From:	Eva O"Driscoll
To:	Community Affairs, Committee (SEN)
Subject:	Accessibility and quality of mental health services in rural and remote Australia
Date:	Monday, 27 August 2018 4:52:43 PM
Attachments:	

Dear Committee members

The AMA(SA) became aware of the above inquiry via an article in The Advertiser. The Association was most concerned in relation to the reported allegation that doctors are refusing to see patients with a mental health problem. This is not the AMA(SA)'s experience when talking with its members in rural communities, and indeed many rural GPs spend an enormous amount of time managing such situations. Mental Health services in rural SA are a matter or ongoing concern to AMA(SA) and were highlighted in our State Election Priorities 2018 document prior to the last SA election.

The Association is also glad to provide, for the information of the Committee, a copy of a submission made by the AMA(SA) to an SA Parliamentary inquiry into regional health services in 2016, which also includes links to some national AMA policy documents, as well as feedback specific to South Australia.

Yours sincerely
Eva O'Driscoll

On behalf of:
Mr Joe Hooper, Chief Executive, AMA(SA)

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AUSTRALIAN MEDICAL ASSOCIATION
(SOUTH AUSTRALIA) INC

19 October 2016

Ms Robyn Schutte
The Secretary
Social Development Committee
Parliament House
North Terrace
Adelaide SA 5000

sdc@parliament.sa.gov.au>

Dear Ms Schutte

Social Development Committee of SA Parliament – Inquiry into Regional Health Services

Thank you for the opportunity to comment in relation to the above inquiry, and for the extension of time to do so.

Enclosed is a collation of feedback from our members, together with some AMA(SA) commentary and two appendices, one relating to HACS and one relating to Country Health SA contractual/ procurement matters. Also included are links to some relevant national AMA advocacy documents.

The commentary attached is detailed, and we are glad to include with it in this cover letter a brief precis of AMA(SA) points and concerns relating to regional health and the services to support it.

AMA(SA) state level advocacy on rural and regional health

There is much to say about rural and regional health, and the AMA's advocacy interests in this area are too broad for this document. However, medical workforce and planning is an area of particular importance to supporting better health outcomes in rural and regional South Australia, and in that important area, at a state level the AMA(SA) calls for:

- Improved medical workforce planning for rural and regional SA, and a review of the framework for encouraging and supporting medical practitioners into rural locations
- Appointment of 5 FTE rural procedural GP training positions, as negotiated by AMA(SA) as part of the 2015 Rural GP Service Agreement.
- Future exclusion of the burdensome and inappropriate treasury 'procurement' process from future medical workforce contracts in all SA rural and regional areas.
- Country Health SA to see itself as having a significantly broader role than as a mere commissioner of health services, including responsibility for supporting medical training and teaching of future specialists to service rural SA.
- Country Health SA and the rural medical workforce funding framework must acknowledge a role in training and research in rural SA. Such recognition would support early rural experiences and engagement by the younger doctors. This would encourage sustainability and more permanency of our rural medical workforce.
- A reappraisal and an increase in effective collaboration between those with managerial responsibilities and those with clinical, vocational and leadership responsibilities as, in our view, the lines of responsibility and expertise have become unnecessarily and inappropriately blurred.
- Increased support for locally-based medical services, particularly in those areas which are commercially non-viable.

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National Rural Health Issues Survey

The AMA has engaged in significant national advocacy in this area. The AMA's national 2016 Rural Health Issues Survey provided important feedback directly from rural and regional doctors. The report highlights that for there to be genuine improvements in access to health care for rural patients, there needs to be:

- funding and resources to support improved staffing levels and safe workable rosters for rural doctors;
- access to high speed broadband;
- investment in hospital and practice infrastructure;
- expanded opportunities for medical training and education in rural areas;
- improved support for GP proceduralists; and
- better access to locum relief.

Plan for Better Health Care for Regional and Remote Australia

In its national Plan for Better Health Care for Regional and Remote Australia, the AMA has stressed that Governments must focus on measures that will make a long-term difference, and commit to policies that:

- rebuild health infrastructure – particularly public hospitals;
- support the recruitment and retention of the medical workforce;
- provide more opportunities to train medical students and doctors in rural areas; and
- support rural medical practices to ensure they are able to meet the complex health needs of people in rural and remote communities. The AMA(SA) sees the particular need for this requirement in South Australia

AMA/Rural Doctors Association of Australia's joint policy statement/Rural Rescue

The AMA/Rural Doctors Association of Australia's joint policy statement calls for targeted and evidence-based supports to build an adequate rural medical workforce with the right mix of skills. These supports should facilitate high quality rural and regionally-based training, particularly rural generalist training, and provide appropriate financial and non-financial incentives for doctors with the skills for rural practice to live and work in rural and remote areas, including:

- providing locum relief so doctors can leave their communities to undertake professional development or take a holiday;
- providing professional development and teaching opportunities locally;
- supporting flexibility of working hours;
- providing professional support; and
- providing well-staffed and equipped work places; and
- a two-tier incentive package to encourage doctors to work in rural areas and to boost the number of doctors in rural areas with advanced skills training.

You will find detailed feedback from AMA(SA) members in the document that follows.

Yours sincerely

Mr Joe Hooper
LLB(Hons), BSc(Nursing), Dip Applied Science
Chief Executive Officer

AUSTRALIAN MEDICAL ASSOCIATION
(SOUTH AUSTRALIA) INC

AMA(SA) General & Member Comments: Regional Health Services

Thank you for the opportunity to submit to the inquiry by the Social Development Committee of the SA Parliament into Regional Health Services, and for the additional time to make a response.

