Submission No 629

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

Organisation: The Royal Australian College of General Practitioners (RACGP)

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RACGP submission to the inquiry into health outcomes and access to health and hospital services in rural, regional, and remote New South Wales

1. Introduction

The Royal Australian College of General Practitioners (RACGP) thanks the NSW Legislative Council's Portfolio Committee No. 2 – Health, for the opportunity to provide a submission on health outcomes and access to health and hospital services in rural, regional, and remote New South Wales (NSW).

The areas on which the committee sought feedback on were very broad, and so we have provided an overview of the key points, adding in detail where possible. The RACGP would be happy to provide more information on specific topics as needed.

2. Health outcomes

The national picture is well known, with a wealth of research and data confirming that patients in rural, regional and remote communities have poorer health outcomes than those living in the major cities. Evidence has been gathered over several decades, describing the challenges facing these communities, and investigating some of the underlying reasons for the inequity in outcomes when compared to communities in urban areas.

The Australian Institute of Health and Welfare (AIHW) publishes regular reports on the health of the approximately 7 million Australians who live in rural and remote communities, providing up to date information on the national picture in Australia. These reports[i] [ii] detail the poorer health outcomes found in these communities, including:

- Higher mortality rates and lower life expectancy
- Higher road injury and fatality rates
- Higher reported rates of high blood pressure, diabetes, and obesity
- Higher death rates from chronic disease
- Higher prevalence of mental health problems
- Higher rates of alcohol abuse and smoking
- Poorer dental health

These poorer health outcomes are a result of a variety of factors as outlined in the AIHW reports. These include: challenges accessing the appropriate health professional; social determinants such as income, education and employment opportunities; higher rates of risky behaviours, for example smoking and alcohol use; and higher rates of occupational and physical risk including farming or mining work.

A 2016 report from the Bureau of Health Information[iii] shows that the situation in NSW closely mirrors the national picture, with higher mortality rates, lower life expectancy, and higher smoking rates in more remote areas of NSW, compared to the major cities in the state.

3. Access to health and hospital services

Research from across Australia, and internationally, shows that people living in remote and rural communities generally have poorer access to health services than people in metro areas. Medicare data from 2018-2019 show that the numbers of non-hospital, non-referred attendances per person (such as GP visits) were lower in remote and very remote areas (4.8 and 3.6 per person respectively), than in outer regional areas (6.0 per person), inner regional areas and metro areas (6.4 per person for each area)[ii].

We also know that the way people in rural and remote areas access primary care can differ to those in metropolitan areas. GPs are relied upon to provide a broader range of services to a more widely distributed population. There is less infrastructure, and less availability of local specialist services[iv]. The AIHW reported in 2019 that the proportion of people reporting not having a specialist nearby as a barrier to seeing one increased from 6% in major cities to 30% in outer regional areas, and 58% in remote and very remote areas.

The ability of patients to access health services is examined in the Bureau of Health Information's 2016 report[iii]. The report found that in NSW 33% of people in outer regional and remote areas, and 19% in inner regional areas, had difficulties accessing healthcare.

In particular there were unmet needs for primary care:

- 14% of adults in outer regional and remote areas, 15% in inner regional areas, and 12% in major cities said there was a time in the previous year when they needed primary care but did not receive it.

- About four in 10 people said they were able to get a same day primary care appointment when they needed medical attention – regardless of whether they lived in rural or urban areas. However, 39% of people in outer regional and remote NSW said it is very difficult to get out-of-hours medical care, compared with 33% of people in inner regional areas and 17% in major cities.

Commonwealth Government workforce data[v] shows that between 2014 and 2019 the number of full time equivalent (FTE) GPs in major cities in NSW increased by 17%. Over the same period the number of FTE GPs working in outer regional, remote and very remote communities in NSW increased by just 5%. More needs to be done to encourage GPs to choose to work in these communities.

4. Patient experience and quality care

Information from the Bureau of Health Information's 2016 report[iii] shows that overall, the healthcare provided to people in rural, regional and remote NSW is good:

- Across NSW, in both rural and urban areas, more than nine in 10 adults aged 55+ years said they have a regular doctor or GP clinic.

- In both rural and urban areas, seven in 10 patients said their GP 'always' explained things in an understandable way and spent enough time with them

- Among admitted patients, those in rural NSW were more likely to say they were involved – as much as they wanted to be – in decisions about their care and treatment; about discharge; and about medications

However, the issues with access highlighted above do impact on the patient experience. For example, while elective surgery waiting times are high across Australia, the impacts are often greater in rural communities where there are fewer support services to assist patients while they wait. Access to some public allied health and specialist services is also very limited.

GPs based in the mid North West coast of NSW have reported wait times of longer than 18 months for access to speech pathologists, occupational therapists, and ENT specialists. Patients waiting for these referrals also need to consider the costs and travel distances associated with finally getting the appointment.

The current pandemic has given a significant boost to telehealth for both medical and paramedical services. Telehealth has a key role in rural communities – it makes it easier for rural patients to access quality clinical care, while also providing rural health professionals with increased access to professional development opportunities, and support from specialists[vi]. As an example, evaluation of the *Mental Health Emergency Care–Rural Access Program* found that providing reliable remote access to specialist mental health assessment and advice while supporting providers in rural communities resulted in better outcomes for patients and services[vii].

5. Rural GPs' broader scope of practice

A lack of a range of doctors in rural communities means that GPs in these communities often provide care which, in an urban setting, would be provided by a different health professional. GPs often take on these skills to meet the needs of their community. One example of this is palliative care.

