Submission No 593

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

Name: Dr Dominic Horne

Date Received: 15 January 2021

January 13th 2021
Dr Dominic Horne

NSW Rural Doctors Association Doctor in Training Representative
NSW HETI Rural JMO Representative
NSW Rural Doctors Network Cadet

Submission to the Portfolio Committee: State Senate Inquiry into Health Outcomes and Access and Hospital Services in Rural, Regional & Remote New South Wales.

Dear Sir/Madame

Health outcomes for rural and remote populations in NSW are significantly poorer than those compared to larger metropolitan centres. This is especially true for Indigenous people living in these areas who are disproportionately affected. These outcomes are reflected across Australia and NSW is not alone in needing to find solutions to address the issues at the heart of these outcomes. As such both State and Federal government involvement and support is required to find locally meaningful solutions.

My submission and reflection on these issues have been garnered from experience as first and foremost as a resident of one of these communities in rural NSW from childhood more than 200km North West of Tamworth and I have gained a greater appreciation of the difficulties faced by rural patients and doctors as a Rural Doctors Network Cadet, a rural junior doctor and through representative/committee roles with both The Rural Doctors Association of NSW and The Heath Education and Training Institute JMO Forum Rural Representative.

Many of the issues surrounding rural health relate to patient access. Access in the first instance to primary care health providers and subsequently access to speciality services. In addition, access to training for potential career rural doctors. I hope to outline a number of difficulties from the perspective of a junior doctor who is invested and has a desire to be part of the solution to service rural NSW. Many of these sentiments I know are shared by my likeminded colleagues with various career pathways and ambitions.

Experience

- Training and service provision in rural areas does not adequately support or entice junior doctors to continue their specialty training in rural areas. Whilst there is clear support in attracting JMO and RMO level doctors (1st and 2nd year post graduate level) to rural regional centres the next vital steps in training along a specialty career pathway often require relocation to metropolitan centres to facilitate training. This pivotal point in time also coincides with many of the personal changes in a young doctor's life including marriage and children which inevitably result in difficulty relocating away from metropolitan centres even for those with rural career ambitions.

- The above issue is compounded by the majority of hospital specialist doctor training programs being co-ordinated through metropolitan centres who are allocated the lion share of the resources at a local area health district (LHD) level without there appearing to be an equitable patient admission numbers-based sharing of resources (resources being Registrar/Specialist in training). This results in Rural Referral Hospitals often having larger numbers of patients per doctor and the majority of these specialists in training spending most their training years in metropolitan centres from which they do not relocate on finishing specialist training.

- In terms of primary care physicians in rural areas the declining numbers of GPs available in the community is of growing concern and is reflected in the numbers of patients seen through the Emergency Department for issues that would be more appropriately addressed by their regular primary health care physician. However, this does not happen due to the long wait times to access the reducing number of GPs per capita that are remaining to service even larger rural centres let alone the smaller outlining towns. The Emergency Departments in these smaller outlying hospitals in rural areas are then often covered by a local community General Practitioner and for some small hospitals who do not have any medical onsite support are staffed by nursing staff alone. For those that do have onsite or available medical support there is little incentive or offsite specialist support for already overworked rural GPs to manage these cases locally which means further transfers to larger rural referral hospitals at further cost to the health system and the patient (both financially and emotionally). Much of this could be avoided with increased rural GP numbers to share the on-call burden and further rural GP incentives to maintain an ED workload allowing these patients to remain local with off site specialist support as required.

- There is also a growing shift in both these smaller Emergency Departments having to be staffed by locum ED doctors due to the declining GP workforce in these small towns, increased on call burden for these GPs and lack of incentives to cover the ED for local GPs. This locum coverage then comes at an increased financial cost to the health system and a cost to the patient in term of a lack of follow up and continuity of care once this patient is discharged or the locum doctor finishes their time at the hospital. Unfortunately, the exorbitant health system expenditure on ED locum doctor coverage is not limited to smaller outlining centres. Largely due to a lack of incentive and the difficulties outlined previously ED locum staffing which comes at a cost premium is the way in which many larger referral Emergency Departments are constantly staffed rather than increased local staffing rates.

