RURAL DOCTORS ASSOCIATION TASMANIA

Dr Rosalie Woodruff MP
Chair
House of Assembly Select Committee on Transfer of Care Delays (Ambulance Ramping)
Parliament of Tasmania
Parliament House
HOBART TAS 7000

Via email: transferofcare@parliament.tas.gov.au

Dear Dr Woodruff

RDAT thanks the Select Committee on Transfer of Care delays (Ambulance Ramping) for the opportunity to provide a submission to its inquiry.

The Rural Doctors Association of Tasmania (RDAT) is the peak rural body for doctors working in rural and remote Tasmania and represents the views and aspirations of rural doctors. We aim to promote career pathways in rural practice and support services provided by rural doctors in Tasmania. We support our rural communities through advocacy and sustaining health services in rural Tasmania.

In Tasmania, rural ambulance services have been ignored by successive governments leaving people in rural communities without timely assistance, severely compromising their access to hospital care. There is an overreliance on volunteer ambulance officers to support career Paramedics and ambulance wait times in rural areas is increasing.

There is also an insufficient number of rural general practitioners and Rural Generalists who can provide preventive care and early intervention in general practice settings and in rural hospitals to reduce the incidence of transfers to larger facilities. Unnecessary transfer is inefficient, wastes resources that are needed elsewhere and contributes to ambulance ramping and access block.

Investment in rural and district hospitals, and in the training of medical and other health professionals in these areas, has the potential to greatly improve patient experience and care, and to relieve pressure on larger hospitals, including by reducing ambulance ramping and access block.

Yours sincerely

Dr Ben Dodds
President
Rural Doctors Association of Tasmania

Introduction

Across many parts of Australia, ambulance ramping[1], together with overcrowding in emergency departments (EDs) and access block[2], are significant problems impacting on patients' healthcare experiences and care, and leading to negative health outcomes (including, in some cases, death). Media reports point to long delays reportedly due to high demand and out of action and ramped ambulances leading to people seeking alternative transport to hospitals and making the risk that conditions will become life-threatening much higher.[3,4]

Addressing these issues will require that underlying systemic issues – such as: the focus on acute care rather than the primary care and prevention to keep people out of hospital; silo-ed approaches and fragmentation across the health; poor links with social and community services; and the health workforce shortages that exist across Australia – be addressed by a whole-of-system approach and collaborative effort. In some cases this work has already begun but achieving positive results is likely to be a longer term proposition. Difficulties associated with tiered health funding and responsibilities must be resolved to create timely and seamless patient care.

This submission emphasises that:

- Timely access to primary care is essential to prevent potentially avoidable hospital presentations and admissions.
- Rural health services can reduce the load on larger Emergency Departments if they are appropriately staffed and resourced.

Hospitals and ambulance services are a state responsibility, and there are a number of actions that can be taken in the short and medium terms to reduce the occurrence of ambulance ramping and mitigate the negative impacts on patients and the health workforce within Tasmania.

RDAT makes the following comments under each of the Terms of Reference to inform the inquiry.

Response to Terms of Reference

(a) the causes of transfer of care delays, acknowledging Federal and State responsibilities;

RDAT challenges the narrative posited by Commonwealth and state governments that lack of access to timely primary care is a significant contributor to the access block that is a cause of transfer of care delays.

While definitions of 'GP type presentations' (lower urgency) vary considerably based on the actual care that is provided to patients in the Emergency Department[5], these presentations, though they

[1] When the transfer of patients from the ambulance to the Emergency Department is unable to be in a timely, clinically appropriate manner, it is commonly referred to as ambulance ramping.
[2] Access block (also known as bed block) occurs when a patient is unable to be transferred out of the Emergency Department (ED) to an inpatient bed once their ED treatment has been completed.
[3] https://www.abc.net.au/news/2022-07-22/ambulance-tasmania-sends-boy-suffering-asthma-attack-a-taxi/101260638. Viewed 9 October 2023.
[4] www.theadvocate.com.au/story/8302673/scathing-report-sparks-inquiry-into-hospital-ramping/. Viewed 9 October 2023.
[5] https://pubmed.ncbi.nlm.nih.gov/25720647/. Viewed 11 October 2023.

contribute to overcrowding, are not usually transported by ambulance, are normally seen within a 'Fast Track' or 'Ambulatory Care' stream separate from very unwell patients and those that need to be hospitalised, and are then discharged. They do not contribute to access block.

A recent NSW study indicates that the Australian Institute of Health and Welfare (AIHW) definition of potentially avoidable GP-type presentations to Emergency Departments[6] massively overestimates the number of patients that could feasibly have had their care needs met in general practice. Many of the patients in this 'unsuitable for GP care' category received care such as parenteral medication administration (for example, intravenously), prolonged observation, specialist and allied health consultation and procedures[7].

While efforts could be made to better support general practice in the delivery of such care, it is not currently funded or resourced to provide this care.

A more concerning issue for RDAT is that patients' access to continuity of care with their GPs and their general practice teams is being reduced either as result of workforce shortages or cost. This can result in preventable deterioration or exacerbation of chronic diseases that lead to ambulance call outs and hospitalisation.

