Submission
No 582

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

Name: Dr Joe McGirr MP, Independent Member for Wagga Wagga

Date Received: 15 January 2021

Dr Joe McGirr MP
Independent Member for Wagga Wagga

JM7759

15 January 2021

The Hon. Gregory Donnelly, MLC
Portfolio Committee No.2 - Health
Parliament House
Macquarie Street
SYDNEY NSW 2000

Dear Mr Donnelly

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

I am making representations as the independent Member for Wagga Wagga, which is a regional and rural electorate. I also have more than 35 years experience in rural and regional health as a clinician, a senior health administrator and an academic.

I am currently chair of the Rural Policy Advisory Group for the Royal Australasian College of Medical Administrators and I also provided input into the College's submission, both through the committee I chair and as an individual on its policy advisory committee.

I welcome the opportunity to make a submission to the inquiry on this important issue.

Yours sincerely

Dr Joe McGirr, MP
Member for Wagga Wagga

Attachment

64 Baylis Street, Wagga Wagga NSW 2650

P (02) 6921 1622 F (02) 6921 4424
E waggawagga@parliament.nsw.gov.au
www.joemcgirr.com.au

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

Submission from Dr Joe McGirr, independent Member for Wagga Wagga

For many decades now, the health outcomes for people who live in regional, rural and remote NSW have been worse than the outcomes for those living in metropolitan centres. This has been well-documented and has been the subject of considerable research and advocacy. There are a number of factors that impact on this, but an important one is the access to health and hospital services and the quality of those services. I welcome this inquiry into health outcomes and health and hospital services in rural, regional and remote NSW.

The comments below are made in the spirit of improving the health system in NSW. I wish to acknowledge the great work done by health staff, both clinical and non-clinical, throughout NSW. And the NSW health system is highly regarded both in Australia and in the world. In addition, there has been in the past decade a strong investment in overdue rural and regional health infrastructure. Nevertheless, issues remain to improve the health and health care of remote, rural and regional NSW residents. My suggestions are made in this context.

Workforce

Nursing

I receive many expressions of concern from constituents about insufficient nursing staff and the high workloads of those who are employed.

Nurses themselves are concerned about the high use of nursing agency staff. I'm aware that there have been multiple campaigns to recruit permanent nursing staff. Yet I am told that there continue to be high levels of vacancies in nursing establishments. This can create issues for continuity of care as well as building the strong teams necessary to provide the best health care.

Feedback that I receive is that the recruitment processes are long and often lead to applicants finding other jobs in the meantime. It is not unusual for nursing applicants to indicate that they wait for extended periods for their applications to be processed. Nurses on wards have told me that the vacancies on their units can take months to fill.

I have also received feedback that workload at regional centres has increased because of a lack of medical staffing at smaller centres and patients being transferred to the larger centres. There is also a constant pressure to discharge patients because of the number of new patients requiring inpatient services.

I have been told that recruiting to nursing staff positions in smaller centres can also be difficult as full-time positions are harder to find and this acts as a disincentive. I have also heard that staff in smaller centres can be apprehensive in relation to the treatment of unusual emergency cases, especially after hours, when staffing levels are low and there may be no medical practitioner available.

Allied health staff

There are ongoing concerns about the provision of allied health services in rural areas. In particular, in non-hospital settings in small communities, residents often rely on their Local Health District to provide allied health services, which is not the situation in metropolitan areas, where patients are able to access private services, with some funded by the federal government. In recent years it is my perception that this has improved somewhat in regional centres because of a greater range of private providers but access to community health services has not improved. Access definitely remains an issue in smaller communities. It is especially an issue where patients cannot afford out-of-pocket costs and only qualify for a small number of services under extended primary care items.

I question if there is sufficient recognition of the importance of these services and therefore the appropriate funding at state and federal levels. Allied health services play an important role in preventing hospitalisation and therefore reducing the cost of health services and improving access for those in need.

Medical

Rural communities and rural health services in small and medium-sized communities require an on-the-ground on-site medical workforce. It is part of the social structure of the town, part of the economic vibrancy of the community and an important part of the provision of health services. Unfortunately, there has been a trend over recent years that has seen the replacement of on-the-ground medical practitioners with fly-in, fly-out services and telehealth options.

