Submission No 453

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

Organisation: Australian Salaried Medical Officers' Federation (NSW) (ASMOF)

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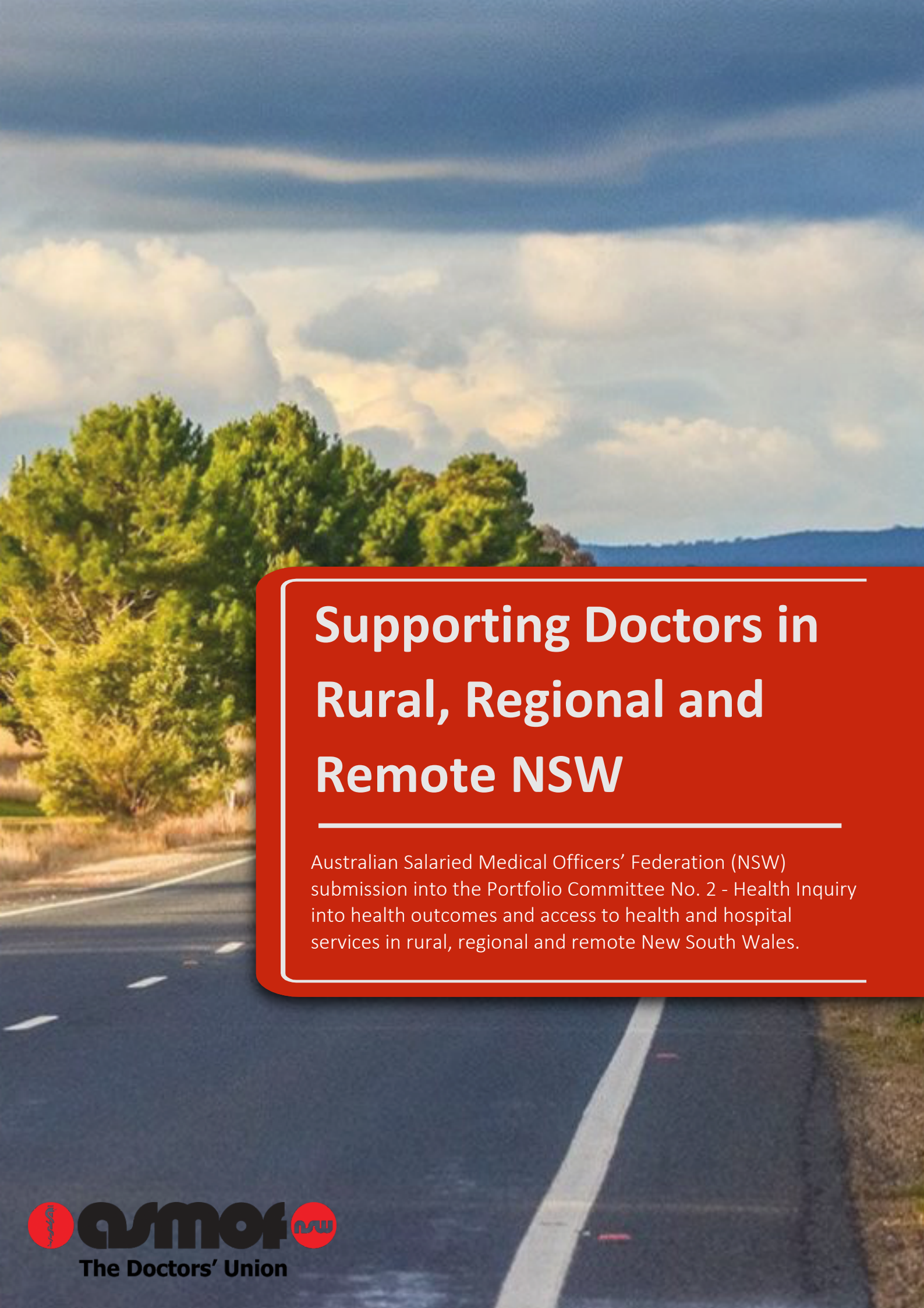

Supporting Doctors in Rural, Regional and Remote NSW

Australian Salaried Medical Officers' Federation (NSW) submission into the Portfolio Committee No. 2 - Health Inquiry into health outcomes and access to health and hospital services in rural, regional and remote New South Wales.

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The Doctors' Union

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The Doctors' Union

Introduction

The Australian Salaried Medical Officers' Federation (ASMOF) NSW is the Doctors' Union, representing over 5,000 Registered Medical Practitioners including Staff Specialists, Post Graduate Fellows, Clinical Academics, Career Medical Officers and Doctors in Training including Interns, Resident Medical Officers and Registrars who are directly employed in the Public Hospital system, Affiliated Health Facilities, Private Hospitals and in Community Health. ASMOF NSW prides itself on its long history of advocacy for doctors working in rural, regional and remote (RRR) health, and for reasonable levels of health services in RRR communities. We are grateful for the opportunity to provide a submission to this inquiry and hope that this submission will provide a meaningful perspective to understand the issues impacting doctors in RRR health.

RRR health faces a plethora of challenges posed by geography, low population density, an ageing population, lengthy travel times and difficulties in recruitment and retention of a skilled professional workforce. The data unequivocally reveals that people living in RRR areas are beset with poorer health outcomes and higher rates of hospitalisations, mortality, injury and less access to health care services, in contrast to those living in metropolitan areas.

In order to better understand the inequities in service delivery, access and health outcomes for people within RRR health, we have sought written feedback and conducted virtual meetings with ASMOF members in RRR hospitals. The experiences of doctors shine a light on the vulnerability of RRR hospitals to systemic understaffing and under-resourcing. These conditions expose patients to unacceptable risks and are known to exacerbate disparities in health outcomes and access to health in RRR areas, compared to metropolitan areas.

We have detailed a range of proactive measures, informed by doctors, which we believe must be comprehensively implemented to ensure that doctors working in RRR health have safe working conditions, are able to provide RRR populations with current standards of accepted medical practice, and are valued and are supported by RRR Local Health Districts (LHDs).

Summary of Recommendations

1. The NSW Government must immediately invest in RRR Health to support the short-term and long-term viability of RRR hospitals and ensure patient care is aligned with community and medical standards.

2. The NSW Government must develop a properly funded, data-based strategy to improve RRR healthcare, with data made public to monitor performance and enhance accountability.

