rdasa Rural Doctors' Association of South Australia Inc.

28 October 2022

Anthony Beasley secretary
Select Committee on Health Services in South Australia

The Rural Doctors' Association of South Australia (RDASA) welcomes the opportunity to provide a written submission to the Select Committee on health services in South Australia.

We would also like to present oral evidence to the Committee.

Workforce

There are currently over 60 GP vacancies across South Australia and the crisis is only set to further worsen as retirements and an ageing medical workforce outstrip the pipeline supply.

Rural maternity units and Emergency Departments are understaffed without enough Obstetricians, Anaesthetists, Midwives or Theatre Nurses to service them. And for those roles that cannot be filled, locums are being contracted at an exorbitant cost to the Government and at a loss of continuity of care for our rural population.

Major reforms are necessary to fill the massive workforce gaps with new rural doctors, ultimately saving the taxpayers money and providing continuity of care for patients in our rural towns.

Of those rural doctors that are providing rural and remote care, many are experiencing burnout and ongoing exhaustion, trying to cover the existing gaps in hospital rosters and providing timely primary care.

"The current model is unsustainable with our workforce shortage. Our doctors are feeling overworked and exhausted, not wanting to staff the

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Emergency roster. Especially when not remunerated to the degree they would like." RDASA Workforce Survey 2020

"We keep going, but only with increasing personal sacrifice from senior docs in the practice. We are just keeping our head above water, but if we were to lose anyone, we will fall over." RDASA Workforce Survey 2020

This workforce crisis has led to considerable distress amongst many rural clinicians who are struggling to provide services because of inadequate workforce planning by the Department of Health and Rural Support Service (formerly Country Health SA) over the years.
Successive governments have failed to grasp the seriousness of the crisis. Opportunities to ameliorate the above issues such as bold policy planning and attractive contracts for current and aspiring rural GPs have fallen flat.

Compounding the workforce problem is that today, only 15% of medical students choose to specialise in General Practice. It has never been so crucial to invest in additional support to attract rural doctors to grow our rural workforce.

When we surveyed 65 rural practices providing primary care and services in regional hospitals in 2020, only 18% described their current general practice workforce for providing community hospital services as 'good'. Over 50% reported severe workforce shortages.

Workforce Planning and the Rural Generalist Program

Over the years, many studies and resources have been poured into creating solutions for the growing workforce gaps. One of the most prominent solutions is the creation of the Rural Generalist Program.

A Rural Generalist Program creates a clear, rural pathway for a doctor to train as a Rural Generalist Specialist and deliver a range of services to meet

the medical and mental health needs of their community. Recognised for their specialty skills, a Rural Generalist is trained to deliver the right services in the right place at the right time.

The current Government must create a well-resourced and well-funded Rural Generalist Program which includes supporting a registrar Advanced Skills Training program. Preliminary steps in the right direction have been made, however, it will take the will and commitment of the new state Government to support and appropriately fund the full Rural Generalist Pathway. State and federal government funds must be committed to achieving this important outcome.

RDASA has lobbied successive Ministers for Health to introduce a rural specific advanced skills training program, and to give Local Health Networks formal teaching hospital status with appropriate budgetary support. This will allow rural Advanced Specialised Training and Extended Skills Training positions to be allocated to those who wish to be long term rural doctors.

Across Australia, perhaps only in Queensland are we seeing a standout Rural Generalist Pathway model. Sadly, for South Australia, our lack of vision is resulting in a migration of doctors to Queensland to access their Pathway and pursue a career as a true Rural Generalist. Tragically, we are losing our rural doctors to Queensland's leadership and resolve to find a rural solution.

There is such a great opportunity and need to create a rural training program in South Australia to provide a long-term workforce solution which will allow patients to be treated locally in their hospitals by local doctors who have the necessary skills and training.

A follow-on effect is that the more patients that can be cared for by a skilled and committed rural medical workforce, the strain felt by metropolitan hospitals suffering severe bed shortages and ramping is lessened.

A well-supported rural training program will also provide doctors with adequate training in preventative health, emergency care, Aboriginal health, mental health services, palliative care, and inpatient hospital care for patients in their own community. Early preventative care ultimately reduces the longer-term, more costly care in tertiary hospitals.

Hospital Contracts for Rural Doctors

There have been ongoing problems with the introduction of six new Regional Boards for the Local Health Networks (LHNs), especially in their delay in settling the most recent Rural GP Contract Agreement negotiations.