This has meant a loss of continuity of care, as well as a possible downgrading of the social and economic infrastructure of the communities involved. It also means that when there is no local doctor available patients are transferred to larger regional centres after hours and on weekends for conditions that could otherwise have been treated locally.

These issues have been highlighted in relation to Tumut hospital in my electorate that has struggled to maintain a full medical roster. The LHD employs a remote health service and video technology to support nursing staff. However, the community rightly expect a full complement of on-the-ground medical staff to support what is a major district hospital. Smaller communities around Tumut have also struggled to find on the ground medical services with local on-call services after hours.

It is important that this reduction of locally resident medical practitioners is addressed. I support discussions that are taking place with the Rural Doctors Network on better means to support medical practitioners using a networked approach.

An important approach is the implementation of a rural generalist workforce, which needs to be appropriately trained and employed in rural and regional areas.

There is a pathway to specialisation in rural general practice that has been well-established through the work of the rural health commissioner. It is up to NSW to now make sure that the right cohort of doctors is trained in this area of practice and attractively remunerated to work in these towns. Support for this model requires the co-operation of the Commonwealth and NSW governments.

There has been a breakthrough in the training of these doctors in a pilot project in the Murrumbidgee Local Health District (LHD) as a result of the intervention, I believe, of the health minister when he convened a bilateral rural health roundtable in Wagga Wagga in December 2019 that involved the relevant federal minister.

However, there also needs to be an examination of the current remuneration packages for doctors who are prepared to work in district and small health services. The current generation of doctors, I do not believe, will work in the conditions of their predecessors. The right remuneration models will ensure

that we can attract doctors with the right skills to come, stay and work in our rural communities. These packages should address issues of salaried versus fee-for-service income, hours on call and after hours work as well as leave and study opportunities and professional support.

Paramedic services

Ambulance paramedic services often bear the brunt of the lack of hospital services when there are no medical staff. They may be required to provide extensive treatment and then undertake prolonged transports which increases time away from their communities and burdens small stations with overtime and excessive hours worked.

While there has been investment in physically upgrading stations, there are ambulance stations that have missed out – including the Tumut station which requires significant upgrading and should be relocated to the soon-to-be completed new Tumut hospital.

It is possible that paramedics could undertake a broader range of roles in rural communities and this is an area that could be explored. However, there would need to be sufficient staff available so that this does not detract from current duties and this is difficult when ambulance officers are required to transport patients when no doctor is available.

Training

Training of health professionals should be linked to the location in which they are likely to practice. Training services should be based in rural locations and operated by rural health services, not operated out of metropolitan centres.

A positive example of where this has worked is the Commonwealth development of rural clinical schools over the past two decades. This has now extended to rural medical schools, accompanied by the development of training pathways and rural training hubs. This means that prospective doctors can complete all their training from undergraduate to postgraduate in a rural location. This promises to provide some improvement in rural medical workforce and should be supported at every turn by the government.

Greater collaboration between the rural local health districts and health training providers is the key, with strong local health district involvement in the

oversight of training and the provision of training posts. Health districts should more strongly link their workforce plans to pathways of training developed in conjunction with training providers.

Transport and access

Patients in regional, rural and remote services are often faced with travelling great distances to access health care. It is therefore important that care is provided at the highest level possible as close as possible to the patient.

Rural people recognise and accept that they will travel to access higher levels of care. However, more can be done to avoid unnecessary travel. We have seen this with the establishment of oncology services in regional centres, which I believe has improved outcomes for cancer treatment for rural patients.

Where oncology services have been established by communities in conjunction with a private provider (such as in Wagga Wagga), they should be eligible for equivalent public funding from NSW Health as centres established primarily by the public sector.

A significant improvement for cancer sufferers in rural areas would be support for them to participate in city-based clinical trials, which ought to be supported by the Isolated Patient Transport Assistance Scheme.

Access to specialist palliative care is also often not available in rural areas as the limited number of specialists in this area practice in metropolitan areas. Palliative care is a very important part of health services. The quality of palliative care services impacts not only the patient but also their family and community. Increasing specialist services and providing training for local health practitioners would assist in addressing these needs.