3. NSW Health needs to increase the provision of essential services to rural hospitals to ensure RRR populations have access to current standard of accepted medical practice.

4. NSW Health must improve rostering arrangements in RRR LHD's, ensuring consultation is undertaken and compliance with the relevant awards, policy provisions and the Work Health and Safety Best Practice guidelines to safeguard the wellbeing of both staff and patients.

5. NSW Health must build a culture in rural LHD's that supports the taking of leave and sick days, particularly in light of the transmission risks posed by of COVID-19.

6. NSW Health must immediately focus on capacity building within the RRR doctor workforce by employing more permanent staff under secure employment contracts.

7. NSW Health must develop a comprehensive retention plan with additional funding to incentivise doctors to relocate to RRR areas, including through scholarships, reintroducing a HECS reimbursement scheme, and assisting and subsidising relocation.

8. The NSW Government must resolve networking deficits between smaller RRR hospitals and better resourced hospitals and work more efficiently with other jurisdictions to optimise healthcare performance.

9. NSW Health must support cultural change within RRR LHDs, ensuring hospital management understands and acknowledges the requirements to provide office accommodation, admin support, non-clinical time and support research under the *Staff Specialists (State) Award* 2019.

Remoteness Classification

This submission utilises data analysed under the Australian Statistical Geography Standard Remoteness Structure, 2016, which defines remoteness areas into 5 classes of relative remoteness across Australia; major cities, inner regional, outer regional, remote and very remote (Figure 1.1). This classification provides a useful framework as it is centred on the Accessibility/Remoteness Index of Australia, which classifies remoteness based on the road distances people have to travel for services. For the purposes of this submission, outer regional, remote and very remote areas will be referred to as 'remote'. The term 'regional' will be used to refer to all areas that fit within the category of inner regional, and the term 'rural' will be used as blanket term used to refer to geographical areas outside of major cities.

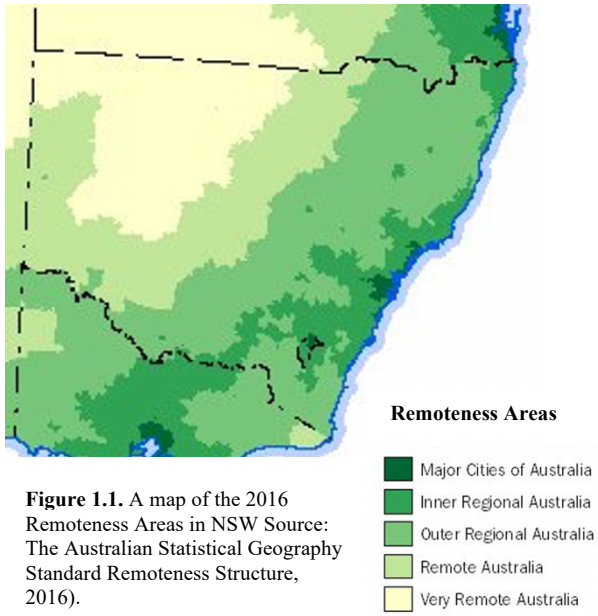

Figure 1.1. A map of the 2016 Remoteness Areas in NSW Source: The Australian Statistical Geography Standard Remoteness Structure, 2016).

The classification of LHD'S is difficult in light of the shear geographical size of some rural LHD's. There are fifteen Local Health Districts responsible for providing healthcare in NSW. The NSW Ministry of Health classifies seven of these LHD's as comprising rural areas: Far West, Hunter New England, Mid North Coast, Murrumbidgee, Northern NSW, Southern NSW, Western NSW.[1] The remaining eight LHD's are classified as metropolitan. However, the rural/metropolitan dichotomy requires a much more nuanced approach, as hinted to in the Bureau of Health Information's analysis, which reveals considerable variation in remoteness profiles (Figure 1.2).

The varying degrees of remoteness within LHD's that are classified as metropolitan is reflected in the marked disparities in access to health and hospital services within these LHD's. During consultation with ASMOF members in Illawarra Shoalhaven LHD, which is classified as a metropolitan LHD, doctors reported that Wollongong is equipped with reasonable resources similar Sydney, however in more rural areas such as Kiama and Shellharbour LGA, one ASMOF member reported that "patients are deprived from basic services". Similarly, doctors in the Hunter New

[1] 'Local health districts', NSW Health**,** (https://www.health.nsw.gov.au/lhd/Pages/default.aspx)

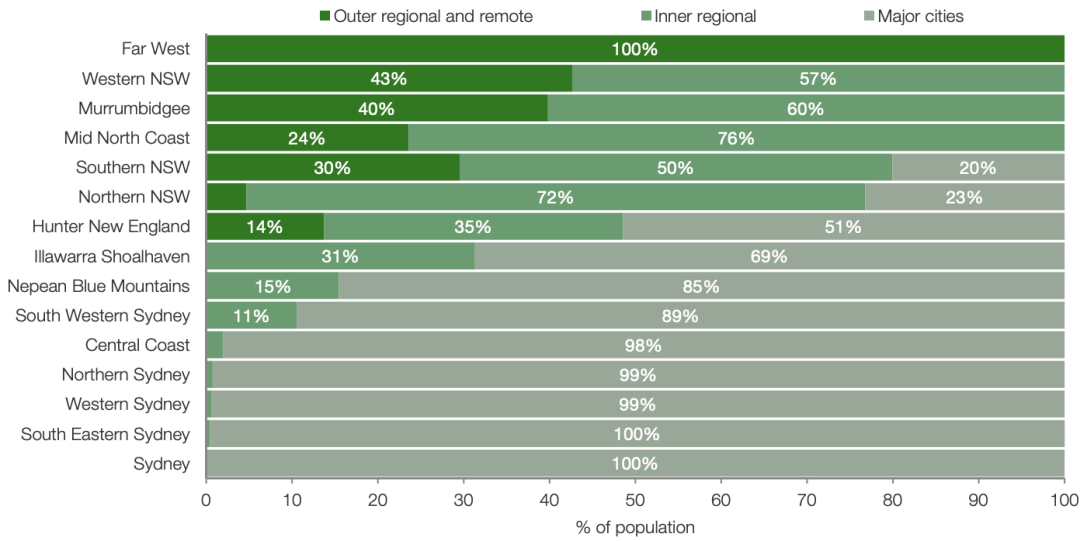

Figure 1.2. Population distribution, by LHD and remoteness category of residence, NSW, 2011.
NSW Ministry of Health, extracted from SAPHaRI, Centre for Epidemiology and Evidence (BHI analysis).