Rural and regional health services are a priority area for the AMA. There are a number of key policy and advocacy documents produced by the AMA that the Committee may be interested in:

- *2016 AMA Rural Health Issues Survey Report*: https://ama.com.au/article/rural-health-issues-survey-report
- *2016 Joint Statement 'Building a Sustainable Future for Rural Practice: The AMA/RDAA Rural Rescue Package'*: https://ama.com.au/media/peak-doctor-groups-call-election-commitments-fix-rural-health
- *2016 AMA Plan for Better Healthcare for Regional, Rural and Remote Australia*: https://ama.com.au/gp-network-news/ama-plan-better-health-care-regional-rural-and-remote-australia

In response to the invitation of the Social Development Committee, we sought input and feedback from our State Council and our members working in rural and regional areas. We received a wide range of comments, including doctors from the Royal Flying Doctor Service (their views are their own and not necessarily those of RFDS), Port Augusta, Mount Gambier, Port Broughton, Adelaide Hills, Berri/Barmera, Cummins, Ceduna, and more, some on an individual basis and some providing a summation of the views of colleagues. We provide below an overview and collation of these comments, for the consideration of the Committee (with minimal editing).

The AMA(SA) does not have particular engagement with the Health Advisory Councils (HACS), although some of our members are engaged with their local HACS. However, we did make comments regarding the Health Advisory Councils as part of a broader submission in response to the Premier's 2014 proposal to abolish, transition or reform various state government boards and committees. We provide those comments as an appendix to this submission. In the same submission, we also called for the continuation of the Health Performance Council, which reviewed the operation of the HACS in accordance with the Health Care Act, as noted in the terms of reference for this inquiry.

The AMA(SA) does, however, have considerable concerns regarding Country Health SA's responsibility to ensure provision of medical services, and their recent application of the procurement process when undertaking contract negotiations for rural specialists.

As a general theme which extends beyond country into metropolitan areas also, we would also like to see a reappraisal and an increase in effective collaboration between those with managerial responsibilities and those with clinical, vocational and leadership responsibilities as, in our view, the lines of responsibility and expertise have become unnecessarily and inappropriately blurred.

The AMA(SA) is particularly concerned about the historical lack of medical workforce planning for rural and regional SA. We have advocated for increased activity in this area, over a long period, with both Country Health SA and the Minister for Health.

We are currently awaiting confirmation and the appointment of rural procedural GP training positions (5 x FTE) that were committed to the AMA(SA) by the State Government and SA Health as part of the last rural GP contract negotiations concluding in 2015. We are advised these are now to commence in

2017. We will not go into detail in this area due to the relatively large amount of feedback below in relation to the terms of reference for the inquiry, but would ask the committee to note that rural and regional medical workforce is a significant and ongoing issue. Telemedicine is promoted as one method of outreach to rural and regional SA (and travel, supported by PATS), but this cannot take the place of appropriately positioned and supported rural and regional GPs and specialists providing local health services.

1. The review by the Health Performance Council on the operations of the Health Advisory Councils in accordance with the Health Care Act 2008.

The AMA(SA) was not involved with the above review, and considers that there is not a high awareness of the HACS in the broader community or medical profession. However, as mentioned above, we did make comment in 2014 on HACS in response to the premier's initiative to abolish various government boards and committees, and those comments are enclosed. Our members also have made more recent comments on the HACs in response to our request for input for this inquiry, as reproduced below.

Comments from a rural/regional specialist

Some do a wonderful job raising funds but few have little influence on the other areas of their charter. Members suggest that centralised management of health is the preferred modeI in SA and the HACs are [seen as] a veneer to suggest community engagement. Our local HAC holds no funds and has no fundraising projects. Some community groups raise funds for the hospital but this is ad hoc. Budgets have not been available to the public since the introduction of the HACs and it is no longer possible to monitor the performance of the management of the hospital. This is an oversight and should be addressed. Each unit should have accounts that can be accessed by the public. Workforce planning is a great deficiency of SA Health and needs to be given greater priority to ensure services that should be delivered close to home are provided there. Proper workforce planning will lead to a better distribution of health services and better outcomes for patients.

2. The current provision and plans for future delivery of health services in regional South Australia, with particular reference to —

a. the role and responsibilities of Health Advisory Councils and the benefits, or otherwise, of the removal of local Hospital Boards;

Comments from a rural/regional specialist

I was around when Health Advisory Councils were instituted. The argument at the time was that local hospital boards were expensive. As far as I could see, there were probably minimal sitting fees and the cost was a cup of tea and the biscuits provided and the time needed for staff to make representation to their local community. Local hospital boards often represented perhaps an older generation of long-term leaders in a community.

With the setting up of Health Advisory Committee Councils staff still need to make presentations and the cup of tea and biscuits presumably still continues. Certainly in the early days, the Health Advisory Councils I saw tended to be people of a younger age group, often representing current consumers and less of the legacy of communities and more pertaining to single-issue viewpoints. One of my perceptions, perhaps falsely, is that by using single issue people, they are there for that single issue, not across the broad scope of things, and often drop out after a short period of time. My understanding is that as time has gone along we have actually returned to an older group of people who once again represent the long-term direction of a community and the long-term thoughts of a community. My perception would be that with the abandonment of local hospital boards quite a lot of goodwill was lost. Changing back to boards won't create that goodwill, as it occurred over many, many years.

Despite being vitally involved in my communities, Health Advisory Councils have had little or no effect upon myself and the delivery of services as far as I can see. It may be that this is different for other people.

Comments from a rural/regional GP

The role and responsibilities of Health Advisory Councils and also of local Hospital Boards should be judged entirely on their demonstrated effectiveness, or failure, to provide for the healthcare needs of the communities which they purport to represent. There must be a balance between parochial interests and system-wide changes lead by SA Health. Senior clinicians, such as those representing procedural fields of anaesthetics, obstetrics and surgery, in addition to the (non-clinical) Director of Medical Services, should be represented on every Hospital Board or HAC.

