Submission No 711

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

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

23 July 2021

Portfolio Committee No.2
Parliament of New South Wales

Dear Committee Members,

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

The value of oral health and its impact on general health and wellbeing, quality of life, in addition to its effect on other Chronic diseases is well known. (WHO, 2005)

I have many long term patients who travel to my practice in Sydney, from rural NSW as they do not have any trust in the level of practitioner and service, they perceive they will receive in their local rural area. They also consult with medical specialist in Sydney. Many are mature age Australians who have chronic medical conditions. They are prepared to make the long journey by road or train, seeking a higher and trusted level of health care. This is a sad indictment and reflection on the medical services available to rural and remote Australians.

This inquiry carries significant importance and one which I have strong views on, and so it is for this reason I make my submission.

Thank you for the opportunity to provide a submission to the NSW Parliamentary Inquiry into *Health outcomes and access to health and hospital services in regional, rural and remote NSW*. In this submission, I will be addressing Terms of Reference (TOR):

a) health outcomes for people living in rural, regional and remote NSW;
b) a comparison of outcomes for patients living in rural, regional and remote NSW compared to other local health districts across metropolitan NSW;
c) access to health and hospital services in rural, regional and remote NSW including service availability, barriers to access and quality of services and
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;

TOR a) and b) are closely related and so will be discussed together.

TOR a) health outcomes for people living in rural, regional and remote NSW.
b) a comparison of outcomes for patients living in rural, regional and remote NSW compared to other local health districts across metropolitan NSW.

It is well documented that living in regional, rural and remote NSW confers inequities in access to healthcare and often, poor health outcomes. Evidence shows that the geographical remoteness of living in regional, rural and remote areas not only reduces health outcomes, but it is usually associated with lowered education, socio-economic status and thus quality of life. (AIHW, 2019) These social determinants also increase the risk for injuries requiring medical treatment. (Peden and Franklin, 2020).
Mitchell, Curtis and Foster (2018) undertook ‘a 10-year review of the characteristics and health outcomes of injury-related hospitalisations of children in Australia’. They found that child injuries

over the 10 year period cost 2.1 billion dollars in hospitalisations. More concerning though was the finding that children had a higher risk of dying from their injuries if they lived in regional, rural and remote Australia. (Mitchell, Curtis & Foster, 2018)

Peden and Frankin (2020) undertook a study 'Exploring the Impact of Remoteness and Socio-Economic Status on Child and Adolescent Injury-Related Mortality in Australia'. Overall, this study identified that lower socio-economic groups experienced higher rates of fatalities, compared to the same age groups with a higher socio-economic status. However, they also observed that with increased remoteness, there was a demonstrable increase in fatalities compared to the same age groups in urban areas.

Western Alliance Academic Health Science Centre (Western Alliance) in Victoria, in its article titled 'The great health divide: Why rural Australians have poorer health outcomes than their urban counterparts' (nd) supports the findings of the Australian Institute of Health and Wellbeing [(AIHW) 2019] that 'on average, Australians living in rural and remote areas have shorter lives, higher levels of chronic disease and injury and poorer access to and use of health services, compared with people living in metropolitan areas.'

These poorer (often fatal) health outcomes, like road traffic injuries, drowning and intentional self-harm, along with the higher incidence of chronic non-communicable diseases experienced, highlight the inequities confronted by patients living in regional, rural and remote NSW.

Frameworks must be developed, which are aimed at educating children and adults living in these communities (NRHA, 2017; Peden and Franklin, 2020) in order to promote health and safety and reduce injury. Examples include education initiatives targeting:

- the importance of healthy eating and a good diet,
- the risks of engaging in dangerous activities (which can result in preventable injuries)
- road safety, and
- knowledge of the available crisis or support help-lines.

These initiatives will help reduce the burden of disease afflicting these communities, and promote a better quality of life, in addition to reducing some of the health inequities they endure. (NRHA, 2017; Peden and Franklin, 2020)

TOR c) access to health and hospital services in rural, regional and remote NSW including service availability, barriers to access and quality of services.

The AIHW (2019) identified that, 'poorer health outcomes in rural and remote areas may be due to multiple factors including …access to health services.' (AIHW, 2019) Reduced access is due to the remoteness of these communities to a primary care facility. Also, there are fewer facilities available to manage patients from far-reaching geographical locations. These patients often have a greater dependence on medical General Practitioners (GPs). GPs are often required to undertake a broader scope of treatment due to a limited access to specialist physicians and/or facilities in rural NSW. However, the shortage of GPs and other health professionals increases with increased remoteness-which further fuels this problem of access. (AMA, 2021)

Bradbury et al.(2017) undertook a study of the 'Actual availability of appointments at general practices in regional New South Wales, Australia'. They found that the chance of a new adult patient

in regional NSW getting an appointment on the day they called, was less than 50%. Getting an appointment within 2 weeks was 70% and not getting an appointment at all, due to the practice books being closed to new patients, was 30%. They concluded that 'this was highly variable across different local government areas.'

