Submission
No 92

THE IMPLEMENTATION OF PORTFOLIO COMMITTEE NO. 2 RECOMMENDATIONS RELATING TO CROSS-JURISDICTIONAL HEALTH REFORM AND GOVERNMENT CONSULTATION WITH REMOTE, RURAL AND REGIONAL COMMUNITIES

Organisation: Rural Doctors Association of NSW

Date Received: 18 November 2024

The Select Committee on Remote, Rural and Regional Health Inquiry into the implementation of Portfolio Committee No. 2 recommendations relating to cross-jurisdictional health reform and government consultation with remote, rural and regional communities

Submission on behalf of the

Rural Doctors Association of New South Wales (RDA NSW)

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The RDANSW is a member organisation representing rural doctors and the health of rural communities. Our members provide care in rural hospitals and as GPs in rural towns. We are well placed to understand the challenges of providing health care in regional and remote NSW.

Introduction:

The RDA NSW provided a submission to the previous inquiry conducted by The Select Committee on Remote, Rural and Regional Health into the implementation of Portfolio Committee No. 2 recommendations specifically relating to workforce issues, workplace culture and funding considerations for remote, rural, and regional health. Refer Submission No.49.

The RDA NSW thanks The Select Committee for the opportunity to provide a submission to the inquiry, that was self-referred on 11 September 2024, on the progress of and issues relating to the implementation of Portfolio Committee No. 2 recommendations relating to health outcomes and access to health and hospital services.

Below is feedback that members of the RDA NSW have provided to the association regarding the progress of and issues relating to the recommendations implemented so far:

ToR 1: Cross-jurisdictional cooperation between the New South Wales and Australian governments, in particular:

> **a) Long-term strategic planning to improve health services and health outcomes in remote, rural and regional areas, including in relation to primary health (including Recommendations 1, 7, 8 and 11)**

NSW has adopted the Single Employer Model (SEM) across the state as a means of protecting industrial entitlements for Rural Generalist (RG) Registrars. This has been a positive step in improving engagement at offering choice for trainees.

The training places have been well subscribed within the RG training program however positions for training remain vulnerable to Local Health District (LHD) engagement/position provision.

Recognition of Rural Generalism within a new industrial Award to allow for scope of practice and skills recognition, as well as development of appropriate roles for RGs within NSW Health has not been achieved. There is still negotiation underway at a federal level however there have been no appreciable developments within NSW. Rural Generalists are leaving NSW to accept appropriate positions in other states where they are industrially recognised to use their skills, such as RG Paediatricians.

Small procedural hospitals in NSW remain under threat due to funding arrangements such as block funding vs activity-based funding. There has been no improvement in service provision within NSW (e.g. increasing birthing rates in smaller hospitals, increasing surgical lists in smaller hospitals), suggesting that the existing funding models are inadequate to allow for expansion of services. Rural maternity services remain under threat in many LHDs, including Kempsey, Cootamundra, Temora, Tumut.

Local Health Districts (LHDs) operate autonomously within NSW Health. This results in very little ability for Ministry to enforce recommendations around operational or budgetary matters. Until there is accountability for improving engagement, in the form of reportable outcomes or KPIs (e.g.: the number of women birthing locally or on-country, the number of surgical cases being completed in rural hospitals) there will be no impetus for LHDs to prioritise rural service delivery.

RDA NSW has recommended that positions be created within LHDs for Rural Generalist Coordinators whose role is to oversee service provision in rural hospitals and to ensure that LHDs support maintenance of skills for existing RGs and maximise the potential for engaging new RGs through the RG training program. This is imperative for maintaining strong rural hospitals and growing service in small towns.

The SEM has been adopted which has been a dual federal/state responsibility. This is positive step however we are yet to see the effect on permanent GP attraction/retention in rural NSW due to the time taken to graduate from the program. There is potential for the training program to produce hospital-based doctors who do not end up in rural towns using their skills due to the loss of places and opportunities to use their skills appropriately with ability to maintain skills through regular base hospital contact.