Comments from a rural/regional GP – currently metro-based

Currently, there is legal protection for country hospitals because of property ownership. It is aimed at decreasing the legal power of HACs as a first step towards closing rural hospitals. They can't close a hospital whilst the HAC owns the infrastructure and so this will pave the way to decreasing rural health services across South Australia. For example, in Loxton and Renmark the community raised the funding to build or improve the hospitals and at that time the hospital Board was the legal entity and therefore owned the property; when the Boards became HACs they transferred ownership of the buildings.

Comments from a rural/regional GP

With the evolution of corporate thinking and broader government/bureaucratic involvement in health, it was a somewhat logical progression to move away from hospital Boards for small rural hospitals. Immediately prior to the change, the Hospital Board held full financial responsibility for its locally held funds and nominally employed the CEO/DON, but ultimately had no control over funding for services provided within its institution. Historically, most small rural hospitals were founded by the local communities and retained a strong sense of local ownership, which has traditionally been seen to sit philosophically on the shoulders of the Board. I think there is a broad understanding and expectation in rural communities of the need for healthcare standards to be met, and for services and facilities to be provided for basic health needs up to a level safely manageable by available local staff.

While there is no longer such a strong sense of "ownership" of the hospital per se, there remains a strong sense of connection to it and reliance on its presence as a core support and resource in the locale it serves.

The community expectations of the Hospital Board and now the HAC are that they hold the power of overseeing the service, engaging with the bureaucracy and will be the canary in the mine in case of any threat to local service provision. As such there is no great need for ongoing awareness and interaction within the community until there is a particular issue or perception of unwanted change. There was quite strong community engagement in the planning process creating the 10-year plans, and any threat of service withdrawal will likely spur a rapid increase in interest and involvement.

Beyond this monitoring role, the HAC has not had the same sense of involvement and import as the previous Board, which carried some greater sense of responsibility that the buck could potentially stop with it, although over the years this risk probably transitioned legally to the State through funding etc.

The community still refers to the HAC as the Hospital Board more often than not and probably has little awareness of the change in its constituted role.

There is a decreased sense of purpose around the table for the HAC compared to the days of being a Board. Previously there was more involvement in understanding budgetary pressures for the organisation, despite having little or no control over income or expenditure. There is capacity

for the HAC to have a role in providing input and actively monitoring the quality of care and the culture of the organisation, though there is little it can do to actively influence this beyond providing feedback.

I think there is still work to be done in better defining the best role and model for the Health Advisory Councils

Comments from a rural/regional GP

The HACs have had changes imposed on them over the years. Spending of their own funds was limited by rules on what they can spend for many years, forcing them to put funds in places that weren't considered part of state funds. At least local admin answer the questions put to them by the HACs. Some smaller HACs do great health promotion in the community, eg. towing and reversing caravans for over-65-year-old women, defensive driving for sub-25-year-olds, and biggest loser competitions. Usually in response to issues in the community. Some valuable hospital equipment has been bought as well.

Comments from a rural/regional GP

I sat for a time on the local HAC. It was difficult to quarantine time for this. I found the meetings, despite the best will of the attendees, to be devoid of utility. The continued existence of the HACs seemed curious, and as I had other demands, I withdrew from the process. With respect to the local boards … these seemed long ago to have been caused to be irrelevant. However, many in the medical, nursing and general community believe they should be reinstated, as the belief more generally is that local input into local health/medical matters would always be necessary.

Comments from a rural/regional GP

Modern board corporate governance requires training and a mix of skill-sets. (Same flaw as local councils where most of them are rather dysfunctional.) The idea of locals having input into local health services has merit but, are they really "boards" or just advisory committees? Are they really heard? People drift away unless they are listened to and valued. This is the key to success.

b. trends in local community fundraising for medical equipment and services;

Comments from a rural/regional specialist

In some communities fundraising was extremely strong. There was a strong sense of ownership for hospitals and that had both good and bad aspects to it. There would be absolutely no doubt in my mind that as we have moved to being very clearly a division of SA Health, that communities are less inclined to raise medical equipment for hospitals. Communities feel they already pay taxes and the many levies raised by the states. They do not feel particularly inclined to put more money into their hospitals. This is understandable.

Comments from a rural/regional GP

Poor access to equipment, which should be standardised across ALL country hospitals in South Australia is both unacceptable and constitutes a source of clinical inefficiency as well as unnecessary risk. All regional hospitals in Queensland, where I practised anaesthetics (GP anaesthesia), had standardised resuscitation equipment, a video laryngoscope and a well-maintained difficult airway trolley available in their Emergency Department and theatre.

Every hospital wherein obstetrics and or surgical services are to be provided must, as a matter of fundamental importance for optimal patient care, have a High-Dependency Unit (HDU), sufficiently staffed and equipped to provide necessary 'pre-ICU' care. HDUs help to ameliorate the disparity in mortality and morbidity between those living in rural and remote regions compared to their metropolitan counterpart who have suffered a critical injury or illness.

Any contribution from local and community fund-raising for medical equipment and services should be matched (1:2) by the State Government; every dollar raised in the community would be matched by two from SA Health. Consequently, questions on "how funds currently and previously raised by local communities are held and spent with particular regard to authorisation and decision-making" should reasonably be made jointly and guided by a broadly representative HAC or Board.

Comments from a rural GP

I have seen the closure of very hard-working and well-intentioned voluntary fund-raising group and a substantial bequest from locals keen to support their hospital taken up and mis-spent by a misguided and controlling CEO/DON. I fully support hospital auxiliaries but they are not subcommittees of the hospital and should not be subject to such control. Fundraising must be encouraged with autonomy.

Comments from a rural procedural GP

I am unable to comment in any precise way on trends. There are diametrically opposed views. On the one hand, that the State should provide everything, all the time, as most of us pay taxes. On the other hand, that the community should further top up the local services/facilities, if they are deemed to be inadequate.

