New South Wales

Special Commission of Inquiry into Healthcare Funding

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Name: NSW Rural Doctors Network

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NSW RURAL DOCTORS NETWORK
CELEBRATING 35 YEARS

31 October 2023

Mr Richard Beasley SC
Commissioner
NSW Government Special Commission of Inquiry into Healthcare Funding

NSW Rural Doctors Network submission to the NSW Government Special Commission of Inquiry into Healthcare Funding

Rural Doctors Network (RDN) is an independent not-for-profit, non-government charitable organisation that celebrates its 35th anniversary in 2023. The charity's purpose is to improve access to health and social services for remote, rural, regional and disadvantaged communities.

For disclosure, RDN receives funding from the NSW Government for delivery of programs related to the scope of the Special Commission of Inquiry into Healthcare Funding. The organisation also receives funding from the Australian Government and acts as the Australian Government's designated Rural Workforce Agency for health in NSW.

Further, I also acknowledge that in October 2023 I was appointed by Minister Park to Chair the Regional Health Ministerial Advisory Panel (RHMAP). In addition, members of RDN's Board, staff and contracted medical and clinical panel hold positions on various NSW Health committees.

Please see attached RDN's submission. It has been constructed to respond to the Inquiry's terms of reference that relate areas of RDN's expertise and role in supporting rural communities' access to quality primary healthcare, supporting the capability of the rural health workforce, and enhancing the capacity of organisations that impact rural patients and health practitioners.

To ensure integrity of the submission, we have looked to acknowledge the disclosures above and where RDN has a funding, or other potential vested, interest. I welcome the opportunity to provide further details and evidence where necessary to support the Commission's investigations.

Yours sincerely,
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NSW Rural Doctors Network activities are financially supported by the Australian and NSW governments

RDN response to The Special Commission of Inquiry into Health Care funding

RDN's goals are to support rural communities to have access to high quality primary health care, to support the capability of the health workforce that provides their care and contribute to the capacity of organisations that impact care for rural people and the rural health workforce[1]. These aims are consistent with the 2022-32 NSW Regional Health Strategic Plan and its priorities that include strengthening the regional workforce, increasing access to health services engaging with communities, integration between primary health and hospitals, and harnessing innovation[2].

Healthcare funding mechanisms impact rural communities' access to health care because they affect the viability of health services, the attraction and retention of the health workforce to work in rural towns, available health infrastructure and the capacity of health service leaders and managers.

RDN's submission to this inquiry focuses on areas relating to the rural health workforce, opportunities to improve rural communities' access to care and health outcomes, and increased cost effectiveness through enhanced collaboration at all levels in the health system.

RDN acknowledges the strengths, challenges and diversity between rural communities and those categorised as remote, rural and regional locations. For brevity, the use of the term 'rural' in this submission is used to describe all three remoteness categories unless otherwise specified to refer to a specific category of communities.

Highlights

- *Integration of state and federally managed healthcare systems is critical to the sustainability of health access for rural populations.*
- *Workforce incentives and other workforce models developed by state or federal government must be cognisant of the impact (positive or otherwise) on, and by, the other side of the system.*
- *Aboriginal expertise must be considered when designing services for Aboriginal people.*
- *Locums and visiting specialist workforce models have a place in sustainable rural healthcare access.*

1) The rural health workforce and community access to quality healthcare

a) Locums appropriate and otherwise

RDN believes the current state of locum arrangements for medical and other health professions is becoming increasingly concerning to the sector – not just in terms of cost, but also recruitment and retention. It is important to also identify that these issues have been exacerbated in the past five-years and were trending towards increased reliance on locum models before the COVID-19 pandemic.

The original purpose of locum workforce strategies related to education, respite and welfare of long-servicing in-community clinicians. The need for such clinician support is greater than ever before, however, locum solutions are becoming a workforce replacement strategy.

When used appropriately, locum GPs and other locum clinicians play an essential role in the retention of rural health practitioners. Rural GPs with demanding workloads can take annual leave, time off for personal or health reasons, or increase their clinical skills through undertaking a course of study when a locum is available to care for patients in their absence. Locums can support nurses and other clinicians working rural primary health or hospital settings for similar reasons. This locum model supports the

[1] NSW Rural Doctors Network
[2] NSW Regional Health Strategic Plan 2022-2023

capability[3] and wellbeing of health practitioners, which has a positive impact on patient access to quality health care, retention of rural clinicians, and increases the likelihood of clinicians considering a rural role in the first instance. Relevant to this Inquiry, it is also good value-for-money when managed with strong governance. This is demonstrated by the locum program administered by RDN, that is available to rural GP practices and Aboriginal Community Controlled Health Services (ACCHS) that employ permanent GPs[4]. RDN strongly encourages the continuation, and extension, of locum programs that enable clinician education, respite and wellbeing.