The John Flynn Pre-vocational Doctor Program (JFPDP) allows for junior doctors to spend pre-vocational time in rural locations, working between general practice (private) and the hospital. This is known to be a very beneficial initiative for rural GPs (assisting with workload) and to improve exposure positively to rural generalism as a career. Unfortunately the JFPDP placements are not prioritised so junior doctors are often retained in the feeder hospitals to fill positions, rendering many placements in rural areas repeatedly undersubscribed. More positively there is discussion to open the position to metropolitan junior doctors.

General practice remains critically understaffed throughout rural NSW. Initiatives such as using the SEM to provide state-funded primary care in thin market towns have been adopted in some areas and there is likely to be expansion of this as these areas are identified.

Protection of existing GPs in rural towns is important to preserve what services do exist. Use of remote GP services (telehealth) has been helpful to cover hospital on call when VMO numbers are too small to sustainably provide the service. Caution is required to ensure that any local services run by private general practice are not adversely impacted by state-dictated remote or otherwise hospital staffing arrangements.

Nurse practitioners are being engaged in some locations however there has been little engagement with GP VMOs locally to understand their scope of practice and the role of the GP in supervision and follow up.

Emergency departments visitations are increasing still, reflecting the saturation of community general practice.

There has been very little improvement in engagement of rural GP VMOs in MSCs which are predominately based in metro and regional hospitals and therefore there continues to be a lack of GP VMO representation.

There do not appear to be any improvement in the number of locums engaged by hospital that are also engaged to work in the local general practice to improve access to appointments in general practice and reduce ED presentations.

Credentialling and appointment of VMOs in rural hospitals does not appear to have improved. Members are still reporting that VMO contracts are being offered for, e.g. 3 month or 6-month periods, or contracts being offered that do not include credentialling of the VMO for work that they have an AST and experience in.

More support is needed for Australian Doctors Trained Overseas (IMGs) to provide VMO services as (often they are not credentialled or experienced in Australian hospitals. There is opportunity here for this to occur.

ToR 2) Collaboration between NSW Health and Australian Government bodies on particular initiatives, services or training programs (including Recommendations 9, 10, 14, 21, 22 and 39)

The implementation of the Single Employer Model for GP trainees across rural, regional and remote NSW has largely been achieved. Please note that this is for Rural Generalist GP Registrars only, not GP registrars as a whole.

The RDA NSW is not aware of a *Rural Area Community Controlled Health Organisation (*RACCHO) pilot being established in NSW.

The Single Employer Model is used for some thin market areas for provision of primary care in a state funded model.

Whilst GP registrar positions within the RACGP and ACRRM training colleges have had increasing numbers (RACGP and ACRRM currently fully subscribed) this is yet to translate to more rural registrars - it is too early to see the flow on effects rurally. Support for Australian Doctors Trained Overseas (ADTO) remains a federal issue which impacts on small communities due to their reliance on this workforce.

There have been increasing numbers of medical students graduating however the numbers of junior doctors choosing rural/regional GP/non-GP specialist training remain low. There remain obstacles to train rurally in non-GP specialties. There remains inequity in funding and positions available and models for training which would benefit rural/regional training for non-GP specialties.

Universities are increasingly training medical students rurally, however, appears to be no accountability regarding outcomes for rural career uptake hence there is little incentive for review of systems/content which may influence outcomes. Whilst universities and rural training schools have responded to the tenet that rural/regional people trained rurally/regionally are more likely to return to or stay rural/regional, the non-GP specialty colleges appear to remain mute on this subject and do not show strong leadership for rural/regional training and support.