England LHD pointed to the inequitable distribution of resources between Tamworth and Tenterfield hospitals and the inner regional areas of Cessnock and Maitland, and the metropolitan area of Newcastle. Thus, this submission recognises the importance of NSW Health understanding the inequitable distribution of resources within LHD's, even those that are primarily metropolitan (Figure 1.3).

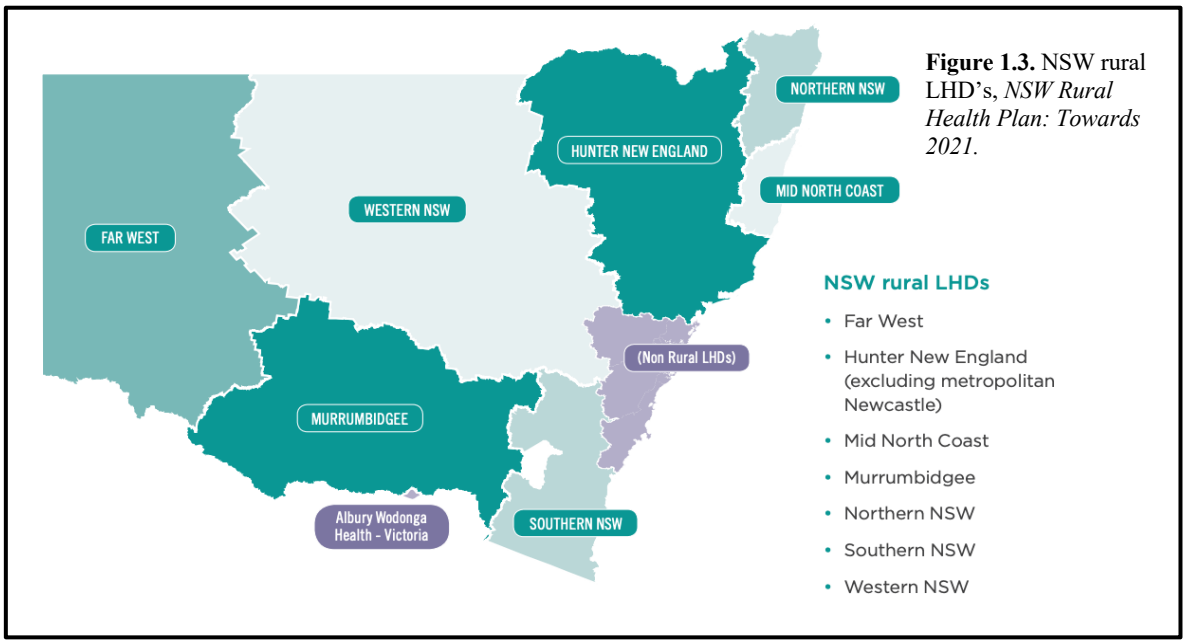

Figure 1.3. NSW rural LHD's, *NSW Rural Health Plan: Towards 2021.*

A. Health Outcomes in Rural NSW

We firstly recognise that there are inherent difficulties in measuring health outcomes due to the gaps in the availability and coverage of health data in RRR areas. ASMOF would welcome strategies to address gaps in coverage and ensure more data is made publicly available to monitor

performance and enhance accountability. Nevertheless, the data reveals that, on average, health outcomes of patients living in RRR NSW are much poorer than other local health districts across metropolitan NSW.[2]

According the Australian Institute of Health and Welfare (AHI1) Rural and Remote Health report, people living in RRR NSW are prone to shorter life expectancy, higher levels of disease and injury, higher prevalence of mental health problems, higher road and fatality rates, and poorer access to health services, compared with people living in metropolitan areas.[3] Additionally, the data reveals that potentially avoidable deaths increase as remoteness increases, with 94 per 100,000 people in the major cities to 129 per 100,000 in rural areas.[4] These inequitable health outcomes have been shown to extend across aged populations, disability and culturally and linguistically diverse (CALD) groups.[5]

C. Access to Health in Rural NSW

There are a number of barriers to availability and access of quality services in rural NSW. 2016 data from the Australian Bureau of Statistics Survey of Health Care Australians reveals that people aged 45 and over living in rural areas are more likely than those living in Major cities to report barriers to receiving health care.[6]

The 'tyranny of distance' is well known, with many rural communities required to travel long distances to access health services or receive specialised treatment. In order to provide a full complement of services to a population, the NSW Health system aims to work together in a coordinated way, sometimes sending patients outside their LHD of residence to receive the services they need. Patients prefer it when care is provided close to home and in recent years a number of initiatives have sought to bring specialist care to patients, through telehealth, mobile clinics, fly-in–fly-out consultant visits and additional investment in local capacity for some services.[7] Although these initiatives show promise, the unfortunate reality for many rural communities continues to be

[2] Australian Institute of Health and Welfare (AIHW) 2018, Australia's health 2018. Australia's health series no. 16. AUS 221.
[3] AIHW 2019, Rural & remote health, Cat. no. PHE 255
[4] Ibid.
[5] Ibid.
[6] AIHW 2018, Survey of Health Care: selected findings for rural and remote Australians, Cat. no. PHE 220.
[7] Samina Syed et al., Traveling Towards Disease: Transportation Barriers to Health Care Access, C*ommunity Health*, 2013; 38(5): 976-993.

travelling considerable distances to access medical treatment, which has been linked to lower rates of healthcare usage and worse health outcomes for rural communities.[8]

The methods of accessing primary health care are restricted in rural areas because hospitals and facilities are generally smaller and have less infrastructure to provide basic services. Consultation with ASMOF members revealed that there are instances where relatively simple services such as a cardiac pacemaker insertion cannot be performed in regional hospitals, leading to the need to transfer patients to Sydney. Without access to public hospitals with modern facilities and equipment, doctors are unable to maintain their procedural skill levels and deliver the the same standards of care to rural patients as those living in metropolitan NSW.

