a greater extent in the densely populated urban regions for which it was designed. Current siloed approaches to funding, training and health service provision that separate acute and chronic care, mental and physical health, and hospital and community care are failing both our rural patients and clinicians. Patients fall through the cracks when service integration is lacking.

In urban settings distance is not a major problem nor is geographic isolation, in rural and remote areas however, distance and isolation can seriously impede the effective delivery of health care. Rural communities want local, culturally responsive and connected health care services with professionals with whom they can build connections and trust. Neither fly-in fly-out services nor a rotating cycle of *locum tenens* are considered optimal by communities.

Local determination of health services and the co-design of models of care with community, ensures cultural appropriateness and acceptability. Historically paternalistic paradigms of

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measures contained in the *Stronger Rural Health Strategy* to address education, training and service provision and reproduces the successful strategies for producing a rural workforce demonstrated by the medical schools at James Cook University and Wollongong University.

service design have resulted in services that community members are unwilling and feel unsafe to utilise. Rural and remote people are calling for service delivery that is close to home and provides continuity of care by known carers.

To address rural health inequities, what is needed is 'fit for purpose' and locally designed rural models of care with structured support for the health professionals who work within them. These models are currently being tested in some rural and remote subregions in Australia.

In New South Wales, the Australian Government has recently announced funding to implement five rural models of care designed by local communities and health services, in rural areas where thin markets and workforce shortages have existed for some time. These models are collaborative, have meaningful intersections across sectors, share workforces and operate at multi-town, sub-regional levels. These models are exploring how health services can integrate across public, private and not for profit sectors and associated funding streams, functioning as single subregional systems of care.

Concluding Remarks

Generalists with broad knowledge and skills who can work with people of all ages and cultures and treat a wide range of conditions are needed in regional, rural and remote Australia. The adage that common conditions occur commonly is worth remembering and speaks to the required skill set outside urban centres. Rural Generalists provide a flexible workforce, increasing adaptability in the face of changing demand. Local generalists working in multi-professional sub-regional teams, supported through telehealth services and visiting specialists is a sustainable and achievable model for regional, rural and remote Australia.

Current attempts at siloed approaches to funding and service provision are failing both our patients and clinicians in regional, rural and remote communities. Drought, bushfires and the COVID-19 pandemic have highlighted the importance of local generalist clinicians to respond to immediate needs. Integrated health services across primary care settings and the acute care sector and across subregions will assist both care for people experiencing acute and chronic conditions and in the care continuity required in their management and recovery.

[i] E. C. Schneider, D. O. Sarnak, D. Squires, A. Shah, and M. M. Doty, Mirror, Mirror 2017: International Comparison Reflects Flaws and Opportunities for Better U.S. Health Care, The Commonwealth Fund, July 2017. [cited 2020 Sep. 16]. Available from: https://www.commonwealthfund.org/publications/fund-reports/2017/jul/mirror-mirror-2017-international-comparison-reflects-flaws-and

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[ix] Australian Institute of Health and Welfare. Survey of Health Care: selected findings for rural and remote Australians [Internet]. Canberra: Australian Institute of Health and Welfare, 2018 [cited 2020 Sep. 16]. Available from: https://www.aihw.gov.au/reports/rural-remote-australians/survey-health-care-selected-findings-rural-remote

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[xiii] *Ibid,* p. 15; Australian Institute of Health and Welfare. Medical Practitioners Workforce 2015. Canberra; Australian Government: 2016.

[xiv] Australian Institute of Health and Welfare 2019. Rural & remote health. Cat. no. PHE 255. Canberra: AIHW. Viewed 04 December 2020, https://www.aihw.gov.au/reports/rural-remote-australians/rural-remote-health