Comments from a rural GP

In relation to b) and c) the process of holding community raised funds has become more complex since the transition from Boards to HACs. This has sadly coincided with a downturn in State funding being made available for required upkeep of buildings and equipment. The members of the HAC and the community strongly feel that moneys raised locally ought to be able to be spent without any impediment if the HAC deems the purpose appropriate. Locally the Board and subsequently the HAC has held funds for expected replacement of the locally-owned hospital bus against pressures to spend the money on basic upkeep and maintenance of buildings. The community has become aware of difficulties in being able to freely choose items for funding and with the perception of funds being held by the government rather than by the local body and there is a sense of reluctance in seeing the hospital as the best place to donate money. The Hospital Auxiliary is now often the preferred conduit for these funds as it can function more freely compared with the constraints currently seen to sit around the HAC moneys. Locally there has been a sense of coercion for the HAC to provide funding for basic maintenance needs to meet hospital occupational health and safety requirements such as flooring. Attempts to get an up-front and honest response from the department or the politicians about the expectations around upkeep and who is ultimately responsible has been elusive.

Comments from a rural GP

In relation to 2 a) to e) these all relate to the same thing. The HAC of each hospital officially controls all of the hospital assets. These means technically the HAC I am best aware of has control of many millions of dollars. Of course it does not actually control this. It sees this as a ceremonial role only. Other HACS use this more as leverage. Country Health see the major and hopefully only role of the HAC is fundraising. Country Health do not like the HACS always being involved. I think the HACS do need to be involved. The HAC is the community's advocate. If the community is involved in decision-making there are two advantages for Country Health. One advantage is that if the community is involved they are generally pretty sensible, so any changes that Country Health want to bring in they are more likely to cooperate with. Also, if the community are involved, fundraising is more successful. Country Health appreciate this but find it hard to relinquish any power. Power sharing is hard work but leads to more effective practices. Our HAC has raised a very large amount of money. Our hospital auxiliary raises tens of thousands of dollars a year. They do not like it to be spent on the day-to-day provision of health services or essential equipment. They prefer it to be spent on items to improve the quality of the hospital experience. They put in all of the TVs in the local hospital, which is essential. They do a lot of landscaping.

Comments from a rural/regional GP

In Port Lincoln there is a strong tradition of fund raising for specific services - eg. an op shop for the nursing home, a second hand shop for palliative care services.

c. how funds currently and previously raised by local communities are held and spent with particular regard to authorisation and decision making;

Comments from a rural/regional specialist

Over the years I have been asked to give many talks to GPs. These have often been sponsored by drug companies. I refused to take drug company money for many years, but then did take the money and put it into our ward account so that nurses could go off on training courses or flowers could be bought at the death of a child on the ward or for some particular event. At the time that the hospital board disappeared there would have been several thousand dollars in that account. My understanding is that money disappeared. However, in recent months I have been reassured that that money is still available and could be accessed by us. Apparently we would need to apply for it. Neither myself nor the nurses on the ward have been aware of this for at least 4-5 years since local hospital boards disappeared. We now have to apply to the Health Advisory Council. I am well aware that some communities had large sums of money and that there was a terrific fight to see whether the government could actually take over that money. My understanding is that some communities spent the money. I have no evidence of this other than anecdotal comment from people.

Comments from a rural/regional GP

The best decisions actually meet specific needs. This must involve the local doctors and community members. Examples such as a cardiac events monitor, training mannequins, furnishing the local palliative care ward, purchase of a slit lamp, are pricey but meet a real need and strongly motivate volunteers, especially when the local doctors support this and explain what they will be used for etc ... Using fund-raising to do capital works or other things which the government should fund risks eroding the goodwill of such groups and expedite their demise. Therefore, decision-making needs to be shared and based on needs.

d. timing of provision of finalised operation budgets in country hospitals;

Comments from a rural specialist

As a senior [hospital medical specialist] I am somewhat involved in the budget. Traditionally, budgets for SA Health have come out many months after June the 30th. They have sometimes been as late as September/October. It is very difficult in this environment to take budgets seriously. Currently, I think budgets are finalised at a senior level and therefore I have no knowledge of them and little impact on them. My experience in South Australia has been similar to other environments. There is a huge focus on very small amounts of money and also on squeezing staff to save money. However, on the other hand, some contracts are made very badly and huge sums of money are haemorrhaged. Once again, of course at my level, I have no evidence of such things.

Comments from a rural/regional GP

This is no longer in the purview of the HACs.

Comments from a rural/regional GP

No useful opinion, though we still have episodes where procurement before a particular date, of new equipment, is suddenly foisted upon hospitals. I may be mistaken about this in the more recent times.

Comments from a rural/regional GP

Rural hospitals need security through longer-term funding. Most have been there for 50-80 years. Three yearly is a minimum.

e. ownership and transfer of property titles of country hospitals;

No major comments made

f. the process and timing of the hiring of staff for new and existing positions;

Comments from a rural/regional specialist

I noted in the early years when I came to South Australia that people would be in very different positions from their substantive position. They may have a full-time permanent position at a relatively low level and be operating at a very high level and greater pay but with no security. This problem seems to have disappeared in recent years, although there can still be people working one to two years out from their last substantive position, still in temporary zones. This delay and actually resolving issues slows up progress of people and leaves everybody in an uncertain and precarious situation. Temporary positions, as I understand it, also make it difficult to raise a mortgage and have certainty of a loan from banks.

Even when somebody resigns and it is necessary for them to be replaced, it is certainly policy that the person must leave their position and all of their accrued leave, sick leave or other entitlements be extinguished before the position is advertised. This can mean that other staff are going to need to cover a position for quite a long period of time. This may be as long as 3-6 months in my experience. There is then the additional lag of actually advertising and putting somebody in the position. This puts a strain on everybody, reduces capacity and of course is unsettling to the community.

Comments from a rural/regional GP

The process and timing of the hiring of staff for new and existing positions should also have local (HAC or Board) input to ensure that long-term, culturally appropriate and community-orientated imperatives both guide and provide impetus for robust recruitment of Australian medical graduates (AMG) into rural and remote communities. There is currently a detrimental tendency of over-reliance on International Medical Graduates (IMG), with a concomitant loss of long-term stability and resilience in the 'rural' medical workforce. (This effect is over and above the known detrimental effects on the medical workforce of 'donor' – typically less developed – countries, which has been noted in the international medical literature.)