RDN also utilises short-term locum placements as a strategy to ensure access to services in townships where health workforce has been removed in crisis or emergency situations (1-week to 3-months). On occasions, this method is also important in medium-term workforce and service model plans (3 to 6-months), while more permanent strategies are in development. Once again, the notion of locum strategies has value where critical needs are evident.

However, as noted above, locum models that are utilised to fill GP vacancies in communities are becoming more commonplace when there is no permanent GP or a chronic health practitioner shortage; however, these arrangements can contribute to sub-optimal and costly health care in the long term. The continuity, and therefore quality, of care communities receive can be disrupted if there is a high churn of locum clinicians. This particularly impacts the quality of care experienced by people living with chronic diseases or mental health conditions. This locum model can also deliver relatively low value-for-money because locum rates are generally much higher than the cost of salaried employees. There is anecdotal evidence that the disparity in locum versus employee wages can create perverse incentives that cause a disproportionate number of clinicians to pursue locum roles. This can contribute to a negative cycle of workforce disruption and increases service costs for some rural services.

Solutions for reducing low-value locum models would ideally include establishing high value-for-money workforce recruitment and retention services (which may include those that are block-funded), have relevant expertise, are culturally responsive, have strong governance and are designed to improve community access to quality healthcare and support the capability[3] and wellbeing of the workforce. RDN's experience in supporting rural health recruitment and retention programs[5] demonstrate the benefits of this approach that involves recruitment processes for GPs, nurses and allied health practitioners that minimise costs for employing services and offer eligible clinicians site visits to rural communities and workplaces, relocation grants, social linkages for their partners and families, and scholarships[6] to support their continuing professional development and retention. Scaling similar models to other areas of the health system is likely to be more effective for health practitioner recruitment and retention and achieve higher value-for-money in the health system.

b) Visiting specialists

When the attraction and retention of specialised local health practitioners is not a viable option in rural areas, workforce solutions that achieve community access to quality care will necessarily include long-term visiting and virtual workforce models that are embedded with local health services and are designed and delivered in partnership with rural communities.

Rural health services provided by visiting medical specialists and multidisciplinary teams of allied health practitioners, nurses and Aboriginal health practitioners are vital complementary health infrastructure for many rural communities. If not for the visiting specialist model, many rural communities would not have access to specialised services due to their smaller sized and lower density populations. The current business models associated with non-GP specialists have caused a high maldistribution of non-GP specialists in rural (versus urban) areas. For example, the Australian ratio of cardiologist-to-population is less than one per 20,000 people and even less outside urban centres and 89 per cent of cardiologists

[3] Martiniuk A et al., 2020, Capability… what's in a word? Rural Doctors Network of NSW Australia is shifting to focus on the capability of the rural health professionals, Rural and Remote Health 2020; 20: 5633. https://doi.org/10.22605/RRH5633
[4] RDN Locum Program
[5] RDN Recruitment Support program
[6] Health Workforce Scholarship Program

work in urban (MMM 1) locations[7]. Rural towns with populations of less than 5,000 people are very unlikely to ever have a locally based, full-time cardiology service (private or public) because market forces attract the workforce to larger population centres. Similar non-GP medical specialist-to-population ratios, and distributions, are observed for other specialties and are higher for some disciplines such as ophthalmology and dermatology[7].

RDN has experience in supporting rural and Aboriginal communities to access visiting specialised health services through more than 20 years of delivering the federally funded Outreach Program[8] . This initiative supports more than 1,000 services annually that are provided by hundreds of non-GP specialists and other health practitioners who visit rural and Aboriginal communities across NSW and the ACT. These visiting services are integrated with local primary health teams – including GPs, nurses and Aboriginal health workers – and are designed, delivered and governed in partnership with local community health organisations including ACCHSs, not-for-profit organisations, Local Health Districts, GP practices and Primary Health Networks. In conjunction with face-to-face clinics, many visiting health practitioners also use telehealth technology to provide virtual consultations for patients who access care at local health facilities, further increasing community access to timely care.