Based on self-reported data, the proportion of people who reported the lack of a specialist nearby as a barrier to seeing one increased from 6.0% in major cities to 22% in regional areas to 58% in remote areas.[9] Due to the lack of availability of local specialist services, many rural populations are forced to rely on general practitioners (GPs) to provide health care services.[10] Unfortunately, GP's often do not have the training to deal with acute medical conditions such as strokes or acute cardiac medical conditions, resulting in patients failing to receive to current standard of accepted medical practice.

Variable access to good quality care in rural Emergency Departments (ED's) has been an issue for many years and appears to be getting worse. There are major issues with accessing out-of-hours medical care in rural hospitals, with 39% of people in remote NSW reporting extreme difficulty compared with 17% in major cities.[11] Consolations with ASMOF members revealed that there are currently a large number of rural and regional ED's in NSW with no doctor on site in the evenings and overnight. These conditions have recently been in the spotlight following a series of recent media reports of avoidable deaths at Gulgong hospital where the community was allegedly left without a doctor and without a locum, Cobar hospital due to alleged rostering and resourcing deficits, and at Tenterfield Hospital where there was reportedly no doctor on shift or on call.[12] One

[8] Charlotte Kelly et al. Are differences in travel time or distance to healthcare for adults in global north countries associated with an impact on health outcomes? A systematic review, *BMJ Open* 2016; 1-9.
[9] AIHW 2018. Survey of Health Care: selected findings for rural and remote Australians.
[10] Department of Health 2016.
[11] Bureau of Health Information. *The Insights Series – Healthcare in rural, regional and remote NSW*, Sydney (NSW); BHI; 2016.
[12] *SMH,* Parliament to launch inquiry into 'appalling' state of NSW country hospitals, September 15 2002; *SMH,* The NSW hospitals putting lives at risk in the central-west, May 18 2020; *The Northern Daily Leader*, Tenterfield hospital death while no doctors on duty, October 29 2019.

ASMOF member said that doctor shortfalls in rural and remote communities and after-hours presentations "creates a perfect storm for preventable mortality". A 2018 report by the AIHW confirms that people in remote areas are two and a half times more likely to have a potentially avoidable death compared with people living in major cities.[13]

Doctors say:

- "How can NSW Health advertise rural hospitals as being "open for business" where there are not appropriately trained doctors (or any doctor) on site to deliver care?"
- "It is already hard to get any doctors at the weekend, and in January it is likely there will be no doctors between 1800 and 0800 on weekdays and no doctors at all at weekends, ie no doctors at all after hours."
- "Doctor shortfalls in rural and remote communities and after-hours presentations creates a perfect storm for preventable mortality."

Crucially, though, NSW Health cannot rely on doctors to work unhealthy working hours and unsustainable overtime to provide care to rural communities. The chronic under resourcing of health services in rural hospitals is causing risk to patient safety and doctors who are overworked and at risk of burnout. It has been well reported that exhausted doctors are not capable of providing the finest care for their patients and can actually exacerbate poor patient outcomes.[14] NSW Health must ensure rostering arrangements in LHD's are the product of meaningful consultation with doctors and are compliant with relevant awards and policy provisions to ensure the safety and wellbeing of both staff and patients. Further, improved funding is needed to employ more staff and ensure on site medical support is available in rural communities.

ASMOF acknowledges that certain types of care can only be provided in a limited number of locations and we understand the inherent difficulties in developing the equitable access and provision of health services between regional and metropolitan areas. There are a number of structural and geographical barriers that cannot be fixed overnight. However, NSW Health needs to ensure a reasonable level of health services accessible to rural, regional and remote communities. Increasing the provision of essential services in regional areas would decrease pressures on the tertiary hospitals to take up additional caseloads, relieve interhospital transport services, be more

[13] AIHW 2019, Rural & remote health.
[14] *SMH,* Tired junior doctors fear making mistakes, harassment by patients, September 11 2020.

aligned with patient expectations and assist in attracting more medical staff. Further, improving the health of people in rural hospitals with high rates of potentially preventable hospitalisations will, in the long run, reduce health costs.[15] We urge the NSW Government to manage the barriers to access that contribute to adverse health outcomes, and strive towards more equitable health system, so that postcodes are not an overwhelming determinate of health outcomes.

Telehealth

Telehealth services can deliver flexible and convenient modes of access to health services into rural communities, monitor chronic conditions and help educate, train and support isolated healthcare workers on location.[16] The COVID-19 pandemic has been a vehicle for the digital health transformation of health care and the promotion of a range of innovative telehealth services in rural NSW. In rural and remote communities, telehealth has the opportunity to improve access to care by alleviating the requirement to travel to see a specialist.

While the transition to telehealth to help reduce the risk of community transmission of COVID-19 has been generally welcomed amongst rural health providers and consumers, the quality and appropriateness of telehealth services are outstanding issues that need to be addressed. ASMOF members reported that videoconferencing is the preferable mode for patient assessment and is most effective when doctors are staffed on both ends of the videocall. Without a doctor on site, members have concerns of potential false diagnoses and the reliability of telehealth to deal with people with serious medical needs. Members also noted that the lack of access to reliable and affordable high-speed broadband in rural areas continues to present a barrier to the quality of telehealth services.

ASMOF members are concerned that 'virtual care' is a misleading because it infers that the service is an alternative to local medical care and somehow 'equivalent'. Additionally, rural communities have detailed extensive concerns over consultations through telehealth, particularly over patients who are non-verbal or have complex health conditions. A petition started by Gulgong resident to reinstate a doctor at the Gulgong MPS reached more than 2,000 signatures by October 2020, which suggests a reluctance amongst rural communities for total reliance on telehealth services.[17]

[15] AIHW 2020. Disparities in potentially preventable hospitalisations across Australia: Exploring the data. Cat. no. HPF 51.
[16] Australian College of Rural & Remote Medicine, Telehealth.
[17] *ABC News*, Western NSW Local health District under fire as Gulgong forced to rely on telehealth, October 2 2020.

The move to replace medical staff with telehealth across rural NSW, as reported widely in the media, is unacceptable and has been implemented without proper consultation with doctors or Unions. ASMOF members are deeply concerned that the hospitals and services at Gulgong, Bourke, Walgett, Cobar, Braidwood, Rylstone and Yass, which previously had robust face-to-face medical support have lost doctors and now regularly resort to telehealth. Leaving remote and regional communities without on-site ED cover is a failure of service provision, leading to patients and staff being put at risk. NSW Health must address existing understaffing issues in rural hospitals before telehealth is widely adopted in rural NSW. ASMOF recommends significant increased funding to hospitals in rural areas to boost the rural health workforce and ensure emergency medical staff and care is available to rural communities. This is essential to ensure better access to healthcare and would support capacity building within rural emergency departments.

