Submission No 585

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

Name: Mrs Janet Price

Date Received: 15 January 2021

SUBMISSION TO THE INQUIRY INTO HEALTH OUTCOMES IN REGIONAL AND REMOTE NSW.

Janet Price – concerned citizen

January 2021.

Having lived in remote communities and currently being involved in both agriculture and education, I see the welfare of our rural communities is paramount to our economic, social environmental and cultural wellbeing.

The many anecdotal stories, both in local communities and the media suggest some serious systemic problems for health care in rural and remote communities.

Remote communities are by definition many km (often more than 100) from the next town. They need to be more independent or self reliant than urban or coastal communities in many services including emergency services, education, job creation, aged care and **health**.

The current health model seems to be centralised in a large regional cities and all remote communities are serviced from there. That sounds good until all of the problems of distance are factored in.

The following comments are offered in the spirit of improvement in outcomes for ordinary Australians and are related to the terms of reference where possible. Red text indicates positive suggestions.

Terms of reference

a) health outcomes for people living in rural, regional and remote NSW;
(c) access to health and hospital services in rural, regional and remote NSW including service availability, barriers to access and quality of services;
(g) an examination of the staffing challenges and allocations that exist in rural, regional and remote NSW hospitals and the current strategies and initiatives that NSW Health is undertaking to address them;

Health outcomes are significantly affected by the inability of NSW health to ensure there are enough appropriately trained and willing doctors available in remote communities.

Often GPs working in remote communities are burdened with 24/7 on call duties often being the only doctor for 100s of km. Many currently practicing older GPs were, and still are, willing to do after hours on call work. Not so the new younger doctors. They rightly expect to be able to have time when they are not on call. Further any worker who is working very long hours is known to be less efficient.

In many remote hospitals NSW health rotates locum doctors in 2/3 week blocks. How can this lack of consistency benefit patient outcomes? While these doctors are doing their best the situation is less than appropriate.

Health has a major role to play in developing a system where remote doctors work at least in pairs and are paid appropriately for after hours work. This alone will make a big difference to patient health outcomes. There does need to be extensive subsidies paid to remote doctors to encourage experienced operators to service these areas. We have such a system in education. Why not Health?

We need a system that specifically selects students from rural and remote areas to work in health and especially train as GPs with the view to returning to their local communities to make a difference. The current school based VET model training nurses is making progress in the nursing shortage; we need a similar approach for Doctors. Some universities are starting to encourage prospective young people to enter medicine and offering come and try days and scholarships to train in rural medicine – a good start.

In the very early stages of doctor training there needs to be specific compulsory units addressing remote and regional health and the important role doctors have to play in rural Australia.

Government needs to fund local traineeships in nursing and aged care through a partnership with the local hospitals/ aged care facilities and schools and TAFE to train **young people and older people** from the **local community**. We are half way there with government funding traineeships this year. Every remote school should have a VET course in nursing so school students can do school based traineeships.
This is not very costly, it will encourage staff stay in the community and it will improve employment opportunities.

Terms of reference
h - the current and future provision of ambulance services in rural, regional and remote NSW;

Emergency ambulance services -000 operators who ask for the closest cross street are a serious **danger to health!** The next cross street may by 80km away from the emergency.

Remote ambulances need **local operators** with local knowledge to ensure the best outcomes. There are many anecdotes where people have died because local knowledge was not available.

There are often other paramedic services available especially in mining communities. These need to be used if they are closer to the emergency than ambulance.

The current situation where ambulances cannot leave their local area has merit but while there is such a centralised system in place there is also need for appropriate on call patient transport for everything from blood transfusions to physiotherapy.

Terms of reference

(b) a comparison of outcomes for patients living in rural, regional and remote NSW compared to other local health districts across metropolitan NSW
(j) the access and availability of palliative care and palliative care services in rural, regional and remote NSW
(e) an analysis of the planning systems and projections that are used by NSW Health in determining the provision of health services that are to be made available to meet the needs of residents living in rural, regional and remote NSW;

Remote hospitals need flexibility to allow beds to be used as needed by the community, not adhering to urban numerical models although these have value in city settings). E.g. When an elderly or palliative resident needs a few extra days for recovery why can't they stay in their local hospital when there are beds available rather than be transported 100s of km away from community just to satisfy a model of no more than 32 days before forced discharge.
The NSW health bulletin -Beds IB2020_001.pdf does not work well in remote settings.

The local hospital CEO needs to be required to meet regularly with the local GPs and local council to allow the hospital to function for the community not for NSW health. Some flexibility in management needs to come back to the community. Often it is too late by the time bureaucracy gets around to it.
Historically hospital boards were involved in the management of local facilities. Perhaps aspects of this model could work again to assess factors of remote care not understood by urban decision makers.

Terms of reference
the access and availability of palliative care and palliative care services in rural, regional and remote NSW; and aged care.
Federal government aged care needs to be working with NSW health to manage transition from hospital to aged and /or palliative care.

There is currently an issue in the Cobar community where aged residents are being sent to other remote communities when there are 15 brand new aged care beds literally down the hall but the federal ACAR has not gotten around to signing them off. REALLY! If this were any other business they would be sacked for poor service!

Since writing this piece ACAR have licensed the beds and some are now in use.
This incident serves to remind government that there are some very inefficient practices that need to be rectified NOW.

Another such incident in Cobar defies belief. The NSW hospital and the community aged care facility are joined by a corridor but if an aged resident needs hospital care they call the ambulance from the building on the other side of aged care and transport the patient 50 m by road to the hospital. – A colossal waste of time and money!!
I encourage a healthy dose of practicality and common sense for NSW health bureaucracy!

Lastly regarding the aged and palliative care issue – and again from the Cobar area. In December the Premier handed back land to the local indigenous people amongst great fanfare and that is fantastic, **but** with the other hand NSW health will happily send indigenous elders off country in their last days because state and federal government can't provide culturally appropriate end of life services.

Their needs to be special attention and policy developed in conjunction with the local indigenous peoples to ensure their elders can remain on country during ill health and end of life. Not an expensive process but not mentioned in the terms of reference.