Outreach Program evaluations indicate permanent visiting health services that are integrated with local health practitioners and delivered in partnership with communities increase access to quality care, achieve high patient satisfaction, high retention of the health workforce, and deliver good value-for-money. RDN's Outreach Program recently celebrated the two-millionth patient occasion of service[9], with 93 per cent of patients satisfied with the service they received[10]. Similarly, 92 per cent of visiting health practitioners reported satisfaction[11] and survey feedback indicates 82 per cent of visiting health practitioners intend to continue the service for three-plus years, whilst 57 per cent expect to stay for another five or more. This is consistent with actual workforce retention: visiting practitioners are often some of the longest-serving clinicians in their communities, with some practicing for more than 10, up to 20 years, in the same communities. RDN has benchmarked the cost-per-clinic-hour for visiting services and these compare favourably to alternative models including the cost of community members travelling to larger centres and the economic and health costs of populations not accessing timely specialised care.

c) Public sector workforce incentives and avoiding unintended consequences

Effective health workforce policy will necessarily consider and address the impact on community access to quality health care in both public and primary health settings. RDN is very supportive of appropriately remunerating and providing other incentives for clinicians working in our public hospitals, especially those dedicated to remote and rural service; however, these policies should also identify and address unintended impacts on the capacity of primary care services that are vital to putting downward pressure on state health system spending.

For example, study subsidies of up to $4,000 each year were recently announced for healthcare students who make a five-year commitment to the NSW public health system[12]. This may have a beneficial impact for students considering a career in health; however, it may detract from the health system's overall cost effectiveness because it places barriers for early-career health practitioners to undertake roles in primary health services that are vital to minimising potentially preventable demand for hospital services.

[7] Australian Government Department of Health and Aged Care Medical Workforce Reform Advisory Committee fact sheets
[8] RDN Outreach Program funded by the Department of Health and Aged Care
[9] RDN's Outreach Program celebrate two million patient consultation
[10] Islam M et al., 2022, Patient-Reported Experiences and Satisfaction with Rural Outreach Clinics in New South Wales, Australia: A Cross-Sectional Study, MDPI Health Care https://doi.org/10.3390/healthcare10081391
[11] Islam M et al, 2023, Job Satisfaction of Health Practitioners Providing Outreach Health Services during COVID-19 in Rural New South Wales (NSW) and the Australian Capital Territory (ACT), Australia, MDPI Healthcare, https://doi.org/10.3390/healthcare11010003
[12] NSW Health media release, Health worker study subsidies will bolster recruitment and retention

RDN and its partner Australian Primary Health Care Nurse Association (APNA) have collaborated to implement the Nurse Student Placement Project[13] that aims to increase the number of nurses pursuing rural primary health careers by providing nursing students with positive experiences working in settings such as GP practices, ACCHSs and aged care facilities. This program was developed recognising that nurses have and will continue to play a vital role in expanding the capacity of primary health services to provide rural communities with access to quality healthcare. However, nurse students who receive the aforementioned NSW Health study subsidies would experience a significant cost barrier if they were to pursue a non-government primary health career after graduation, which reduces potential benefits to system cost effectiveness.

Improvements to such policies would ideally include expanding their scope to include graduating healthcare students who pursue clinical careers in all health settings including GP practices, ACCHSs and residential aged care facilities. Ideally, flexible workforce models will be supported by the system, and could include role rotations of clinicians, including nursing and allied health professionals, between hospital and primary care practice settings, to support role diversity and strengthen linkages between the acute and primary health services.

Other health workforce policies that will benefit from considering the impact on the whole system include announced public sector wages increases[14] and seeking to address relative remuneration disparity to other essential health roles. Wage increases may well be warranted; however, there is anecdotal evidence that some nurses are leaving primary health jobs to take up hospital or residential aged care roles due to the difference in remuneration. The Australian Primary Health Care Nurse Association (APNA)[15] estimates average remuneration is 25 to 30 per cent higher for nurses in government-employment roles. Improving the attractiveness of nursing careers in all clinical settings will benefit the whole health system cost effectiveness and necessarily include coordination between the state and federal governments.

2) Whole of system approach to cost effective care

Effective, long-term collaboration at the highest level that cascades throughout the health system and adjacent sectors would contribute to improved health outcomes and increased cost effectiveness. In rural areas, this system integration, is a critical factor for sustainable healthcare access.

System integration could involve collaborating to resource prevention and health promotion initiatives, supporting the capability[3] of the health workforce and increasing access to quality primary care. These all contribute to reducing demand on state systems, by reducing potentially avoidable emergency department presentations and hospital admissions.

