Submission No 394

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

Organisation: NSW Rural Doctors Network (RDN)

Date Received: 18 January 2021

18 December 2020

NSW Parliament Portfolio Committee No. 2 – Health
C/O Mr Chairman, The Hon. Greg Donnelly, MLC
Parliament House
Macquarie Street
SYDNEY NSW 2000

To the Portfolio Committee,

NSW Rural Doctors Network response to the NSW Parliament inquiry into the health outcomes and access to health and hospital services in rural, regional and remote New South Wales

NSW Rural Doctors Network (RDN) is a not-for-profit, non-government charitable organisation that provides solutions to support the multidisciplinary rural health workforce. RDN acts as the Australian Government's designated Rural Workforce Agency for health in NSW, and is the NSW fundholder for Rural Health Outreach and range of associated service programs.

RDN takes a strategic, evidence-based and collaborative approach to develop localised workforce and service models that enable access to health care. Over more than 30 years, RDN has demonstrated that improved health outcomes and practitioner wellbeing are best achieved through a patient-centred, multidisciplinary team-based primary health care service model. This approach also provides a range of opportunities to improve primary health care workforce attraction, recruitment and retention in rural NSW.

RDN's history

RDN began in 1988 as an organisation supporting the recruitment and retention of rural general practitioners (GPs). The organisation has evolved to support the broader multidisciplinary rural health workforce including GPs, rural resident and non-resident medical specialists, allied health practitioners, nurses, midwives, Aboriginal Health Practitioners and Workers, practice managers, carers and health administrators.

RDN today

RDN's work adapts and responds to contemporary issues and needs using evidence-informed approaches. RDN is acutely aware of the direct and indirect impacts of Federal and State policy, changing population distribution, climate change, natural disasters and emergencies, digital technologies, business governance and legislative requirements, health workforce demographics and life-balance expectations.

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NSW Rural Doctors Network activities are financially supported by the Australian and NSW governments

Today, RDN's service streams navigate these and related issues to develop and provide town-based and regional workforce planning, workforce and practice support, sustainable practice business models, health outreach services, grants and scholarship initiatives, education and training, future workforce programs, health policy and industry network coordination, and health workforce data and knowledge mobilisation. More information about RDN's strategy and activity is available at the following links:

- RDN's website
- 2019-22 RDN Strategic Plan
- RDN Primary Health Workforce Needs Assessment
- Rural Health Pro
- Rural Health Together

RDN welcomes the opportunity to provide input to the NSW Parliament inquiry into the health outcomes and access to health and hospital services in rural, regional and remote New South Wales (the Inquiry). This submission captures the general views of RDN and its policy advice that is drawn from annual primary health workforce needs assessments, evaluations, reporting activities, surveys and subject matter experts.

The disparity in health outcomes and services access for rural communities is well documented and RDN supports the Inquiry's intent to address this challenge. This submission includes recommendations that are relevant to RDN's role and work across the rural health system that encompasses both state and federally funded components. RDN supports the Bilateral Health Forum between NSW and the Federal Government and believes this joint approach will lead to positive outcomes.

These recommendations respond to improving health outcomes and access to health and hospital services in rural, regional and remote NSW.

The scope of RDN's input comprises five recommendation categories:

1. Support the rural health workforce to increase access, including General Practitioner proceduralists, Visiting Medical Officers and Rural Generalists.
2. Support the capability of the workforce to deliver deliberate team-based care
3. Support collaborative planning for regions
4. Support technology-enhanced care and telehealth as a quality and access improvement tool that is complementary to face-to-face care and a workforce retention tool
5. Support access to health services for rural and vulnerable populations, including children, older Australians, Aboriginal people and those with culturally diverse backgrounds.

Recommendations

RDN identifies the following recommendations as being relevant and useful for the Committee's final report to endorse or consider. RDN also acknowledges there is a range of existing initiatives and programs in place that align with these recommendations.

R1. Support the rural health workforce to increase access, including General Practitioner proceduralists, Visiting Medical Officers and Rural Generalists.

R1.1 As a matter of state priority, invest in the development and implementation of a targeted recruitment and retention strategy that also addresses the workforce's capability, wellbeing and succession planning for the ageing rural primary health workforce. This strategy should include the rapidly decreasing numbers of General Practitioner (GP) proceduralists, Visiting Medical Officers (VMOs) and Rural Generalists (RG).

R1.2 That state agencies support the provision of rural GP and RG training to be more accessible, appealing, provide employment security and reduce complexity. The future workforce can perceive current GP training pathways as having substantial barriers, lacking clarity, segregated and reduced employee benefits that may be unappealing for the future workforce.