It was also identified that if a practice did not bulk bill (the average out of pocket (OOP) expense being around AU$30) then patient's went untreated, as they could not afford the OOP cost required to attend the medical appointment. What this study demonstrates is the inequity confronted by patients living in regional, rural and remote NSW in timely access to primary healthcare, as a consequence of geographical remoteness and cost.

As highlighted by Woodburn (2021) healthcare facilities are under resourced with doctors and nurses, and so those working in these facilities often experience the effects of burnout. Their fatigue is high, and it often results in a lack of care towards work and patients, poor clinical judgement, and overall risks to patients health and well-being. Sometimes the result is a preventable death. (Fellner, 2021) So when patients actually get seen by a healthcare professional, their care is likely to be a compromised.

TOR 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.

According to the Australian Medical Association (AMA, 2021) the number of GPs decreases the more remote a region becomes. It is well known that hospitals in regional, rural and remote areas struggle to attract and keep GPs and other healthcare professionals.

Burnout is a phenomenon which was reported by Maslach (2003) as 'a prolonged response to chronic emotional and interpersonal Stressors on the job and is defined … by …. exhaustion, cynicism, and sense of inefficacy'. Workers afflicted by burnout have been identified to have a negative (or dysfunctional) effect on their colleagues and in the case of healthcare workers, on their patients as well (Maslach, 2003). Lewin (2019) highlights that for the first time *Burnout* has been recognised as a medical condition by the WHO. Burnout affects healthcare professionals working in regional, rural and remote NSW.

Woodburn (2021) reports that this 'NSW parliamentary inquiry hears rural doctors' and nurses' workloads are crippling staff, harming patients'. These are the classic signs of burnout reported by Maslach (2003).

Consider this. Would anyone from a metropolitan area, choose to leave behind a healthy income, a comfortable lifestyle with a healthy work-life balance, in order to relocate to a regional, rural and remote area in NSW to practice, knowing that their workload would be plentiful, rest would be scarce and work-related burnout would be high? In addition to the knowledge that there would be nowhere to retreat from the burden of being the only on call doctor, often required to practice outside of your professional scope? No. Consequently, regardless of the incentives being offered, without changes to these work limitations, nothing would make this an attractive offer to an urban health professional. An article published in ABC (Grindley, 2017) titled, 'Why $400,000 house and car packages are not enough to attract GPs to stay in the bush' highlighted this issue. Grindley (2017) identified that huge salary incentives and lifestyle 'perks' being offered by governments, were not enough to incentivise GPs into regional, rural and remote Australia. Reasons cited included lack of

lifestyle amenities, climate, limited basic resources like fresh food, safety concerns, higher crime rate, staff burnout in addition to practice costs not being viable.

Strategies for change to incentivise Healthcare professionals to relocate to rural and remote NSW

1. Task substitution by introducing lesser trained professionals to undertaken the scope of a doctor (or other health professional) *is not* the solution

Governments should not fuel the inequities already faced by regional, rural and remote NSW populations with the substitution of medical GPs (and dentists) by the lesser trained and less capable Nurse Practitioner, Physician Assistants (and Oral Health Therapists) (Western Alliance, nd). Increasing the scope and changing the registration requirements of these allied primary healthcare professionals was made on the premise of meeting the medical (and dental) practitioner shortfalls experienced in regional, rural and remote NSW. Nurse Practitioners, Physicians Assistants (and Oral Health Therapists) undergo less training, to a lower standard than a doctor (or a dentist) as their scope of practice is different. As highlighted by the Royal Australian College of General Practitioners (RACGP) entry requirements and education and training programs are not equivalent to those completed by GPs. (RACGP, 2016; RACGP 2018; USyd, 2021a,b & c)

It is well documented that Australians living in regional, rural and remote Australia have:

- a reduced life expectancy, are
- affected by non-communicable disease eg heart disease and diabetes more than compared to their metropolitan counterparts, and
- have a greater socio-economic disadvantage. (AIHW 2019, Western Alliance, nd) compared to those living in Metropolitan areas.

Consequently, patients in regional, rural and remote NSW have higher more specialised treatment needs, which the Nurse Practitioners, Physician's Assistant (and Oral health Therapist) cannot diagnose, treat and manage appropriately. 'Nurse practitioners seeking the same level of authority, autonomy and scope of practice as GPs will compromise the quality, safety, efficiency and cost effectiveness of patient care' (RACGP, 2016) in regional, rural and remote NSW.

Issues to consider with the suggested solution of using Nurse Practitioners, Physician Assistants (and Oral Health Therapist) to fill the medical GP, and other healthcare professional, shortages in regional, rural and remote NSW include:

a. How does the government propose to incentivise these allied primary healthcare professionals into regional, rural and remote NSW, any differently to medical GPs and other health professionals? Of the James Cook University Physician Assistant students, only 50% reside in regional areas. (RACGP, 2018)

b. Will these professionals be trained and registered by Australian Health Professional Regulatory Authority (AHPRA) with their scope limited to certain postcodes? Or will they be trained and 'let loose' to practise in metropolitan areas, to further 'exacerbate the issue of patient over-servicing in urban areas' (RACGP, 2018) and undermine patient safety and quality due to their reduced education and training limitations compared to GPs? (RACGP, 2018)

c. By increasing the scope of these lesser educated and trained allied health practitioners and restricting their practice to regional, rural and remote NSW is the Government agreeing to, and

condoning the notion that regional, rural and remote Australians do not have the same entitlement to registered doctors and other health professionals, as patients living in metropolitan areas, and thus furthering the inequities already identified in this population group of Australians?