Doctors say:

- "It is a mistake in rhetoric that we deliver care via telehealth. You cannot deliver care with telehealth; it is just another tool like a stethoscope or a thermometer. It stands on clinicians that are using the tool, and you need clinicians at both ends working as a team."
- "Telehealth is ok when following up with chronic conditions but in acute situations, you need doctors on site to ask for advice but also to carry our therapeutic and diagnostic operations."
- "Telehealth is being used to paper over the cracks of inadequate medical staffing in rural hospitals."

Mental Health

People living in rural communities are more likely to struggle to find the appropriate support because there are fewer mental health professionals and delays in access.[18] The uneven distribution of mental health professionals across NSW leads to different rates and types of care between rural and metropolitan populations.[19] Rural populations have inequitable access to mental health services and are more likely to consult a GP or use emergency hospital services for a mental health problem rather than a mental health professional, which may lead to inappropriate care. ASMOF members in the Hunter New England LHD expressed concern that mental health services in rural hospitals are only

[18] Mental Health Commission of NSW, Rural Communities.
[19] Ibid.

available until 4:30pm from Monday to Friday, with the state-wide service only available from 6pm, leading to gaps in coverage without specialist consult. NSW Health needs to develop a comprehensive approach to attract and retain mental health professionals and ensure gaps in coverage are addressed in rural areas.

G. Workforce Shortages in Rural Hospitals

Hospitals in rural NSW are characterised by workforce shortages and deficiencies in economies of scale. As noted throughout this submission, access to rural health services is compromised by workforce shortages where rural hospitals fail to recruit and retain doctors.

Understaffing

Consultation with ASMOF members revealed deep concerns about patient safety and dangerous levels of understaffing at hospitals throughout rural NSW. The rate of specialists substantially declines with increasing remoteness, from 143 per 100,000 population in Major cities to 22 per 100,000 population remote areas.[20] Access to appropriately trained staff and resources has been a problem for a long time in remote and regional hospitals. ASMOF members in nearly every rural LHD said that there has been a large number of full-time roles unrecruited in their hospitals for years.

ASMOF members expressed concern that the cancelling of shifts in rural emergency departments have occurred without consultation and such decisions are completely out of touch with the reality in ED's. One ASMOF member reported the cutting of a 1400-2400 shift at one regional hospital, which resulted in only one doctor working between 1800 and 2200 in a department that saw 3-4 patients arriving per hour. A member at another hospital reported that there are nights with no doctor and because the FACEM is on call, they are at risk of being expected to work 20-hour shifts, with 4 hours off before the next shift.

ASMOF members expressed concern that regional base hospitals that have coverage of more remote hospitals are understaffed and unable to deal with referrals from remote hospitals. One member said that a rural area over 100km in diameter risks having no doctors after hours for most of the start of 2021 due to systemic understaffing. These workplace shortages have been proven to increase preventable deaths, morbidity and permanent disability.[21]

[20] AIHW 2019, Rural & remote health.
[21] AIHW 2018, Australia's health.

Doctors say:

- "I'm an oncologist in Newcastle. We are at 1.47 oncologists per 100'000 for the LHD. Half of the numbers for Vic - lower than anywhere else in NSW."
- "It is likely that an area over 100km in diameter will have no doctors after hours for most of January. There are likely to be a few preventable deaths each week, plus preventable morbidity and possibly permanent disability."
- "Metropolitan hospitals are ridiculously well-staffed compared to regional ones, in the regional ICUs I worked it was one doctor per 4 beds, in the city it's been one doctor for 2.6 beds - and that makes a big difference to workload/exhaustion)."
- "It is clear that there is not enough money spent on staffing."
- "There are times when staffing levels are dangerous."
- "At Tamworth hospital, there are no medical registrars overnight, essentially it is a hospital with 300 beds run by a single RMO overnight."

Rostering

Safe, fair and equitable rosters are fundamental to the proper functioning of rural hospitals because they affirm that staffing resources are allocated appropriately to provide high quality patient care. The Australian and international evidence about the damaging effects of onerous hours is undisputed. Unsafe working hours and practices are a significant risk factor in the health and wellbeing of doctors. The evidence suggests that reducing excessive work hours, increasing available resources and exploring new rostering initiatives are three prevention solutions that should form part of a broader range of wellbeing and support mechanisms for doctors.[22]

In September 2020, a group of Registrars at Maitland Hospital raised the alarm about unreasonable hours, inadequate supervision and support, and underpayments. ASMOF succeeded in having a new roster implemented and extra staff employed.[23] Consultation with members at another regional hospital exposed unsafe practices such as the hospital management purposively keeping the roster concealed from staff, so they do not know they are working solo until they arrive for their shift,

[22] NSW Health JMO Wellbeing & Support Plan, November 2017.
[23] ASMOF News, Maitland Hospital will lose more doctors without urgent action, 20 November 2020.

because the staff will pull out if they know due to the medicolegal risk. Such rostering practices within rural hospitals are completely unacceptable and dangerous. Members also revealed that some doctors were expected to be on call 24/7 seven days a week in remote hospitals, which is in breach of award provisions for reasonable on call and significant downtime.

It is essential that NSW Health ensure that rosters conform to the relevant industrial awards and NSW Ministry of Health policies. We recommend that all rural hospitals undertake a transparent review of doctors working hours in consultation to improve rostering and ensure that doctors and patients are not placed at risk.

Reliance on locums

Locums, temporary replacements for health professionals or professionals who are brought in to fill vacancies, are crucial in providing ongoing care for patients and good working conditions for doctors in rural communities. However, in rural hospitals that do not employ sufficient staff to cover on-call rosters and allow for leave, locums face significant difficulties in providing internal relief. ASMOF members argued that where no permanent doctors are on staff, the reliance on locums to keep health services operational is an unsustainable staffing practice. The potential unfamiliarity that locums have with the hospital they're working in and the resourcing of the hospital raised concerns for doctors. Further, members were worried that understaffing and poor workplace planning would result in a shortage of locums over summer and holiday periods, which, when combined with the lack of permanent staff, would lead to a high morbidity and mortality rate in rural NSW, particularly in areas prone to natural disasters. Crucially, members cautioned that the large reliance on locums and sessional VMO's in rural areas impacted on the level of service and did not meet community expectations for a high level of competency in ED's.