Comments from a rural/regional GP

There have been delays in staff appointments awaiting checks and clearances from police. While police checks are a useful adjunct in risk reduction, it is probably wrong to rely on this as the be-all and end-all of risk reduction. Harm may be occurring because of the inability to provide a service while awaiting a low likelihood adverse response from a police check or need for internal advertising prior to open advertising.

Comments from a rural/regional GP

The hiring of staff I feel is the responsibility of Country Health. What is controversial is volunteers, which the hospitals are relying on more and more. The volunteers are a huge asset. However, it is essential that volunteers are not involved in the core provision of services. I have been concerned about the use of volunteers in areas such as mental health where the responsibility is huge. The volunteers must be protected. The HAC, as above, can act as a community advocate and advise what medical services they would like promoted. In the past I have pushed for mental health services. Now I am pushing for more physician services. The hospitals often prefer surgical services.

Comments from a rural/regional GP

This seems to occur more on the basis of availability of funding, than community need.

Comments from a rural/regional GP

What is the process for this? Does it rest purely with the CEO/DON? A fair and transparent process is needed.

g. South Australian Ambulance service arrangements, including the role of volunteers, fees and fundraising and the benefits, or otherwise, to local community events;

Comments from a rural/regional GP

Local communities highly value their SA Ambulance service and its volunteers. I am not aware they have any focus on fundraising now-a-days. Many small units have a recurring struggle to fill rosters and are often not able to have a presence at local events such as weekly sport. A response is always available but it sometimes has to come from the next nearest town.

Comments from a rural/regional GP

Given service 'gaps' identified by organisations such as the Aboriginal Research Group (Wardliparingga), together with knowledge of the unnecessary delays which affect the retrieval or transfer of patients from country to tertiary Hospitals, the South Australian Ambulance Service arrangements should consider including a role for the Royal Flying Doctors Service Central Operations. Such a contribution has been successfully implemented on a large scale by the Victorian Section of the RFDS and on a smaller scale in a number of remote South Australian communities (Andamooka, Marla and Marree). The advantages for the local community, patients and their treating clinicians of a non-urgent and urgent RFDS patient-transport service, which would be coordinated by the RFDS in Pt Augusta already involved in patient care and transfer, is likely to enhance safety as it would certainly gain efficiencies. Acknowledgement of the crucial role for the RFDS would be likely to embrace a role for the St John and other community volunteers in a way that facilitates fund-raising and provide benefits for local community events. (Note: this member has a connection with RFDS, so speaks from expertise)

Comments from a rural/regional GP

Volunteers are the lifeblood of many of the local services and attend community events, teach in schools and go to sporting events, all in their own time. They raise funds for their local service at shows and gatherings. They are often first on the scene at motor vehicle accidents and natural disasters. They are a precious resource and I have been very grateful for their efforts over my 35 years in rural practice. The demands to meet minimum standards can, however, be a deterrent and see the demise of volunteers' services. This must be avoided. You can't make it so difficult that volunteers give up and leave. That puts lives at risk and adds enormous costs where salaried officers are then used. Support for volunteers, and training, must be supported and acknowledge that such a service is better than none at all.

h. scope of practice of general practitioners to country hospitals and the provision of accident and emergency care;

Comments from a rural/regional specialist

I work mainly between Port Augusta and Whyalla. Our community of doctors includes a strong general practitioner contingent. When I first arrived, general practitioners had a huge range of skills and had been in position for many years. GPs came from many parts of the world and often had anaesthetic, obstetrics, emergency and a wide range of skills that made them function at, at least, a level of senior registrar in general medicine. As time has gone by, we still have a wide range of practitioners from around the world, and very few Australian-born doctors working in Port

Augusta and Whyalla. This is also true of many of the smaller centres. Arguably, the Australian character is strongest in rural and remote areas and arguably we would train Australians because they will understand the culture and provide the best fit of medicine and culture to people in their own country. We are now reaching a stage where we have an excess of Australian graduates who show no inclination to move rurally. We have shown no leadership in providing ongoing training positions in rural, or analysing the needs of young people moving to country practice and then putting in place systems that would encourage them to come and remain in rural practice.

The provision of Accident and Emergency care in places such as Port Augusta and Whyalla is quite thin. We are reliant on a small number of overseas trained doctors who are adjusting to Australia and rapidly learn skills. They have minimal support and supervision from the rest of the system.

Comments from a rural/regional GP

The scope of practice of general practitioners to country hospitals and the provision of (high quality) accident and emergency care has been impeded by an insidious feedback loop whereby lack of recruitment of Australian medical graduates into rural communities diminishes opportunities for the necessary leadership and training of new rural recruits that is provided by an 'increasingly scarce' supply of long-term resident – usually older – experienced local clinicians. These truly 'local' clinicians have been exceptional mentors and their contribution is fundamental to the replenishment of a robust cohort of both generalist and specialist doctors having a resilient motivation for their vocation in rural medicine.

Comments from a rural/regional GP

Rural general practitioners have little option but to provide care to all presentations to country hospitals. Support from Medstar is highly valued, and care needs to be given to timely adjustments to fee-for-service arrangements, particularly regarding linkages to the Medicare Benefits Schedule which current governments have frozen for an extended period. Emergency response to victims of rape and sexual assault, with timely access to forensic medical examination, has declined over the last few decades, which risks leaving victims needing to travel in soiled clothing to Adelaide or hours away within country to access a service. This is currently funded in an ad hoc way by SAPOL but a better coordinated systematic response though the Rural GP fee-for-service model as is available interstate would send a clear message that this is a specifically recognised core role.

