Submission No 104

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

Name: Ms Sarah Elliott - Troy

Date Received: 15 November 2024

Sarah Elliott

[redacted]

Legislative Select Committee

Rural, Remote and Regional Health

NSW Parliament.

Re: Terms of reference for 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.

Dear members,

I am writing this submission to address the terms of reference for the current inquiry into rural, remote and indigenous health.

I am a Registered Nurse, Registered Midwife and Nursing academic with Charles Sturt University. For many years I have been aware of the deteriorating state of rural, remote and regional health care. My professional backgrounds have compelled me to lobby the government at both State and Federal levels to intervene with meaningful and appropriate action. Unfortunately I have been left disappointed in my attempts to engage the relevant Health Ministers at both NSW State and Federal Governments and their staff. I must stress however that I am extremely grateful to my State Local Member of Parliament, Trish Doyle who made many representations on my behalf and assisted me to bring the inquiry to Orange in the Central West of NSW.

For this submission, I address the following Terms of Reference.

1). Cross jurisdictional cooperation between the NSW Government 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 recommendations1, 7, 8, and 11).*

Cross jurisdictional collaboration will be highly necessary for rural, remote and regional health care. NSW Health often hold much of the State Health data and knowledge of services. Universities including rural universities such as Charles Sturt University function within the Federal jurisdiction, but depend on NSW Health to provide required practicum placements for Nursing, Midwifery, Medical, Paramedicine and Allied Health Students. Universities in particular need to have greater input into the practical experiences of their health students of all disciplines to ensure that they are receiving quality experiences and learning for their degrees.

Paid placement has been an important policy enacted by the current Federal government to assist students on placement where placement poverty has been a significant issue and often a barrier for students, especially mature aged students to complete placements while maintaining the ability to pay their bills. A co-operative employment model to employ nursing and allied health students during their degree in NSW Health while enabling them to attend university online or in blocks may help in boosting the health care workforce while also providing students with valuable practical skills that can be counted towards their university degree.

NSW Health Primary and Community Care services can be valuable for providing insights into primary health care deficits, especially in regards to community access to GP's and other primary health services that can prevent people from needing to be hospitalised. Nurse Practitioner working within Primary and Community Care in NSW Health or independently as Nurse Practitioners could be valuable for ensuring access to primary care services including health assessments, prescription of medicines and orders for pathology and imaging for people waiting to see a GP. Nurse Practitioners would be able to ease the workload burden on rural GP's while also filling gaps where there is no access to GP services.

2). Collaboration between NSW and the Australian Government bodies in particular initiatives, services or training programs (including recommendations 9, 10,14,21, 22 and 39).

Training needs to be very seriously examined to determine how students in health and medical courses can be retained to complete their courses and also retained within rural, remote and regional communities. Orange Hospitals 'Grow your own Nurse" program could be an example of how rural communities can develop a workforce from within their own communities. School based initiatives could be considered to incentivise local high school students to consider a career in health while providing them with additional tutoring they may need to transition successfully to university and into the health system.

The Endorsed Enrolled Nurse course used to be a course that was completed in cooperation between TAFE and associated hospitals and was a paid training course. It was a very successful course in that it was often an avenue for transition back into the workforce for parents returning to work after having children or for those who wanted a career change into nursing, but needed to retain employment. Since this course has become a non paid training course and has a HECS type of fee attached to it, it has become less attractive to many people. In order to boost the health workforce, this could be re-examined to return to a paid course.

The Federal government, universities and NSW Health should examine the availability of Nurse Practitioner courses to enable Registered Nurses of a reasonable experience level (no less than 5-6 years) to be able to undertake the NP course. Charles Sturt University at present does not hold this degree as it has been deemed as 'no demand' for the course. Given that NP's are an important part of the workforce and will be needed to overcome primary health access in rural, remote and regional areas, incentivising rural universities such as CSU to provide the NP course for rural nurses would assist in providing education through rural universities that understand the needs of rural health.

For medical students, it has been identified that many of Charles Sturt Universities medical students wish to remain in the rural and regional areas. However the threat is that they may be lost to the city in order to gain specialist training. A specialist training plan should be developed now before the graduation of the first class of CSU Medical students so that they gain specialist training without leaving the regions. Some cooperatives with city universities could provide interim specialist lecturers and specialist medical doctors until such time as future regional specialists can take up an academic role.

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).

As a Registered Nurse, Midwife and Academic, I have been calling on both State and Federal Health Ministers and their relevant secretaries to consider a 'round table' in regional areas so that the needs of the rural, remote and regional communities can be heard. All agencies both government and NGO need to be able to put forward their needs and strategies so that a road map out of the disastrous mess that is rural health can be agreed on with government oversight and accountability. However, accountability will also need to be placed on the government also to ensure that the government at both levels meet their obligations and agreements.

In terms of communications, local health district boards, including local councils could potentially provide yearly reports to each level of government to ensure that the needs of rural areas are continuing to be met and alert the government for any new needs of the community. The boards should be able to speak without NSW Health managerial bias that tends to gloss over problems in order to give impressions of good managerial performance.

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

The NSW Government needs to provide separate health funding for the regions to ensure that the bulk of the health dollar is not swallowed up in the city hospital systems. It is important also to ensure that smaller hospital and multi purpose services receive fair and equitable funding to ensure that money is not lost to the largest hospital in the region. Again, a round table as advocated above can provide a better snapshot of the needs of the communities and how each rural health district and community needs to be funded at both Federal and State levels.

Further, as above, initiatives need to be made in the interim to provide specialist training for post graduate medical students who wish to specialise and remain in the regions. The potential of rural post graduate medical students having to leave the regions for the city to train and potentially be lost to the city has been identified.

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 it's previous inquiries.

Rural health continues to deteriorate. Action is needed urgently. Communities such as Gulgong have lost their GP who has now retired and was known for some time to be coming into retirement. But the GP has not been able to be replaced. As a result, the community of Gulgong have had to travel into Mudgee to access GP services which has overwhelmed GP practices there. This has caused Mudgee GP's to close their books leaving Gulgong residents with no access to a GP without having to travel to Wellington or Dubbo which are considerable distances away. This in turn will also increase presentations to Mudgee Hospitals ED and Gulgong's MPS as people become more unwell having no GP access.

I call upon the committee along with the NSW State Government and Australian Federal Government to act on this urgently and consider not only sourcing a GP service for Gulgong but also consider mobilising Nurse Practitioners to Gulgong and other areas in the same predicament to ensure that these communities receive access to vital primary health services that will keep them from ending up in hospital. Or worse. Dead.

Kind regards.

Sarah Elliott – Troy

RN/ RM,

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