There are a number of services where patients, especially children with complex conditions, are still required to travel to specialist centres in Sydney for relatively brief follow-up appointments. There are models where teams travel from the metropolitan centres; however these are not always available because of lack of funding.

An example is Nazeen and Shaleen Ali and their daughter, Beni, who was diagnosed with lupus in 2017. The diagnosis came just months after Beni celebrated five years in remission after a battle with cancer (Acute

Lymphoblastic Leukaemia). Shaleen, Nazeen and Beni have to travel frequently to Sydney to see treatment and attend medical appointments. Shaleen said other parents from regional areas like Wagga cannot make such regular trips and have tried other options such as seeking an adult rheumatologist in Canberra, simply because it's closer to Wagga. She says families are facing issues like cost and a lack of care for other children.

Beni's doctor, paediatric rheumatologist, Associate Professor Davinder Singh-Grewal, has written to me as follows:

"As you are aware Shaleen Ali and her family have been strong advocates for this proposal and I understand that she has spoken to you again on this issue recently. As you are aware we have been struggling to get NSW Health and the Sydney Children's Hospitals Network to understand the disadvantage that children with rheumatic diseases and their families face at present in NSW particularly in regional areas. I for one am sick of seeing families haul themselves through the 10-hour round trip to Sydney to see our service for a 15 minute follow-up appointment, often with both parents missing a day of work and with siblings and the patient themselves all missing a day of school for this privilege. While Telehealth has a role in regional service provision and is something we use quite frequently, rheumatology is one of the few subspecialties which still relies on examination in patient assessment so is indispensable."

This is one very clear area where health services to regional areas could be improved.

The submission from the Royal Australian College of Medical Administrators notes that there is no adult equivalent of the Neonatal Emergency Transport Service. As a result transfer of adults with complex urgent conditions to higher level tertiary care in the cities can be difficult to arrange. Although there are networks for trauma and critical care, the feedback I have received is that adult urgent transfer arrangements can be difficult and time-consuming to arrange and are often at the mercy of the capacity of the city-based facilities.

Another barrier to access also includes high-out-of pocket expenses for specialist care. While this is an issue across the health system, it can be worse in rural areas where there is a shortage of specialists and GPs.

Commonwealth-state co-operation

The nature of rural health services is such that the division between primary and hospital care is often artificial. Traditionally, health practitioners often provided primary care services as well as hospital services. Practice has changed in rural communities so that doctors may choose to work only in primary care and not in the hospital. This leaves the hospital relying on expensive locum services or nursing staff with remote telehealth medical support. Alternatively, the LHD as the provider of last resort is left to provide both primary and hospital care. As a result the state hospital system is at risk of being required to provide resources for primary care provision without appropriate funding, or provide hospital services at a significantly greater cost that the funds available. One way to address this would include cashing out primary care and hospital funding in smaller communities. In any case much more formal commonwealth-state partnerships are needed.

A recent example of Commonwealth State cooperation has been in the training of doctors for rural generalist roles in the Murrumbidgee LHD; as a result of a bilateral roundtable between the state health minister and his rural health federal counterpart a training pathway is being piloted that allows doctors employed by the LHD to work in general practice.

NSW has also worked with the Commonwealth over more than ten years in the HealthOne model where commonwealth and state funding for GP and primary care has been integrated. Consideration could be given to expanding this program.

I would encourage the commonwealth and state health departments to work collaboratively in relation to public health especially in relation to the prevention of suicide. This could be done through the Primary Health Networks and Local Health districts and requires strong leadership at the government level. Locally there have been good relationships developed between the LHD and the PHN and I believe these partnerships should be encouraged and appropriately funded.

Clinical governance

In recent times, there has been a number of well-publicised incidents of poor patient outcomes in some rural services.

The key to improving the safety of health services rests in good clinical governance. One key component of good clinical governance is clinician engagement. This was highlighted as an issue with the Garling Report. Sadly, a recent Auditor-General's examination of the outcomes of the Garling Report indicated that it the progress in relation to clinician engagement had been disappointing. Many of the incidents reported in the media seem to reflect a breakdown in communication between management and clinicians.