Comments from a rural/regional GP

As a country GP I am used to general practitioners providing most of the medical services in country hospitals. I feel GPs have provided a very comprehensive and inexpensive service. Country Health does not always agree with this. My concern, if country GPs are not involved, is that Country Health may find out too late how many services are provided by country GPs. Country Health think that country hospitals very rarely do any after-hours work and do not deal with serious illness. The reality is country GPs get called a lot for services. At my hospital we provide this service without being paid an on-call fee. Country GPs sort out a lot of issues at an early stage, avoiding transfer to a tertiary centre. We also do a lot of aged care, often keeping patients locally, after consultation with family, and again avoiding escalation to a tertiary centre. There may be need for some resident and specialist services, especially at bigger centres. If this does occur there needs to be clear patterns of referral. At present it is confusing, as tertiary centres tell us to transfer patients to regional hospitals, but then the regional hospital does not have the infrastructure to manage these patients. Specialist services are expensive and need many layers of assistance (for example, resident staff who then need supervision) I would not like to see services ceased in smaller centres to compensate for the provision of specialist services in other areas. I am concerned that any cessation of services in smaller areas will have adverse outcomes for population health

Comments from a rural/regional GP

GP services to the Port Lincoln Hospital include Obstetric, Anaesthetic, Emergency and surgical assisting and after-care. The close connection of the GPs with the community provides excellent continuity of care. Pre- and post-admission care is well coordinated. All producing excellent patient service and satisfaction. Not to mention cost efficient.

Comments from a rural/regional GP

The matter of appropriate levels of training of GPs servicing rural hospitals, scoping of practice, the ideal quanta each year of CPD/CME, in both general and procedural practice, as well as emergency care, is a huge topic, exercising several learned colleges and professional societies. The places of re-certification and re-accreditation are being examined. There is no consensus. The aging of the current cohort of experienced rural GPs, is relevant, as is the increasing role of international medical graduates. It is clear to me that there are, even now, very large variations in practice, care, competence, and confidence amongst rural GPs.

Maintaining recency in any area of in-patient care is very difficult, particularly in emergency care and resuscitation. Even yearly CPD/continuing medical education in these disciplines cannot provide adequate training and competence/competence in emergency care. There is a wealth of such courses, but they only provide a taste of requirements for most participants.

This places patients and the State in very vulnerable positions, and an unfortunate lottery exists. The current reliance on the City Hospital, and emergency transport providers, is expensive, not cost effective, and ultimately not sustainable, even if the actual numbers of patients does not rise. A new model, or models, for the provision of in-patient and emergency services should be sought. This must involve the current rural GPs, and as a matter of urgency, their likely successors. Initial training must be extensive, intensive, consistent across all sites, and backed up with robust maintenance of recency in the critical areas.

Whether we go to re-accreditation or re-certification, I have not yet a firm view. Rural Hospitalists? Maybe, but we only have a few centers large enough to make them work. The "lottery of care" must be removed, but not replaced by the "carnage of learning". This is a huge topic on its own, at least as big as the issues surrounding end-of-life decision making, appropriateness of certain kinds of care in those of advanced age and infirmity, and the interface with excellence in palliative care.

Comments from a rural/regional GP

I have three funded days of emergency medicine training each year. This is appreciated but not enough. There are hundreds of emergencies which can potentially present, from electrocution, burns, heart and airway problems, to paediatric and obstetric emergencies, poisoning, psychiatric, drug misuse, orthopaedic, neurological, respiratory problems etc etc etc. Three days is insufficient, as we are expected to manage these remotely with minimal staff.

I train myself at my own cost in a whole range of these areas when I can. I want more! I would appreciate a formalised arrangement to work in an ED several days a year as well to maintain skills. This should be formalised and paid and not be up to me to grovel to get it. The educational allowance of salaried consultant staff at RAH is a guide.

i. Procurement by Country Health SA and the benefits, or otherwise, to country communities

Comments from a rural/regional GP

Wherever possible, rural hospitals should be empowered to procure produce locally to help reduce the ecological footprint, as well as assist viability of providers in small communities. This social contract must be considered against possible cost savings when looking at state-wide buying.

Comments from a rural/regional GP

In a population of 1.6 million, mostly in a city state and a few small or very small centres, standardization of procurement seems good sense to me, the caveat being that all potential recipients/users of standardized procurement are involved in the evaluation processes.

IMPORTANT NOTE: AMA(SA) understands procurement processes were used in relation to Mount Gambier orthopaedic and ophthalmology specialist contracts. This process was significantly suboptimal. The AMA(SA) provided considerable support to the Mount Gambier specialists during a protracted period as they dealt with the overly bureaucratic and stressful 'procurement' machine … which resulted in the clinicians who had provided services for over 20 years being contracted for a further term. A similar process was undertaken for ophthalmology at Mount Gambier. A letter outlining the Mount Gambier orthopaedic surgeons' experience is included as an Appendix to this submission, with the members' permission.

The AMA(SA) calls for a review and the exclusion of the treasury 'procurement' process from medical workforce contracts in all SA rural and regional areas. Whilst the process may be suitable for major bulk contract provision, it has proven itself to be totally unsuitable, and indeed hazardous, to medical workforce engagement. The AMA(SA) recommends a review of the framework for encouraging and supporting medical practitioners into rural locations.

In addition, the AMA(SA) has encouraged Country Health SA to see itself as more than a commissioner of health services. Country Health SA and the rural medical workforce funding framework must acknowledge a role in training and research in rural SA. Such recognition would support early rural experiences and engagement by the younger doctors. This would encourage sustainability and more permanency of our rural medical workforce.

j. mandated fees to DPTI for management of maintenance and minor works;

Comments from a rural/regional GP

Locally we have had no recent experience of being able to progress minor works for this to be a known issue

k. the implementation of EPAS in country hospitals;

IMPORTANT NOTE: The AMA(SA) has been apprised of significant and ongoing concerns about EPAS over time. In this submission we are including just the recent comments of members who have responded to our call for input into this current inquiry, not earlier feedback, which may now be outdated in some respects.