2. Strategies to get the right professionals managing the primary, and beyond, healthcare needs of rural, regional and remote New South Wales communities.

Governments and Healthcare Associations need to strategise ways to create living and community environments which support and attract rural GP placements, as well promoting regional, rural and remote community engagement. An example of this is evidenced in the Northern Territory town of Katherine. RAAF Base Tindal has a community of base personnel and their families. These base personnel and their families contribute to 10% of the entire Katherine population. (RAAF Base Tindal, 2021) Base personnel and their families primarily live on-base, in community defence housing, which includes recreational facilities like a pool and gym. The defence community contributes to the local community with their children attending local schools, participation in community activities like fund raising. There is a supportive collaboration between Defence and local community members. It is reported that 'Tindal is remote, but it is this remoteness which has forged us into such a special and tight-knit community'. (RAAF Base Tindal, 2021) Personnel are willing to be posted there with their families.

This example of developed communities to support local work requirements, is also seen in the Middle-East, for example in Saudi-Arabia. The demand for western workforce accommodation surged after the 'discovery and exploitation of oil' (Glasze & Alkhayyal, 2002) in the 1940s and saw an increase in residential compounds being built in Saudi-Arabia. These compounds were purpose-built for western professionals who worked in the oil industry, they are 'accompanied by their families…(the compounds) are generally well maintained, landscaped, and offer a range of support services such as kindergartens and local clinics as well as amenities like tennis courts, swimming pools, etc'. (PeiBker-Meyer, cited in Glasze & Alkhayyal, 2002). These purpose-built compounds or gated-communities, provide a lifestyle, independent of the surroundings and provide security, support and most of the services of a small self-sufficient town. Hence making the move to Saudi-Arabia by foreign personnel attractive, whilst also supporting the industry that is dependent on them. Thus dealing with many of the issues currently deterring attracting health professionals to regional, rural and remote NSW.

As well as providing an attractive relocation incentive to prospective healthcare workers, the local community will benefit. Not only access to quality healthcare professionals increase, but also;

- local jobs will increase, from increased development requirements,
- demand for supplies including fresh food increased, so facilitating better diet choice and
- the socio-economic status increases, in these otherwise regional, rural and remote communities.
- increase of available resources and amenities, arising from population growth attributed to the healthcare provider compounds, thus promoting better quality of life.

Ultimately, more healthcare providers will be available, resulting in improved access to healthcare and consequently, improved and equitable treatment.

Conclusion and recommendations

Having read through many of the submissions already addressing the issues confronting patients and healthcare workers practising in community based or private healthcare facilities in regional, rural and remote NSW, it is manifest that there is a problem which is not new, but which needs a novel approach, if these problems are to be addressed and resolved.

My evidence supported proposal includes:

1. Investing in injury and disease prevention interventions for regional, rural and remote populations. (NRHA, 2017; Peden and Franklin, 2020). As stated by Mitchell, Curtis & Foster (2018), 'The development of a national multisectorial childhood injury prevention strategy in Australia is long overdue.'
2. Investing in infrastructure into regional, rural and remote areas, and creating healthcare community compounds similar to those created for military personnel in the Northern Territory (eg RAAF Base Tindal) and overseas, for example the gated-communities in the Middle-East.
3. Use of a military-based posting model where health care professionals employed in the state network are given the option to work in these regional, rural and remote areas for an agreed time period, with incentives of:
    a. Subsidised accommodation in the resort-like compounds, housing the healthcare workforce including salary incentives and tax offsets.
    b. Increased annual leave per annum.
    c. Contracted period of employment eg 3 years with view to extend if desired (similar to the commercial leasing options).
    d. Intergovernmental agreements on a national framework which provides healthcare workers with the option to work in similar facility in a regional, rural and remote area, interstate.

The aim should be to attract GPs (and their families) to regional, rural and remote NSW not only with monetary incentives but with promise of job satisfaction, support and lifestyle. This also has positive flow on effects in the community the greatest being a larger pool of happy healthcare professionals providing equitable access to quality health care. Thus, improving health outcomes.

'People residing in regional, rural and remote areas and from low socio-economic backgrounds already face significant health and lifestyle challenges associated with disadvantage'. (Peden and Franklin, 2020). They should have access to the same standard of medical care as patients in metropolitan and regional areas. (RACGP, 2016)

Thank you for reading my submission and its recommendations. Its aim is to support bridging the gap towards improved healthcare outcomes, in addition to removing the health care inequities confronted by residents living in regional, rural and remote NSW.

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