There remains large out -of-pocket costs for patients accessing private regional cancer service where there is no option for public care. The RDA NSW is aware that from 1 July 2024, there will be no out-of-pocket costs for patients who may receive radiotherapy and medical oncology treatments in Wagga Wagga at the Riverina Cancer Care Centre due to a new agreement. Apart from this, the RDA NSW is not aware of any other changes to reduce costs to patients.

NSW Health is currently due to implement a new medical records system that reportedly has improved capability for communication with primary care. This is still in the implementation-phase. Feedback from some members is that logging into the patient's records is time-consuming and retrieving information is difficult.

PHN work remains largely disconnected from the LHD in a functional sense. There is no shared communication process that affects general practice as the main coordinator of patient care in the community. However, there does appear to be collaboration happening at an organisational level between LHDs and PHNs (e.g.: the recognition of the relationship between Murrumbidgee LHD and Murrumbidgee PHN. How this translates into better primary care is not clear from a practical level).

There remains great potential for programs to be developed to reduce patient cost (using public hospital-based funding) and reduce load on primary care in rural areas. This includes chronic kidney disease care, chronic liver disease (the growing metabolic liver disease prevalence which requires 6 monthly disease surveillance at significant cost to patients if no bulk billed imaging is available) and potentially childhood obesity.

Service provision by PHNs remains vulnerable to changes in funding and piecemeal funding which can result in segmented care that is difficult to navigate (collaborative care using external providers can contributes to confusion about referral processes due to potential for provides to change and specific referral requirements). This is a federally funded service. There has been no change to this in recent years.

ToR 3) NSW Government consultation with health stakeholders and communities in remote, rural and regional New South Wales, in particular:

> **a) Improving communication between communities and health services (including Recommendations 5, 42), and**
>
> **b) Developing place-based health plans (including Recommendation 43)**

It is RDANSW's opinion that communication by the health services with local community groups and charities appears to occur in a post hoc manner, rather than pre-emptively. Interval service "plans" carried out by LHDs will give the current statistics of a health service or facility and the services required and anticipated. Community feedback is then sought once the plan has been developed and future services forecast. This is not collaborative, nor is it capacity building in its approach. It would appear to be a budgetary response.

Infrastructure changes, such as building new facilities, does follow community engagement however it is difficult to know how much feedback is actually taken into account or whether the overall design has been decided on and the process is merely ticking the box of consultation.

Closure of services, such as operating theatres, will often occur in a poorly forecast manner with little engagement prior to or during the process. This leaves communities feeling betrayed and staff/practitioners discounted. Community response is then reactive rather than engaged and the LHD response is then defensive.

*Local Health Advisory Committees (*LHAC) remain active within rural communities and do engage with each other across health districts. They are important for community representation on health service delivery. RDA NSW is not aware of any changes to LHAC engagement or methods for informing rural communities about current available or planned services.

It is too early to discern if there have been any significant changes to current procedures with respect to Place-Based-Needs-Assessments and Local Health Plans within rural catchments. Data is extracted from general practice via PHN systems which helps to guide the provision of services within PHN boundaries – there has been no apparent change to this process since the inquiry.

ToR 4) NSW Government action to prioritise the health of regional communities in government decision making (including Recommendations 36, 37 and 44).

NSW has maintained a Regional Health Minister (currently a co-portfolio with the NSW Health Minister). The position allows for escalation of rural issues however the minister is inhibited by Treasury and by the autonomy of LHDs in terms of direct power to enact recommendations.

The Regional Division of Health and newly created Deputy Secretary of Regional Health have also allowed for improved visibility of rural/regional health issues and for direct communication with positions of influence. The utility of this from a practical view (actual authority to enact change, and seeing changes occur) remains uncertain.

ToR 5) Any updates or final observations relating to the progress of implementing any Portfolio Committee No. 2 recommendations that the Select Committee has considered in its previous inquiries.

RDA NSW maintains a good relationship with the NSW Minister for Health, the NSW Deputy Secretary of Regional Health and the Ministry of Health. There has been good engagement and understanding of regional issues. However, RDANSW remains responsive to member concerns about continued loss of services in rural areas. There are significant workplace communication and culture issues at LHD administrative levels which are difficult to resolve.