Comments from a rural/regional specialist

I have now worked with EPAS for two years … It is important to state that I use technology just as much as any other person over sixty years. I have iPhones, iPads and use computerised prescribing in my private consulting practice. I have no objection to a high quality electronic record. My concern is that EPAS is not a high quality electronic record. It is cluttered in its layout, is not intuitive and does not bring together things in a way that would make sense to me.

Traditionally, paper notes have included a single page, including pulse, respiratory rate, temperature, oxygen saturations and the weight of children. Just by glancing at this sheet, whether it is for four hours of recordings or 24 hours of recordings can tell me whether a child is getting better or worse.

This is then backed up by a sheet showing the fluids that have been prescribed and are to be given, and against that is what is actually given. Funnily enough, these are often different. Lastly, there will be a sheet with prescribed medications and once again compliance with that.

By looking at these sheets of paper, I can often tell whether a patient is getting better or worse and whether the appropriate treatments have been instituted or not. EPAS essentially takes all of these and separates them out into complex and difficult to see pages or tiles. Certainly, electronic prescribing leads to greater clarity and less mistakes. Any electronic program will do this.

The other issue with EPAS is that each and every record is a separate item. We have spent a hundred years developing medical notes that are a single rolling record that includes all practitioners contributing. In this way, people reviewing notes whether they be a consultant or junior doctors or nurses or even the coroner, can read the story of the patient for that admission. This is lost when you need to click open every episode of care.

The program can also be incredibly slow, cannot be used at the bedside and at times quite frankly just loses data. Even currently, I find that results on the weekend are not on EPAS and yet are available on the Legacy system called OACIS. These problems have been worked through the system. They continue. It may be that as this program takes a bigger role within the city environment that improvements will happen to make it workable. My suspicion however, is that the program is intrinsically of poor design.

Comments from a rural/regional GP

There was a flawed process of managerial reasoning in the introduction of EPAS into country hospitals, where the support of Resident Medical Officers and Registrars remains, at best, barely adequate for the diverse and unpredictable demands on their services within rural hospitals. The current nursing and medical workforce has been modelled and established with little, if any, redundancy. The system of electronic health record, EPAS, represented a potentially useful innovation in patient care. Unfortunately, EPAS was poorly researched, its purchase lacked robust reasoning, and poor planning of its implementation has resulted in manifest inefficiencies. These are particularly apparent in the small rural hospital of Pt Augusta, which has insufficient resources to ensure its flawless introduction.

Comments from a rural/regional GP

Beyond shared local knowledge regarding dissatisfaction with the implementation and lack of user-friendliness of EPAS, its introduction to smaller units would not seem to be likely any time soon.

Comments from a rural/regional GP

There is a lot of concern about EPAS. The computer service implemented in aged care is clumsy and slow compared to the computer services we use in our general practices, but it is very hard to convince Country Health of this. Computer services are essential but must work.

Comments from a rural/regional GP

The implementation of EPAS to Port Lincoln was requested to improve coordination of care for patients as they move to and from metropolitan care. We were advised that EPAS would not come to Port Lincoln until 2017. We would hope that its roll-out would be adequately supported in the form of technical support, training and computer hardware.

Comments from a rural/regional GP

Our local health unit has had the Sunrise EPAS for 2 ½ years. The need for a workable electronic health/medical record (familiar to GPs world-wide), has been long recognized. We were keen to see it and use it. Before roll-out, some aspects looked cumbersome. The training was very poor … and the stock control was a strong feature of the training, though it was never explained that way. The EPAS is an "Excel" based stock-ordering, stock control, and audit tool, with a bit of "Word" for the occasional use of free texting. Most of the clinical users, who are generally very comfortable with electronic medical records, have consistently reported a litany of machine and software issues, which were identified very early as likely not remediable. Its driving program is

quite small, and in many applications, the search capability is very poor. The ICD10 and Snomed are not at all simple to use … though some of this is due to the arcane nature of those coding systems. Many panes are very fussy, with a wealth of data, but devoid of information. Some tasks are illogically arcane. Multiple potential error-forcing issues were identified, one of which remains a recurrent frustration. We believe that the improvements thus far applied have made very little difference in terms of safety … a prime concern, speed, or simplicity of use. Fortunately, speed of use was never a selling point. As we are stuck with it, we use it, but finding work-arounds is a daily feature of the EPAS use. Some of our younger colleagues are digital natives, and have similar concerns. I suspect it would be very good in the running of a large department store.

Comments from a rural/regional GP

Where is the training for this? "Doctors will have to just cope ..." The suboptimal medical record is a source of litigation and good records take time. I see EPAS as a barrier to good care and something I will not be instructed about sufficiently. I would think it reasonable to be paid to undertake training to learn this, being imposed by the employer.

l. integrated mental health inpatient centres for regional South Australia;

Comments from a rural/regional specialist

I have had little to do with this; however, I have had at least one adolescent who needed a long admission in the inpatient centres. One of the things I have noticed over my 23 years is a marked improvement in mental health care in regional centres. I note that the implementation of a quiet room in our Emergency Department and appropriate staff to staff it, has certainly improved a lot of mental health patients and their quality of care. The ability to admit low-level people rather than committing them to a psychiatric institution and have them come back home within 24 to 48 hours is a far more sensible option. I have also worked with the regional mental inpatients centre for at least one of my adolescents in Whyalla. This has been very beneficial for that patient and I was impressed with the quality of care.

Comments from a rural/regional GP

Regional mental health inpatient centres have helped provide rurally-based services for rural patients, but often with the cost of significant removal from local family and support, and often further from home than metro-based services would be.

Comments from a rural/regional GP

Little use unless coordinated with ambulance transport between small rural centres, supported by telemedicine 24 hours a day, additional training in psychiatric emergencies, etc ... Think of a psychotic schizophrenic and paranoid patient, agitated, wielding a pair of scissors wandering about the hospital in Orroroo, with two night nursing staff and the one doctor with no police or ambulance backup ... how will [a] regional centre help this situation in the next few minutes ...