An example of true system integration is the national expansion of the single employer model pilots[16], originally developed and trialled in the Murrumbidgee region of NSW[17]. This expansion has high-level support from both state governments and the Commonwealth. Mutual, high-level, ongoing support from both levels of government is noted by RDN as an essential success factor for system integration. Although these models currently focus on temporary trainee placements, rather than permanent clinicians, principles of success and learnings from these models could be utilised in creation of more permanent rural staffing solutions.

a) Targets for collaboration

At the highest level, an agreement already exists between states and the Commonwealth to collaborate on these issues, namely the long-term health reforms in the 2020-25 National Health Reform

[13] APNA-RDN Nurse Student Rural Placement project
[14] NSW Government Media release: End of former government's wages cap delivers for essential public sector workers
[15] Australian Primary Health Care Nurse Association
[16] Commonwealth of Australia. Budget 2023-24 Budget Measures Budget Paper No.2. Part 2: Payment measures. 2023.
[17] Murrumbidgee Rural Generalist Training Pathway

Agreement[18] and associated Roadmap. These reforms, committed to by all Australian health ministers, include enhancing community health literacy, prevention, paying for value and outcomes, collaborative local planning, enhanced health data integration and use of technology to delivered effective and affordable care.

The health and cost benefits achieved by these objectives would be strengthened through joint accountability for their delivery and outcomes in all state and Commonwealth-funded parts of the health system. This could take shape through expanding hospital, primary health service and training provider targets and KPIs to include changes to community health outcomes over appropriate time horizons at national, state, regional levels and sub-regional levels.

b) Collaboration with other sectors

Whilst access to quality health care is a key contributor to community health outcomes, these outcomes are also impacted by adjacent sectors including local government, aged care, disability, education, housing and employment. A more effective and cost-efficient health system would expand its collaboration with other sectors who have the capacity and interest to contribute to improved health outcomes through coordination of activity and collaboration on joint initiatives[19]. For example, collaboration with other sectors may result in improved food security necessary to facilitate healthier lifestyles in rural communities. Similarly, collaboration with local government and housing planners can contribute to the attractiveness for health practitioners considering rural careers and lifestyles.

c) Aboriginal expert input to health system governance

Aboriginal and First Nations Australians carry a higher burden of disease than non-Aboriginal people[20]. There are a wide range of initiatives funded by the NSW Government and Commonwealth that aim to reduce this disparity.

Aboriginal Community Controlled Health Services (ACCHSs) have expertise and capacity to deliver a high standard of culturally responsive healthcare that is consistently provided to Aboriginal people across NSW and Australia[21]. RDN recognises this expertise and works closely with ACCHSs, First Nations peak bodies including the Aboriginal Health and Medical Research Council, and Aboriginal experts to govern and deliver a range of initiatives that effectively increase healthcare access for Aboriginal people and support the capability of the health practitioners working with Aboriginal communities.

Governance mechanisms that achieve Aboriginal expert decision-making or advice to identify priority needs, design programs and implement them are essential to improving outcomes and cost-effective healthcare for Aboriginal and First Nations people. Where health spending relates to Aboriginal people, RDN recommends the strengthening or establishment of governance mechanisms at national, state, regional and sub-regional levels that achieve input or decision-making from people with Aboriginal expertise, lived experience or are chosen by Aboriginal communities to do so.

d) A collaborative approach example

In recognition of the diversity of rural communities and environments, RDN supports and endorses genuinely collaborative approaches that involve working with communities, the health workforce, health organisations and key stakeholders to identify priority healthcare needs and develop solutions that build upon the unique strengths and challenges in each community.

[18] Schedule C of the Natural Health Reform Agreement
[19] Institute for Government, 2023, Cross-government co-ordination to improve health and reduce inequalities
[20] Aboriginal and Torres Strait Islander Health Performance Framework: summary report July 2023
[21] National Aboriginal Community Controlled Health Organisation, 2021, Key Facts – Why ACCCHS are needed

RDN has developed, and is piloting, the Collaborative Care approach in several rural NSW communities[22]. This is a community-centred approach to addressing primary healthcare challenges in rural areas. It aims to improve community health service access by working with community to investigate and prioritise needs, and co-design and implement solutions. By ensuring enduring ownership of the program, and resulting solutions, by the community itself, this program also delivers a sustained increase in health system literacy[23] and enhanced ownership over their own health services.

As a result of implementing the Collaborative Care approach, these pilot sites have also developed innovative models of care in each of the pilot locations. These models are also being individually tested as part of this program of work.

The challenges faced in the pilot communities, and rural communities more generally, include providing access to primary care services, the recruitment and retention of health practitioners, and the sustainability of these services.

RDN believes similar collaborative approaches will benefit the health outcomes and cost effectiveness at all levels of the health system.

[22] NSW Rural Doctors Network - Collaborative Care
[23] Martiniuk, A., Colbran, R., Ramsden, R. et al. Hypothesis: improving literacy about health workforce will improve rural health workforce recruitment, retention and capability. Hum Resour Health 17, 105 (2019)