Rural generalism has been widely adopted as one of the areas of growth for NSW. The SEM is being implemented across NSW however RG training places still remain undersubscribed and there is workforce shortage which remains critical across rural areas. There has been little progress in ensuring that Rural Generalist trainees are able to access positions in rural areas where they are able to practise their newly acquired skills. This is indelibly linked to reduction in rural surgical/anaesthetic opportunities (i.e.: carrying out surgical procedures in rural sites) and the reduction in rural birthing. The lack of an appropriate award for recognising rural generalist skills and the lack of RG positions with appropriate scope of practice that is adopted within a workforce framework is impacting on workforce retention within NSW as RGs leave to move to states where rural generalism is integrated within the health system both industrially and functionally for service provision.

Until rural LHDs are held accountable for the numbers of rural procedures carried out, the prioritisation of rural placements for JMOs, the engagement with the RG workforce for service provision and skills maintenance/development, then the situation in rural hospitals will not improve.

Non-GP specialty services in regional areas are also under pressure and there is potential for growth in registrar training opportunities rurally however this relies on the non-GP specialty colleges championing rural/regional health and training as a priority and there is little evidence that this is occurring. Metrocentric models predominate still.

The RDA NSW has been engaged by NSW Health through the Rural Doctors Employment Arrangements (RDEA) Working Group, to create alternative industrial arrangements for GP VMOs employed in RDA Settlement Package (RDSP) Hospitals.

Funding for a Fixed Daily Rate (FDR) to be offered in select RDSP is yet to be approved. The FDR will offer a fixed rate to VMOs to provide certainty of income, in particular to GP VMOs working in rural hospitals with low patient through-put in the hospital.

The introduction of 3 new item numbers to remunerate GP VMOs for the additional time taken to complete discharge summaries & medication reconciliations for admitted public patients in the electronic medical records system has been well received. The item numbers continue to increase in use as VMOs and checkers become more familiar with them.

A new item number for GP VMOs providing agreed, planned supervision of junior doctors has also been added to the Rural Doctors Settlement Package and is continuing to be monitored for use.

Appropriate remuneration and the increasing burden of credentialling processes and paperwork for GP VMOs who provide supervision to medical students continues to be raised by members. As the number of medical students continues to increase, more support is required for GP VMOs and practices to apply for accreditation and offset the reduction in income due to less patients able to be seen by the GP VMO.

A non-standard remuneration determination that permits select GP VMOs to be incremented at higher hourly rates has been approved for LHDs to offer sessional VMOs at RDSP sites in 2024. The RDA NSW do not feel that this has not been effectively communicated to relevant stakeholders and are not aware of any sessional VMO contracts at the higher hourly rate being offered. The RDA NSW has sought information from the Ministry of Health to communicate to members to promote this new option to VMOs and to GPs who are considering applying for VMO work.

Statewide credentialling is underway for medical officers contracted to NSW Health but is not functional yet. Credentialling remains arduous and restricted to individual LHDs. A system for GP VMO accreditation statewide and a database of GP VMO locum availability have not been created. Discussions around creating a locum pool for rural hospital relief, administered by NSW Health, are underway however this has not been fully explored nor resolved.

The RDA NSW continues to receive communications from medical members regarding antagonistic behaviour of administrative staff at all levels of management within LHDs. This is as severe as situations consistent with reprisal against our members raising concerns. It has proven to be very difficult to escalate these concerns due to administrative complacency and ministerial handballing.

Anecdotally there are facilities within NSW that remain highly dysfunctional with long term staff leaving due to poor workplace culture. This affects staff morale, service provision and has also resulted in the loss of medical practitioners from those facilities. Some nursing staff report high rates of stress in many facilities and have poor working relationships with management.

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