There is increasing demand for palliative care services across Australia, and a lack of specialist care services to meet this demand. In Australia, while around one third of the population live outside major cities, only 16% of palliative care specialists work in rural communities[viii]. Conversely, older Australians are more likely than the general population to live outside of major cities[ix]. As a result, GPs are the principal local healthcare providers for patients with end-stage conditions in rural, regional and remote Australia. The barriers facing GPs providing palliative care include: inappropriate reimbursement; fewer resources (e.g. limited access to medications after-hours); insufficient training, with very limited funding to support training; and an unclear role for the GP[viii].

In NSW the picture varies across the State. While palliative care services are generally limited in regional, rural and remote NSW, there are good services in some areas. A great example is the service in Coffs Harbour which recognised the need for better integration between generalist and specialist palliative care, and developed a specialist palliative care program to help train GP registrars in the mid-north coast.

6. Recommendations

The RACGP has been advocating for a range of approaches to tackle these issues. Solutions can be broken into three main areas: supporting trainees, attracting GPs who are working in more urban areas, and supporting the GPs already working in rural communities. Specific recommendations based on these three themes, are outlined below.

Training

Evidence shows that the two key drivers of GPs choosing to work in rural areas are: the quality and duration of rural training experience; and having grown up in, or spent a considerable time living in, a rural community[x]. It's important therefore to ensure that there is a focus on selecting rural-origin medical students, and providing positive rural placements.

1. **Increasing the number of rural-origin students in medical school**
2. **Increasing exposure to rural general practice in undergraduate and graduate medical courses**
3. **Increased support for rural GP supervisors, including increased funding for compensation, and access to training and professional development.**
4. **Increasing support for GPs training in rural communities, e.g. bursaries to train in rural communities, travel expenses, accommodation provision etc.**

Attracting GPs to rural areas

Established GPs who are interested in rural practise may find it difficult to know what steps to take to successfully move to a rural or remote community – there is often no clear path. A recent project (a collaboration between the Mid North Coast Regional Training Hub, and Regional Training Organisation, GP Synergy), is looking to provide a pathway for interested GPs by providing detailed, tailored support, including identifying education gaps, supporting the GP's partner and/or children to find work and education options, helping the GP settle into the community etc.

The RACGP will be launching a program this year, Practice to Practice, which links up practices in rural and metro areas and helps them build a mutually beneficial relationship which could include mentoring, upskilling, locum opportunities, telehealth support etc. One of the key aims of the project is to provide more exposure of rural practice to metro GPs, to make it more likely they may choose to work in a rural community.

5. **Encouraging initiatives to support GPs to experience rural medicine, and to move to rural communities**
6. **Streamline credentialing processes so that it's easier for GPs from other areas to locum in rural communities to fill gaps**
7. **Encouraging a whole-of-community approach to settle GPs into rural communities, for example**

Supporting rural GPs

GPs working in rural communities need support to meet their community's needs. This means support for them to gain necessary additional skills, to support their community through disasters, and to attract and train the next generation of rural GPs. It would also be helpful to allow sharing of some of the successful healthcare models that currently exist in remote and rural communities across Australia, and to support the development of new models to best meet community needs given available resources.

8. **Provide greater incentives, rebates, and scholarships for rural GPs to gain and maintain additional skills to benefit their community. This should include both procedural (e.g. anaesthetics, obstetrics) and non-procedural (e.g. mental health, paediatrics, palliative care, emergency medicine) skills.**
9. **Involve GPs in disaster management plans, and help them support their communities when disasters happen**
10. **Supporting innovative models which are adapted to suit particular communities**

7. Conclusion

The RACGP would be very happy to discuss any of these issues further.

8. References

[i] Australian Institute of Health and Welfare 2010. Australia's health 2010. Australia's health series no. 12. Cat. no. AUS 122. Canberra: AIHW.

[ii] Australian Institute of Health and Welfare 2020. Australia's health 2020 data insights. Australia's health series no. 17. Cat. no. AUS 231. Canberra: AIHW

[iii] Bureau of Health Information. The Insights Series – Healthcare in rural, regional and remote NSW Sydney (NSW); BHI; 2016.

[iv] Australian Institute of Health and Welfare 2019. Rural & remote health. Cat. no. PHE 255. Canberra: AIHW.

[v] Australian Government, Health Workforce Data, General Practice Primary Care Statistics (calendar year); 2014 to 2019.

[vi] Moffatt JJ, Eley DS. The reported benefits of telehealth for rural Australians. Australian Health Review 2009; 34(3): 276-281

[vii] Saurman E, Lyle D, Perkins D, Roberts R. Successful provision of emergency mental health care to rural and remote NSW - an evaluation of the Mental Health Emergency Care-Rural Access Program, Australian Health Review, 2013;38(1):58-64.)

[viii] Ding J, Saunders C, Cook A, Johnson CE. End-of-life care in rural general practice: how best to support commitment and meet challenges? BMC Palliative Care 2019; 18 (51)

[ix] Australian Institute of Health and Welfare 2018. Older Australia at a glance. Cat. no. AGE 87. Canberra: AIHW.

[x] Ogden J, Preston S, Partanen RL, Ostini R, Coxeter P. Recruiting and retaining general practitioners in rural practice: systematic review and meta-analysis of rural pipeline effects. Medical Journal of Australia 2020; 213 (5): 228-236.