Extra Workloads

ASMOF members pointed out that rural LHD's and hospital management have a complete lack of understanding or acknowledgement of the requirement under the *Staff Specialist (State) Award* to provide office accommodation, administrative support, non-clinical time and support research. The failure to recognise what needs to be provided under employment entitlements contributes to excessive workloads and often results in doctors having to spend spending significant time on administrative duties that deprive rural communities of hands-on clinical work. Rural emergency doctors are required to have a broader scope of practice and have additional tasks than metropolitan doctors because many patients have to be transferred. ASMOF members estimated this takes an

extra 30-60 mins of a doctor's time because there are no inpatient teams completing documentation and medication charts, and no physios or nurse practitioners to do plastering/suturing/cannulation etc. Improved funding is desperately needed to alleviate rural doctors' excessive workload, and it is critical that LHD's recognise their obligations under the relevant industrial instruments.

Leave

NSW Health must build a culture in rural LHD's that supports the taking of leave and sick days. ASMOF members reported being unable to take leave or Allocated Days Off (ADOs) because there was never adequate cover. Members mentioned that they did not feel comfortable about taking ADOs because their colleagues would then be required to do (often unpaid) overtime. Similarly, members reported immense difficulty in accessing sick leave and finding cover when they were sick. As reported widely this year, the COVID-19 virus is susceptible to spreading in hospital environments, especially where workers are exhausted and have difficulties accessing sick leave.[24] NSW Health needs to support a culture of taking sick leave and paid special leave so that staff can be supported to get tested for the virus and self-isolate if necessary.

Doctors say:

- "I sent my resident home from work just after she arrived because she obviously had the flu. I didn't want any of the patients to catch it from her. I called Medical Admin to tell them I'd sent her home as she was sick and would be gone a couple of days and asked if I could have another resident assigned to our team was told that no, I'd decided to send her home so that was on me and I'd just have to manage."
- "I would have had over $30,000 worth of ADOs and additional leave (from working holidays and weekends) that I had paid out because I could never take it and it all accrued."

Access and Retention of Staff

Multiple ASMOF members identified the difficulty of attracting and retaining specialists into rural hospitals where they will not be adequately supported. A supportive and safe working environment in rural hospitals is crucial to attract doctors for short-term and long-term employment. The understaffing and under-resourcing of regional and remote hospitals is a significant contributor to

[24] ACTU, Paid Pandemic Leave, 29 July 2020.

excessive workloads and exhaustion experienced by rural doctors. Indeed, many rural doctors feel as though they should be compensated for the higher workload and challenges faced in rural hospitals than in metropolitan hospitals.

It was common feedback that one of the major determinants of people returning to regional areas as Senior Medical Officers was their experiences as a registrar, medical student or intern. The logic is simple - if doctors have a good experience and witness the professional and lifestyle benefits of working in rural areas, they are more likely to return as a VMO, consultant or specialist. Therefore, NSW Health needs to invest in doctors in training to support their experience and training in rural hospitals.

The NSW government must recognise the difficulties and challenges of moving to a regional location. It is very expensive to move regionally and doctors often get nothing covered by their employer. At present, the Award details that staff have to be employed by a metropolitan area and take up a permanent regional position in order to be reimbursed any portion of costs.[25] Unfortunately, people moving from one regional area to another regional area are not reimbursed for moving costs and permanent positions within NSW Health are somewhat elusive, resulting in zero financial support. ASMOF recommends the NSW Government to make available a subsidy for housing and relocation costs.

Multiple registrars at rural hospitals cautioned against 12-month employment contracts due to the burdensome cost and effort required to move themselves and their family on a yearly basis. Contracts for 24-36 months would provide registrars with more stability and would be beneficial to the hospital in workforce planning. There is also evidence that enabling people to have longer contracts would give them and their families more opportunity to become part of the local community, making it more likely that they would return for advanced training or fellowship.[26] Alongside longer contracts, the recognition and accreditation of the excellent training opportunities in rural NSW by the Colleges would support the retention of doctors in NSW Health.

[25] Public Hospital (Medical Officers) Award, Part A s 29.
[26] Aaron Nicholas et al., Incentives for relocating to regional Australia: estimates using a choice experiment, NCVER 2014, Adelaide.

Incentives

NSW Health needs to properly incentivise employment in rural hospitals to recruit and retain doctors, fund dedicated pathways for medical graduates and support equity of access to education and training for junior doctors working in regional and remote areas.[27] There are limited incentives for doctors to move to rural towns, which is unfortunate because there is a great medical community in remote and regional areas and the significant professional satisfaction offered by rural practice.

Hospital trainees previously received reimbursement of HECS for working in rural areas under the graded HECS Reimbursement Scheme, where trainees received more reimbursement the more remote their employment.[28] This was essential for junior doctors to offset the costs of moving and incentivise trainees to relocate to a rural area, however it ceased on 30 June 2015. ASMOF recommends a similar reimbursement scheme is reintroduced to incentivise junior doctors to experience the benefits of the rural medical community.

The Rural Medical Trainee Scholarship, managed by the Health Education and Training Institute (HETI), consists of $4500 scholarships to provide financial assistance with course fees, travel, accommodation and other expenses directly associated with the education and training needs of medical trainees in remote and regional areas.[29] ASMOF members commented that regional trainees have previously been excluded from HETI's scholarship due to preferences to award the scholarship to trainees from metropolitan hospitals. This has led to frustration amongst many rural junior doctors because there are already discrepancies in payment between permanent staff in rural hospitals and their colleagues who get paid more for going on secondment. NSW Health needs to ensure competitive renumeration for rural doctors. This is particularly relevant for doctors in training, who are now amongst the worst paid in Australia as a result of the NSW Government's Wages Policy and the lack of any meaningful improvement to the *Public Hospital (Medical Officers) Award* in over 35 years. These wage conditions are causing many junior doctors to leave NSW Health or work as locums.