R1.3 That state and federal health funding mechanisms acknowledge and resource the sustainability of GP practice business models, including the time GPs and practices spend coordinating patient care and navigating the system. This time is integral to better health outcomes but is generally not acknowledged, measured and resourced by current funding mechanisms.

R1.4 Support sustainable and innovative approaches to workforce models in rural communities when needed, such as the 'single employer' model for people undertaking training and supporting GP VMOs. For example, RDN is currently partnering with health agencies and rural communities to trial approaches that achieve sustainable models in five sub-regions in NSW. This approach can be applied to other rural communities with investment.

R1.5 Recruit an appropriate balance of early-career doctors, i.e. 1st and 2nd year or specialist registrars, and experienced doctors in rural health services to facilitate rural workforce consistency and a supportive environment that is attractive for early career doctors.

R1.6 That all rural public health infrastructure investments and government planning encompass consideration of the health workforce capacity needed to support these decisions. This would include planning for the rural health workforce alongside capital investment into new or expanded hospital infrastructure, refugee migration to rural communities and other development or social initiatives.

R1 context

The GP, VMO and Proceduralist workforce is a highly trained and multiskilled medical cohort well suited to remote and rural community service. It enables the delivery of high-quality primary care in community practice, emergency, acute and sub-acute care in Local Health District (LHD), Multipurpose Services (MPSs) and district facilities. The GP VMO Proceduralist workforce is in decreasing supply in rural

NSW, with 177 remaining in practice as of September 2020, with just over half of these aged over 50. Such trends suggest the cycle of declining numbers will not abate and could mean the rural NSW GP Proceduralist workforce dwindles to fewer than 100 in 10 years. The situation will worsen without targeted intervention which would have a negative impact on rural communities' access to health services and patient outcomes.

There are several contributing factors increasing the strain on clinicians, providers and communities, including systems-related difficulties in establishing and sustaining a cohesive succession plan for an ageing workforce. This strain has a cumulative impact - real or perceived - on the attractiveness of rural general practice and engagement in rural GP proceduralist activity.

The future health workforce can perceive barriers related to pursuing rural general practice as a career. At the point of becoming a GP, doctors need to leave their employment with hospitals and essentially become self-employed, working out of a private practice, while still being required to train under supervision, and lose any accrued employee benefits in the process.

The amount of time and effort GPs and their practices spend supporting patients is not measured or adequately acknowledged and resourced. Time spent coordinating patient care and necessarily supporting patients to navigate the system results in a lack of time to attended to other patients or perform non-acute activities such as preventive health. This activity is generally not measured or remunerated, which may impact on the sustainability of these important coordination, navigation and prevention roles and the consistent quality of patient care.

Feedback indicates that an imbalance of early career and experienced doctors can result in high turnover of the medical workforce. Early career doctors, specifically year 1, 2 and specialist registrars, are required to rotate around health departments and settings as part of their training which may reduce consistency for communities. In addition, if not given adequate support, early doctors can be 'thrown in the deep end' which may be a disincentive to pursuing a rural health career. Early career doctors have an integral role in contributing to rural health service capacity and are tomorrow's experienced workforce; however, their utilisation should be balanced with appropriate support from experienced doctors.

R2. Support the capability of the workforce to deliver team-based collaborative care

R2.1 Invest in a sub-regional workforce planning approach which considers the strengths and collaboration of towns within a region to build a sustained and viable, team-based model that has the necessary critical mass. This approach would include resourcing groups of communities, health professionals, practices state facilities to partner and pool workforces, funding streams, link systems and coordinate patient-centred care. Examples of this are discussed at R1.4 and would include the non-GP health workforce.

R2.2 Invest in technology systems, tools and their uptake by the health workforce and facilities that will increase the quality of effective and efficient communication and patient record management between health professionals in private practices and acute facilities.

R2.3 Support mechanisms that build resilience and strengthen capability at individual, community and operational levels to prepare for natural disasters and emergencies.

R2.4 Facilitate the state-wide credentialing of the health workforce, including GPs and doctors, nurses and allied health practitioners, to support rapid responses to any LHD region facing natural disasters or emergencies such as bushfires, drought or pandemics.

R2.5 Take steps to acknowledge and celebrate rural health professionals and the world-leading health services they provide to support the retention of the rural health workforce and promote the attractiveness of a rural career. This move is proposed to counteract sometimes negative portrayals of rural health providers caused by the public profiling of anecdotal or inflated adverse events.