RDASA have a long-year history of brokering contracts for rural doctors but never before have there been such protracted negotiations since the creation of the new LHNs and the Rural Support Service. A number of GP practices were stalled in signing their contracts due to disputed promises by the LHNs, requiring RDASA to step in and further assist to negotiate contracts on behalf of many rural doctors.

With an already fractured workforce, this only served to further erode trust and security, plunging rural doctors to feel the lowest levels of morale. And just when they believed there was light at the end of the tunnel, there was late notice changes in medical indemnity affecting rural proceduralists, ultimately threatening the ongoing viability and maintenance of essential maternity services.

RDASA is happy to provide oral evidence of these contract negotiation debacles.

Transforming Health

RDASA understands that the current health system is in crisis across many parts of regional Australia with recent enquiries in NSW and Tasmania. The

Transforming Health initiative in South Australia has led to confusion amongst many clinicians as to what services will be provided at which metropolitan hospitals. This in turn has led to increasing bed pressures and extra time spent by rural doctors on phone calls and paperwork.

There are considerable delays in the transfer of patients via ambulance because of ramping, bed blocking and the lack of availability of metropolitan beds. The feedback from rural GPs has been of exorbitant time spent calling around hospitals and pleading with bed managers rather than attending to the rural patient's care. As a result, those requiring a higher level of care are placed at substantial risk which means a delay in receiving the right treatment in the right place at the right time.

The extended length of stay of high-risk patients in rural hospitals heightens stress levels and places a greater workload on already overworked doctors and nurses providing care.

This also extends to the care of many at risk patients with acute mental health problems who require detention and transfer to Adelaide.

There are several high acuity patients who have had to wait over 12-24 hours for ambulances to transfer them to metropolitan hospitals because of delays in bed availability.

In addition, MedSTAR and SA Ambulance Service appear not to recognise or be able to categorise these patients as a priority to transport to larger centres for higher levels of care.

RDASA believes that this is related specifically to the Transforming Health process, where there has been an inadequate number of beds being made available for the system, especially with the closure of the Repatriation Hospital and a decrease in the number of nRAH beds when moving from the previous site.

There are significant delays in the capacity of the system to discharge patients from hospitals to aged care facilities and the complexity involved with organising care packages and getting ACAT assessments has further added to the stress and pressure on doctors to provide ongoing care. Patients unable to access care packages in their homes, ultimately leads to an increase in the length of hospital stays and further clogs up the system.

EPAS

When EPAS was trialed in Port Augusta eight years ago, RDASA recognised inherent system problems and strongly lobbied the government against proceeding with broader implementation. Our cries fell on deaf ears, however, and EPAS was rolled out with increasing problems.

EPAS has since been resuscitated as Sunrise however rural Doctors are unable to access the system from their Practice computers, limiting their capacity to review relevant tertiary hospital information.

RDASA believes that it is critical that the voice of our clinicians is heard. If the advice of RDASA had been acknowledged in the early stages, then the problems regarding the failures surrounding EPAS would never have occurred, saving taxpayers many millions of dollars.

Community health services

Over the past few years, there have been considerable changes in the community health sector, with the introduction of more Federal Government monies for Mental health, Aboriginal health, and Drug and Alcohol services.

These have been delivered by both the Adelaide Primary Health Network, and the Country SA Primary Health Network, but there does still appear to be gaps in the services provided across the sector.

It is most important that the State hospital services and Federal funded community services are coordinated so that patient outcomes can be maximised.

There are still some deficiencies in the system in relation to providing packages for patients' care, especially those who have been discharged from hospital, and those requiring ongoing mental health services.

More and more primary health care, including wound care and dressings, have been delivered by GP practices as community nursing services have decreased. In the past these were previously funded by the State but they have not kept up with demand as our population ages.

Sadly the availability of 24-hour palliative care nursing is still problematic in many areas which means more terminally ill patients are requiring unnecessary inpatient care or after-hours SAAS assessment.

Medical Records

The lack of Practice access to OACIS/Sunrise, means doctors are unable to search the hospital system for results and discharge summaries from metropolitan hospitals. Many clinicians are utilizing their own practice software to complete discharge summaries and access patients' medical results as information is only available if the doctor is present in a Country Health SA Hospital.

In Conclusion

Access to primary care services is a key issue in rural South Australia, where health outcomes are considerably worse than in metropolitan communities. It is essential that we have a well-defined rural health training pathway, a well-supported primary care system to support rural clinicians and adequately funded rural hospitals for us to give the highest level of care we can to all our patients.

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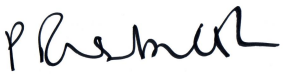
Yours sincerely,
On behalf of the RDASA Executive and management



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