ASMOF members also communicated difficulties in accessing the HETI scholarship because doctors can only apply for the scholarship reimbursement after payment is made for the requisite course or training. If the scholarship is not awarded, junior doctors who could only afford to

[27] NSW Health, NSW Rural Health Plan: Towards 2021.
[28] The Department of Health, HECS Reimbursement Scheme, (https://www1.health.gov.au/internet/main/publishing.nsf/Content/work-pr-hecs)
[29] HETI, (https://www.heti.nsw.gov.au/Placements-Scholarships-Grants/scholarships-and-grants/heti-rural-medical-trainee-scholarship#:~:text=About%20the%20Scholarship,in%20rural%20and%20remote%20areas.)

complete the training with the scholarship funds risk ending up out of pocket, which members anecdotally said results in many junior doctors not applying for additional training. NSW Health needs to ensure there is ongoing financial support for junior doctors' in rural hospitals to support retention and equity of access to training opportunities. Importantly, NSW Government funding needs to be simultaneously directed at the senior workforce to ensure high quality training programs are available for junior doctors.

Doctors say:

- "If people have a bad training experience in a regional area, they are less likely to come back as a VMO or a consultant."
- "I only went to a regional hospital for internship for the HECS reimbursement and rent reimbursement on offer which came to about $7,000 or $8,000 over the two years - but while I was there, I discovered the excellent aspects of a regional lifestyle and the great patients you have the privilege to look after there (and so spent another four years working in understaffed under-resourced regional hospitals)."

The NSW Government should invest in schemes that assist medical staff in the difficult task of finding a house in a regional or remote area on a deadline. The regional Royal Flying Doctor's Service centres provide quality housing for their medical staff for the duration of their contract, which is a great incentive, although we understand such a program is unlikely to be replicated for salaried doctors. There are limited examples of recruitment specialists in rural hospitals who assist new medical staff in navigating the challenges of relocating to a rural area, such as finding housing, organising school enrolments and finding employment for partners and spouses. This support alleviates significant barriers for doctors looking to relocate, and we recommend all rural LHD's employ similar positions to perform this essential work.

Networking

In NSW, rural health services network between LHDs, across state borders, and with regional or metropolitan referral hospitals as is necessary to provide patient care.[30] In some of these cases, networking is formalised through agreements and in other cases they are more informal. When

[30] Bureau of Health Information. *Healthcare in rural, regional and remote NSW*, BHI 2016.

networks function effectively, efficiencies are created through flexible models of service delivery and healthcare performance is enhanced.[31]

Consultation with ASMOF members revealed that there are greater opportunities for smaller remote hospitals to better network with larger regional and metropolitan hospitals in a more practical way. NSW Health needs to develop models for effective transfer of care and referral pathways from rural locations to regional centres need to be actively encouraged and strengthened. Further, we recommend that the networking of rural hospitals exists alongside regional training networks that support specialist training and career development in rural areas.

NSW Health needs to work better with other jurisdictions to build effective cross border partnerships. ASMOF Members at Queanbeyan hospital identified trans-border networking deficits, primarily because patients who live outside of the Australian Capital Territory (ACT) are unable to be supported within ACT Health. Additionally, as has been widely reported, there have been serious networking disruptions at Tweed Hospital throughout 2020-2021 due to border closures between Queensland and NSW.[32]

Improving Culture and Governance

Many ASMOF members spoke to the importance of improving the governance in rural LHD management. Doctors throughout NSW are concerned for patient safety and the medicolegal risks that arise when requests for extra patient resources or additional staffing are repeatedly rejected by management. When critical incidents occur after doctors' request have been ignored, it is critical that the management of rural hospitals are held accountable. Importantly, hospital managements need to ensure compliance with the relevant awards and NSW Health policies. As previously mentioned in this submission, NSW Health must build a culture in rural LHD's that acknowledges employee's entitlements and supports doctors in the taking of leave and sick days. More broadly, ASMOF members believed a cultural shift is needed within NSW Health to counter widespread beliefs that rural medicine is 'second grade'. Rural medicine is incredibly rewarding, and we received many comments about the immense professional satisfaction experienced by rural doctors due to close community connections, the variety of presentation, the quality of consultants, the greater responsibility and the strong doctor-patient relationships.

[31] Ibid.
[32] ABC News, Doctors terrified Tweed Hospital will be forced to close due to 'catastrophic' hard border closure, 13 August 2020.

D. Patient Experience

Although the NSW population is predominantly urban, one quarter of the population live in rural areas. The NSW Government is responsible for ensuring that our public hospitals in rural NSW are able to improve the rural patient experience and deliver better care and health outcomes for rural communities.

Rural ASMOF members across NSW reported that chronic short-staffing and under-resourcing is the primary issue affecting patient care. At Maitland Hospital, doctors raised concerns that their workloads were so excessive that they did not have time to deliver proper care, with patients not being assessed thoroughly and some missing discharge plans. Fear over patient safety, the welfare of junior doctors, proper supervision and the doctor's ability to prepare for exams resulted in The Royal Australian College of Physicians stripping its basic training accreditation from Maitland Hospital in November 2020.[33]

NSW Health needs to improve staffing levels so that patients receive appropriate care. Members at a regional base hospital commented that understaffing commonly results in having to see patients late in the day, such that patients who are ready for discharge cannot be discharged because of the distance from the hospital to the patient's residence. Here, understaffing negatively impacts patient experience because doctors could have otherwise seen that patient earlier and therefore discharged them earlier. Similarly, doctors spoke to the exorbitant time required to deal with in-patient duties in rural hospitals, which results in delays in getting to referred patients in ED. While the patient might only require a particular test or scan that could potentially be followed up by their GP or outpatient clinic, the late hour or queue for that particular scan often requires the patient to stay overnight, particular if the hospital is hours away from the patients place of residence. When patients in ED cannot go home and have to be admitted, this takes up a hospital bed and has been proven to have detrimental effects on the patient experience due to interrupted sleep and the unfamiliar environment, which can be problematic for elderly patients, especially if there is cognitive decline or dementia.