- Sadly, locally when systems are put in place to assist in addressing these issues such as ED Telehealth Services to support GPs in smaller local hospitals with an on call FACEM (Emergency Specialist). Funding is then withdrawn despite the subsequent reduction in inter-hospital transfers. This occurs as this funding (as with funding and service provision of specialists in training) is co-ordinated at a district wide LHD (often metropolitan) not a local level to the detriment of rural patients. This type of service is the perfect example of what a rural referral hospital Telehealth outreach service to smaller outlying hospitals and GPs could look like and similar services for medical physician and particularly medical oncology advice and service provision to

provide services closer to home for patients out of a regionally local area are not unrealistic and would greatly improve rural patients access to health care.

Sentiments

- We know that from the increasing number of medical students and graduates from medical schools across the country that there is not an issue with number of doctors. The issue that rural Australia and NSW face is the maldistribution of these doctors with a predisposition toward the larger metropolitan and coastal centres.

- Metropolitan oversight of funding, distribution of resources and allowable service provision by rural referral centres negatively impacts rural patient's health access and the outcomes of patients as well as the perspectives taken by new consultants and up and coming rural junior doctors on future rural careers. It is frustrating to watch new consultants who could, and want to, provide services in these rural referral hospitals facing barriers to doing so. This seems counterintuitive to the narrative about improving rural patient outcomes. The reality experienced by the junior doctor on the ground is that opportunities for change and increased service provision are not facilitated but in fact obstructed. At the very least it appears that this occurs at a local area health district level out of metropolitan centres with a focus on centralisation.

- The impact of watching all of the above for a junior doctor is hard to measure, but not positive. Very disheartening and I don't doubt that some well-intentioned and doctors are lost to rural practice (GPs and in hospital specialists) due to the seeing their mentors being unsupported in addressing these issues and delivering improvements in rural patient outcomes. Junior doctors are watching this process and it affects their decision making for their own futures. This can be contrasted with the expenditure of the health dollar on locum ED coverage both in small GP run hospitals and larger rural referral hospitals. Those local doctors who are willing to continue to train in rural areas are not incentivised but locum doctors largely based out of metropolitan centres and provide short term ED coverage are extremely well compensated.

- All of this is saddening as I would definitely recommend people training in a rural area and I wish to continue to do so, there are great opportunities in an outside medicine, and I am no doubt a better doctor than I would have otherwise been working in a metropolitan centre for these initial years of my career.

Possible Solutions

- Restriction of Medicare Provider Numbers in the areas of workforce oversupply both General Practitioners and Specialists to redistribute the workforce to areas of need.

- Rural specific Medicare Item Numbers for billing to incentivise rural practice to both GPs and specialists to provide services in a rural location. This could be based on the Modified Monash Model with loading based or locality/rurality.

- Increasing the numbers of rural General Practice and Rural Generalist training positions and the co-ordination of rurally based Hospital Specialty training pathways with the support of the colleagues, RDAA/RDA NSW, AMA, AHPRA. These rural specialists particularly in the fields of general and subspecialty medicine, General Surgery, Obstetrics & Gynaecology, Orthopaedics, Paediatrics, ED, Psychiatry, Anaesthetics & ICU could be coordinated training rotationally based throughout a rural training system with the obligatory metropolitan time with a linked metropolitan centre. If a candidate successfully received accredited training on a rural specialist position, they would then spend the majority of their specialist training time out of a rural 'home' hospital and rotate to other potential rural hospitals and down to a metropolitan centre for that required time frame, This would be ensured with a required return of service agreement. This would ensure long term strategic planning for specialty service provision in the said 'home' hospital.

- Increases in local trained axillary staff including nursing, radiography and allied health (local scholarships and return of service post graduation) and rotation agreements to upskill existing support staff at larger metropolitan centres on short term rotation basis prior to returning to rural referral hospitals. The same could be achieved with outlining smaller hospitals with rotations to rural referral centres.

Thank you for taking the time to consider my submission. I look forward to the outcomes from the inquiry.

Kind Regards,
Dr Dominic Horne