Comments from a rural/regional GP

The integrated mental health services are welcome but do have problems They are very hard to access and the bureaucracy surrounding them is horrendous. We can get admission to these units if we go through Adelaide, but it is hard work.The biggest concern about the integrated mental health unit is that they take all the mental health finances allowing very little for community services. Seriously ill mental health patients get referred to primary health care services which is not always appropriate

Comments from a rural/regional GP – currently metro-based

The model of mental health in the new integrated mental health services seems strange – I've heard recently that patients who live in the Adelaide Hills are admitted to the Riverland – my only

guess is that it is because of the CHSALHN boundaries but this couldn't be the closest geographically and it is a long way for families to visit – much less community follow up. My sense is there is a lot to do to improve these services.

Comments from a rural/regional GP

Detained patients are most frequently required to be heavily sedated and flown to Adelaide by RFDS. For the new development at the Port Lincoln hospital – mental health rooms were built but unfortunately they have not been staffed. Our mental health team is only staffed 9 to 5 for five days a week. After hours and weekend support would be very helpful to shorten admissions and reduce transfers to Adelaide. Mental health nursing staff for in patients would greatly improve services.

Comments from a rural/regional GP

This half-hearted experiment has barely made an impact, if this refers to the Whyalla, Riverland and Mt Gambier Psychiatric units. I have been advised that the vaunted numbers of beds never really came, or were reduced. It would be an excellent thing for many patients, to be managed in their own communities. This requires excellence in nursing support, and highly skilled rural GPs, or ready access to consultant advice and assessments. Acute psychiatric care is very time consuming.

As so many acute "psychiatric" episodes are associated with alcohol, or other medications, legal or not, there is an urgent need for the education "system" to be involved in the pre-emptive management of this destructive and costly problem. Acute psychiatric transfers to prescribed centers for care used to be quite uncommon. Local safe places for care are necessary, but the humans needed to man them is a critical issue. Perhaps the flight to the City is the less expensive option!

m. any other relevant matters.

Comments from a rural/regional GP

I am aware that changes are required to be able to continue to provide comprehensive medical services in view of the increasing medical needs of an aged care population. I feel savings can be made by the cooperation of community, general practice and specialist services, and nursing and allied health. My concern is that services will be more centralized, with adverse outcomes for patients and more cost to the taxpayer. We need to be careful to provide medical services locally. This is effective and inexpensive. Where services are centralized there needs to be clear patterns of referral and transport

Comments from a rural/regional GP

If I had some say, a good number of very expensive treatments, or facilities, which actually benefit very few, could be greatly restricted, or removed, and the funds put into education which is where the big benefits really are, if done properly.

Comments from a rural/regional GP

I consistently find there is a lack of resources to help me as a doctor do my work as a rural locum in rural hospitals – medication information, internet access 24 hours a day ... this reflects a long-standing dismissive attitude to resourcing rural doctors, almost in expectation that we will bring it all with us or it is all in our heads.

Country Health rural workforce in SA is a mess and the bureaucracy is equally not well functioning and poorly resourced as metro takes more and more money out of the system. It would be good to get some facts and figures re budgets.

Comments from a rural/regional GP currently metro-based

I am very concerned about this process, and whether it sets the stage for implementation of "Transforming Country Health" or an equivalent poorly planned cost cutting process. Rural South Australia has some of the lowest levels of service and poorest health outcomes in Australia.

The major issues are:

- *Higher levels of chronic disease and comorbidity*
- *Poor access to services – the location and type of services*
- *Mal-distribution of clinicians – there has been no workforce planning to my knowledge*
- *Clinicians have limited skills training and development*
- *PHNs have not yet delivered any services*

There is no longitudinal epidemiological research on the relative health of rural South Australians. I don't think the community is aware of decreases to services; for example, recently there has been cuts to palliative care services. Last night, I spoke to the visiting ENT surgeon who had to cancel his last patient because they were not prepared to pay the staff over time.

I am concerned if this will also seek to make recommendations regarding the rural medical workforce without careful consideration of education and training. Also without consideration that multi-disciplinary teams are the key to better healthcare. It is all about reducing costs and not about improving quality of care. In SA Health there is a view that the level of payment to GPs to provide services is too high. So I [am concerned] this is about trying to reduce the level of medical services overall with the aim of increasing specialist positions that can be funded by the Commonwealth – it is simply cost shifting.

Comments from a rural/regional GP

Australian general practice is one of the most efficient and effective primary health care deliverers when compared to other countries with universal health systems. As far as cost savings [which has been a major theme of state and federal governments] general practice is best placed to deliver those to the health system in general through better and innovative delivery of primary care.

Models of care in rural general practice might offer better models of care for metropolitan care. That is, active general practitioner involvement through all aspects of care as "project manager"; active communication with specialists and other health care providers and care coordination; and leadership from other generalists both surgical and medical. The current "budget crisis" is an opportunity for innovation in health delivery – but it needs to be the right kind of innovation. Rural Australia is bursting with practical innovation born of necessity and a gritty connection with the realities of health care delivery.

South Australia has some unique geographical problems that currently hamper health delivery but are again an opportunity. An excellent example is the ICCnet model of "chest pain" management which equalised MI outcomes between rural and metro, lead by Dr Phil Tideman. The general principle applies that if the difficult problems are addressed, the whole system benefits.

Then there are the perennial workforce and training issues. Considering that approximately half of the rural GPs in SA are international medical graduates (IMGs), ceasing to have IMGs would immediately exacerbate workforce issues. The Medicare freeze makes rural general practice difficult – most of rural after-hours care delivery is bulk-billed. Sending patients who can't pay a private fee to a public A+E is not an option. There is also concern amongst rural general practitioners about private health funding trends and agendas.