NSW Health needs to ensure an effective transfer of care within rural networks and between rural hospitals and metropolitan hospitals. ASMOF members at a regional base hospital emphasised the difficulties in transferring a patient to a rural hospital closer to their place of residence because the

[33] SMH, Hospital banned from training doctors amid alarm over excessive workloads, poor supervision, November 19 2020.

smaller hospital often does not have a GP on duty and an accepting medical officer is required for a transfer. Members also cautioned against delays in transferring patients from regional hospitals to metropolitan hospitals because the appropriate interhospital transport is unavailable and/or a bed at the metropolitan is unavailable. Due to these barriers, staff cannot make progress towards discharge and the patient takes up a bed that is often needed for the next patient. Further, waiting until patients deteriorate such that a patient then requires emergency treatment because they have not had the appropriate treatment is not effective or appropriate patient care.

Doctors say:

- "The current staffing models make it impossible to delivering a standard of healthcare which the community considers reasonable."
- "Being chronically short-staffed affects patient care and hospital flow. Your round might take all day such that you're still working through seeing patients at 4pm, or later. You might get to a patient who you decide is ready for discharge, but because they live 3 hours away, it's too late in the day for them to go."
- "Where patients have to be transferred to metropolitan areas for a particular service, they might spend up to a week sitting about in the regional hospital coronary unit waiting until there's 1) appropriate interhospital transport available and 2) a bed available at the Sydney hospital they're going to. Waiting until patients deteriorate such that a patient now requires emergency treatment because they have not had the appropriate treatment is not ideal patient care."

It is clear that current staffing models make it impossible to delivering a standard of healthcare which the community considers reasonable. Many doctors pointed out that the rural population simply do not get access to current standard of accepted medical practice because of the impacts of understaffing on service delivery. Further, the general public have little knowledge of the level of care available, particularly when changes to the resourcing of regional hospitals are made without sufficient consultation with the community. Many rural communities are rightly concerned that rostering arrangements for doctors at local hospitals will present risks to patient safety when overnight shifts are left vacant.[34] NSW Health must recognise the diverse needs within rural

[34] ABC News, Doctor shortage at Wellington Hospital forces residents to ramp up the pressure, 19 November 2020.

communities and ensure implementation of best practice community consultation in planning and changing health services in rural communities.

E. Workforce Planning & Funding

This submission has made clear that there are a multitude of issues with NSW Health's approach to workforce planning in rural NSW. While a number of programs have been introduced by NSW Health to improve workforce planning and service provision, they have failed to appropriately address systemic understaffing and under-resourcing, which present fundamental barriers to meeting the needs of residents living in non-metropolitan areas. NSW Health must immediately focus on capacity building within the rural doctor workforce, and ensure it is a crucial component of the NSW Health Professionals Workforce Plan 2022-2032.[35]

NSW is not a uniform state, and a one-size fits all approach to funding is inadequate for rural areas because metro-centric protocols are often unsuitable for smaller hospitals and health services. The primary way funding is distributed to LHD's is through a mechanism known as activity-based funding (ABF), with 90% of LHD budgets allocated through ABF.[36] On paper, rural hospitals have lower levels of productivity because rural hospitals cannot operate at the same levels of activity as larger urban hospitals.[37] Thus, many rural sites are marginally viable under ABF because, for example, activity in a 40-bed hospital is not enough to cover 24-7 services. However, rural hospitals provide populations with access to essential and effective healthcare services. ASMOF members have expressed concern over the impossibility of renumerating much-needed staff with ABF, with staff required to detail a business case detailing how additional doctors will be cost-neutral. While some rural hospitals have a greater proportion of their budgets allocated through block-funding, the use of block funding varies significantly across rural LHD's.[38] NSW Health needs to recognise that ABF does not suit many rural sites and ensure there is adequate funding for all rural hospitals through other suitable funding mechanisms.

Doctors say:

- "Rural hospitals operate under tight budgets, with our hospital management requiring us to meet a target to spend $5,000 less each day. This is complicated by costs that are out of our control, such as rising ambulance costs in much of rural NSW."

[35] NSW Health, Health Professionals Workforce Plan 2012-2022.
[36] Bureau of Health Information. *Healthcare in rural, regional and remote NSW*, BHI 2016.
[37] Ibid.
[38] Ibid.

K. First Nations Health in Rural NSW

First Nations Health is a crucial issue to be considered in contemplating healthcare in rural, regional and remote NSW. While a large proportion of First Nations people live in metropolitan LHDs, First Nations people represent a higher proportion of the population in remote areas and regional areas. For example, 11.7% of the population is Indigenous in Far West LHD, and 11.1% in Western NSW LHD.[39]

First Nations peoples have greater health needs and are known to have lower life expectancy, higher rates of cardiovascular disease and chronic disease.[40] Access to appropriate care is major barrier for First Nations communities. In practice, it is extremely difficult for First Nations people living in remote and regional NSW to leave their communities and access hospital services within a reasonable period of time to receive the care they need.[41]

ASMOF members reported a lack of skills within some rural hospitals to deliver culturally appropriate services. NSW Health needs to further implement cultural competency programs in rural health services, as highlighted in the NSW Aboriginal Health Plan.[42] Additionally, NSW Health needs to ensure that care is delivered in partnership with regional Aboriginal health provider alliances and Aboriginal community-controlled health services, so that effective healthcare services are delivered within First Nations communities. In Wollongong Hospital, ASMOF members reported that that establishment of pain services within Aboriginal Health services was reasonably effective, resulting in requests for additional funding to develop pain services in the Nowra and Milton regions. Finally, NSW Health needs to ensure continued investment in the First Nations health workforce through relevant scholarships and training opportunities.

CONCLUSION

An immediate commitment to improve rural health outcomes and access to health in rural communities is needed by the NSW Government. The NSW Government must take action and increase funding for rural hospitals, improve staffing and resourcing, ensure safe and workable rosters, increase the provision of basic services and improve the patient experience. All the recommendations in this submission have been informed by doctors and are reasonable actions that

[39] Ibid.
[40] Ibid.
[41] Susannah Warwick, Young Aboriginal People's Perspective on Access to Health Care in Remote Australia: Hearing Their Voices, *Progress in community health partnerships* 13, no. 2 (2019): 127–128.
[42] NSW Health, *NSW Aboriginal Health Plan 2013-2023.*

would significantly benefit the provision of health care to people living in RRR Australia. They should be comprehensively implemented to ensure that doctors working in rural health have safe working conditions, are supported by their LHD's, and are able to provide rural populations with the accepted standards of medical practice.