R2 context

RDN believes in capability, and that primary health professionals are at their most capable when they are supported to positively respond and contribute to life in rural communities.

RDN defines capability in the context of the rural health workforce as what makes up the whole of the person[1]. This includes clinical competence and confidence; valued continuing professional development options; emotional, physical, 'spiritual' and cultural wellbeing; family wellbeing and stability; social connectedness; financial stability and security; working on a purpose that matters to the individual; healthy and effective workplaces; and a healthy environment and positive workplace relationships.

Greater disaster resilience can be achieved through building capability at the individual, community and operational levels, which can be applied to responding to and recovering from a wide range of disasters and emergencies.

Some clinicians encountered regional/LHD credentialing barriers when responding to areas of workforce need during natural disasters and emergencies in the last 24 months. Credentialing has an important quality assurance function; however, streamlining this through state-wide recognition of LHD credentialing, with the option to adapt scope of practice as needed, would increase cross-region responsiveness to emergencies and generally streamline health practitioner recruitment to regions.

The NSW health system, including its rural components and workforce, is of enviable quality and provides excellent patient care and rewarding careers. In recent times there have been several very negative portrayals of the rural health system in the public domain. These broadcasts, when not accurate or balanced, can foster negative perceptions of rural health among the general public that can impact the incumbent rural health workforce and those considering rural careers.

[1] Martiniuk AL, Colbran R, Ramsden R et al. Capability … what's in a word? Rural Doctors Network of New South Wales Australia is shifting to focus on the capability of rural health professionals. Rural and Remote Health 2020; 20: 5633

R3 Support collaborative planning for regions

R3.1 Support state and federally funded regional health agencies, Aboriginal health organisations and private providers to collaborate in planning and funding the rural health workforce. This support may include utilising the Primary Health Workforce Needs Assessment undertaken annual by Rural Workforce Agencies such as RDN, to inform service planning.

R3.2 Invest in developing the evidence base for effective rural workforce health planning approaches, methodologies and models to inform policy. This investment would include evaluation of current models of deliberate team-based care and sub-regional approaches identified in R1.4 and workforce planning resources that can be used at the state and local health district level.

R3.3 Identify and support mechanisms to focus planning in response to community needs as a common driver. This approach would include collaborative processes state health agencies and other providers can use to overcome fragmentation and siloing of the rural primary health workforce between funding sources, governance and reporting structures, sectors and geographical locations.

R3.4 Support a collaborative approach to multi-agency data mapping and needs assessments including the data collaborations and formalised agreements that appropriately balance the need for providing planners with necessary service need and workforce information to undertake effective planning with the ethical use of data and its analysis.

R3.5 Support communities to access consumer-friendly and contemporary information to enhance their literacy of the rural health workforce, enablers of attraction and retention and broader knowledge of health services and systems.

R3 Context

The challenge of delivering services in small remote and rural communities is well known, and it is clear a one-size-fits-all approach to sustaining the health workforce does not work for every community.

The collaborative approach to a sustainable rural health workforce project is being undertaken by RDN in partnership with rural communities and health agencies (see R1.4). The Project aims to develop an approach that will increase rural communities' access to quality and sustainable health care by developing locally defined, sub-regional health workforce solutions. As part of this project, a scalable methodology that identifies enablers to achieving sustainable workforce models will be developed. It is envisaged the methodology can be translated to other rural communities.

The Project will continue to work in close partnership with local health professionals, practices and state facilities to shape unique primary care models for five sub-regional sites that have been identified. The learnings from developing these sites can then support similar sub-regional approaches in remote and rural areas across Australia.

RDN believes the health workforce literacy of rural communities is important to creating an environment that is attractive and enables the retention of the health

workforce[2]. Literacy includes the community's knowledge about a whole-of-person approach to attraction and retention that extends beyond remuneration or work conditions to the wider professional environment, social connectedness and life opportunities for the workforce, their families and associates.

R4 Support technology-enhanced care and telehealth as a quality and access improvement tool that is complementary to face-to-face care and a workforce retention tool

R4.1 Confirm state government acknowledgement of telehealth and its range of technology solutions is an important tool for increasing access to health care and enhancing its quality for people living in rural areas.

R4.2 Invest in telehealth service and funding models that facilitate community access to high-quality general practice, allied health, nurse-led, midwife and Aboriginal Health Workers. Telehealth service models and supplementary service models have proven to be effective in increasing access and health care quality in Australia. This investment may encompass supporting and profiling exemplars of telehealth best practice that can be used as reference models and resources for other practices.