The best way of facilitating medical clinical engagement is through medical administrators. I believe there could be more provision for the training and employment of specialist medical administrators across rural health districts. These doctors are specialists in clinician engagement and clinical governance and are able to promote a strong culture of safety and engagement among medical professionals.

Coronial autopsies

The centralisation of coronial autopsy services to the city centres in 2016 has come as a blow to rural communities. Families and communities all grieve when there is a sudden often traumatic death, especially affecting young or or otherwise healthy people. To have to send the body of loved ones and friends away with delays for funerals is incredibly distressing for all involved.

Work has begun on a taskforce to examine how this process can be improved. It is critical that unnecessary transfers of bodies for coronial autopsies are avoided. Much can be done to improve this, including some limited examination of victims before they are transferred. I look forward to the taskforce final report and action plan.

Digital health and telehealth

There is no doubt that telecommunications technology can improve the access to care of rural and remote Australians, especially for high level specialist services available only in tertiary city facilities. Telehealth has been used reasonably successfully during the pandemic and can be especially useful where direct patient physical contact is not so critical to ongoing care or for follow up care. To this end internet connectivity is critical and in rural areas there remain many areas and communities where internet connections remain poor. Continued improvements to internet connectivity are required.

Also I do wish to restate that telehealth remote services are no substitute for on the ground in person services which are critical for the economic and social well-being of communities as well as for their health.

Specific health issues

There are a number of health-related issues that should be kept in mind when considering the health of rural communities.

Among many issues I wish to highlight the issues of rural suicide and methamphetamine (ICE) use.

Suicide rates remain high in rural areas. Although NSW health does, I believe, have robust systems for follow up after attempted suicide, the real challenge in reducing suicide rates lies in identifying and assisting those who do not contact or reach the hospital system. In my view this requires a commonwealth and state government combined focus with a much stronger focus on rural communities.

The NSW government has received its report into the "ICE epidemic" in regional NSW and I look forward to the implementation of the recommendations contained in the report. This is a scourge that is deeply scarring our rural communities, especially those who are most disadvantaged.

Aboriginal and Torres Strait Islander Health

Rural communities generally have a higher percentage of their population from Aboriginal and Torres Strait Islander background. The poorer health outcomes of Aboriginal and Torres Strait Islander therefore impact on the need for health services and access to these services. This needs to be closely considered in any review of rural and regional health along with the impacts of the social determinants of health.

Culturally and Linguistically Diverse Communities

Wagga Wagga is home to people from 112 different nations and in recent years has become a refugee resettlement area. The community has welcomed new arrivals and worked well to ensure they become safely established. Refugees in particular come with a range of special needs and it is important that these area recognised and the services to meet these needs are available.

Conclusion

Remote, rural and regional health and hospital services exist to improve the health of the people of their communities. For this to happen the services must be accessible in a realistic way and must be of high quality. Distance, a lack of suitably trained workforce, high out-of-pocket costs, and social factors that lead to ill-health are part of the challenges faced by these communities. Along with alcohol and other drug use, rural communities are now faced with increasing use of ICE. These communities also face increasing rates of suicide. Digital and telehealth services as well as locum and agency provide an important support to health care providers, but are no substitute for on-the-ground services. It is the on-the-ground in person providers and services that are key to the social and economic well-being of communities.

Areas of focus for improvement should include:

1. Improved workforce provision through training that is locally based, timely recruitment and improved remuneration arrangements so as to retain the skilled health professionals rural NSW needs;
2. Improved cooperation between the Commonwealth and State governments with a commitment to establish a formal process for working together on issues related to rural and regional health and to limit waste of resources and out-of-pocket costs;
3. Better clinical governance and relationships between health management and clinicians;
4. Specific actions to target high rates of suicide and use of the drug ICE as well as the challenges of Aboriginal and Torres Strait Islander and refugee communities;
5. Improved outreach services from metropolitan to regional centres for areas of highly specialised care;
6. Better internet and digital connectivity especially to isolated communities.