R4.3 That planning and investment made in telehealth is undertaken through collaboration with rural stakeholders, reduces the burden on rural clinicians, and - importantly - resources rural practices and host facilities to provide telehealth models.

R4.4 Acknowledge that telehealth is a tool that enables access, improves quality and does not replace face-to-face care. This recognition and understanding will support continuity of care.

R4.5 That consideration be given to funding infrastructure required by practices to continue full utilisation and embed telehealth into practice, including communications connectivity between practices and health practitioners in rural areas, and system compatibility between acute and private practice settings.

R4 Context There are concerns about the lack of integrated technology currently employed to support the workforce to deliver team-based collaborative care. Current systems differ between hospitals, private practices and other service providers. Having integrated systems that communicate between all health services in rural and remote NSW would remove some barriers related to service access.

The use of telehealth shows several technical issues; however, a considerable barrier to access is predominately a clinical workflow issue, especially in primary care environments. The current discussion around telehealth often focuses on its rural-to-urban use, rather than the importance it has on improving care coordination and patient outcomes by enhancing team-based care, collaboration and patient access between rural or regional settings. There is no national governance body for the deployment and development of telehealth from a national perspective. It has been

[2] Martiniuk, A., Colbran, R., Ramsden, R. et al. Hypothesis: improving literacy about health workforce will improve rural health workforce recruitment, retention and capability. Hum Resour Health 17, 105 (2019)

argued that such a body should exist and look for tripartite participation from government, private health and private industry.

Medicare does not remunerate most of the primary health workforce to provide telehealth services, and there is minimal funding for rural practices to host patients to attend telehealth clinics which is a resource-consuming service. Only medical specialist and some psychology telehealth attendances can be claimed from Medicare, which leaves most of the rural primary health workforce without access to funded telehealth as a tool to increase patient access to quality and sustainable health services. Outside of temporary COVID-19 measures, telehealth items broadly exclude GPs, allied health practitioners, Aboriginal health practitioners and nurse attendances.

It is known that telehealth is perceived as a retention tool for some local practitioners. Practitioners can seek professional support via telehealth to provide localised care of patients, and it is also a vital tool for training and Continuing Professional Development (CPD) for rural practitioners.

Adoption of telehealth should not be about rural versus urban but rather the benefits it can have on improving care coordination and patient outcomes by enhancing team-based care, collaboration and patient access.

R5 1. Support access to health services for rural and vulnerable populations, including children, older Australians, Aboriginal people and those with culturally diverse backgrounds

R5.1 Invest in services that increase access for patients and carers with child health, mental health and aged care needs. This investment could include a range of models to address these service gaps that include leveraging the primary health workforce through telehealth, rural training opportunities, rural generalists, and multidisciplinary or outreach models that span the acute, primary health and specialist providers.

R5.2 Investment and planning to develop culturally safe public health pathways for Aboriginal patients, carers and families. This investment would necessarily involve co-designing pathways with organisations that represent Aboriginal communities, including Aboriginal Community Controlled Health Services and Aboriginal Land Councils.

R5.3 Support the growth and development of the Aboriginal primary health care workforce across all professions, in conjunction with Aboriginal workforce peak bodies and the Aboriginal Health and Medical Research Council of NSW.

R5.4 Support the provision of integrated training and employment opportunities to allow Aboriginal health professionals to have the choice to remain in their communities and pursue a health career.

R5.5 Support the development of public health services that are culturally suitable and safe for people from culturally and linguistically diverse backgrounds, including migrant and refugee populations in rural areas.

R5 Context

RDN has undertaken and responded to annual service needs assessments or more than a decade. These have consistently identified rural communities have limited access to paediatric and child health services, mental health services and those needed by older Australians.

There is a lack of access to education and career pathways for Aboriginal and Torres Strait Islander communities. This leads to Aboriginal people being significantly underrepresented in the health workforce and impacts on the system's ability to provide culturally informed and responsive care. A perceived lack of career pathway exists, which further results in low attraction to early-career nurse and midwifery workforce and hinders succession planning.

There are examples of rapidly increasing migrant and refugee populations in rural areas that are not accompanied by the necessary investment in planning and resourcing of the primary health workforce and culturally safe services to support and maintain access to high-quality care.

RDN acknowledges the importance of this inquiry for the millions of residents in remote, rural and regional NSW, and the health workforce that supports them. RDN would welcome the opportunity to present and discuss the scope of this submission.

Furthermore, RDN would like to thank the NSW Parliament and the Portfolio Committee for initiating this inquiry and appreciates the opportunity to inform policy through this response.

Yours sincerely,

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