The effects of access block and transfer of care delays are felt mostly in Emergency Departments and the Ambulance 'Ramp', with paramedics and over capacity departments, caring for patients in inadequate and unsafe conditions. This has led to significant adverse outcomes, including death.

A hidden aspect of this is that the longer a patient spends in the ED, the greater the likelihood they will experience higher levels of morbidity for that presentation and poorer health outcomes as a result.

Although it is in the ED that the most pressure is experienced, the issue is a hospital and health system-wide one. A significant number of patients are admitted to hospital when alternative care arrangements – including community/outpatient care, virtual care, hospital in the home, subacute rural admissions and acute rural hospital admissions – could be put in place.

While the issue is often highlighted at the 'front door' of the hospital, the major contributing factor for access block happens at the 'back door': getting patients home again or discharged to other facilities (such as rehabilitation services or aged care).

RDAT is concerned about the underutilisation of Tasmania's 13 District Hospitals as part of the solution to access and flow of health care in Tasmania. The occupancy rates of District Hospitals hovers around 50%[8]. However, the number of rural and remote Tasmanians who have been admitted to hospital has risen by an average of 20-30%[9]. This means that a significant amount of care is not happening in rural communities and we are not utilising our rural health resources to their full capacity.

In summary, the causes of transfer of care delays are manifold and include:

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[6] https://www.aihw.gov.au/reports/primary-health-care/use-of-ed-for-lower-urgency-care-2018-19/contents/summary. Viewed 12 October 2023

[7] https://www.mja.com.au/journal/2023/219/4/lower-urgency-care-emergency-department-and-suitability-general-practice-care. Viewed 11 October 2023.

[8] https://www.treasury.tas.gov.au/BudgetPapersHTML/Budget2023/BP2/2023-24-BP2-4-Department-of-Health.htm. Table 4.4: Performance Information – Output Group 2. Viewed 13 October 2023.

[9] Department of Health

- High demand for care but poor access to general practitioners (GPs) and Rural Generalists means that people may call an ambulance for health issues that could have been dealt with through preventive care and early intervention by these clinicians either in the general practice setting or in local hospitals.
- The closure or downgrading of services in rural Tasmania that means that when ambulances are ramped and paramedics must continue pre-hospital care, there is increased pressure on fewer ambulances and on paramedics.
- An underutilisation of District Hospital Emergency Departments and inpatient beds.
- Cost of living pressures that means that people may choose to go to an Emergency Department for non-urgent care rather than to a GP contributing to overcrowding of Emergency Departments and diversion of resources.
- Hospitals being unable to transfer patients out of the Emergency Department to inpatient care because there are no available beds (access block). This can be because of physical capacity issues, staff shortages or release constraints, including discharge to appropriate care following a hospital stay not being possible at the time it is needed.
- When rural GPs and Rural Generalists do not, or are unable to provide services to residential aged care facilities at the time, staff are more likely to call for an ambulance if a resident experiences an issue that they are ill-equipped to handle. This ties up an ambulance that could be needed for other call outs. Protocols can also mean unnecessary transfer of the patient that can be physically demanding and confusing for those who are frail and can lead to poor health outcomes.
- Local health professionals may also lack of skills and confidence to deal with an evolving situation, for example, an emergency birth. This is even more problematic if retrieval and transfer is not possible because the ambulance has a slow response time and/or is ramped.

RDAT urges the Committee to review the processes that occur within Tasmania's major hospitals to ensure that medical care on the wards is supported by appropriate allied health interventions, and that discharge planning processes are begun at the time of admission, including identifying rural and remote patients early, and investing in transition to home care teams to organise National Disability Insurance Scheme and Residential Aged Care Facility transitions early and to support discharge to home with community care if needed.

(b) the effect transfer of care delays has on:

(i) patient care and outcomes;

Due to the significant number of inpatients (i.e. admitted patients) in Emergency Department beds that cannot be transferred to other wards, there is a significant lack of space to offload Ambulance Tasmania patients and hand over care to the ED. There is also a lack of available of beds for patients who self-present with acute and life-threatening conditions.

This means that patients are:

- Not seen in a timely manner by an Emergency Department health professional.
- Examined or have their history taken in clinically inappropriate areas where health professionals are unable to sensitively inquire about relevant issues, such as in chairs with other patients around.
- Are not monitored on cardiac monitoring or with a sufficient ratio of nurses to patients.
- Experience multiple changeovers of staff as paramedics are required to attend to urgent calls in the community.
- Experience delays in the commencement of treatment, including diagnostic testing (blood tests, x-rays/CTs), pain relief and antibiotics.

There are a number of other negative impacts on that can lead to poorer health outcomes and to deaths that could have been avoided:

- Patients are aware of the ramping issue and there is a tendency to avoid or refuse transfer to hospital because they dread the wait time. Rural doctors report that this hidden harm is quite common and can lead to a worsening of the patient's condition.
- For sick or injured patients, slower initial response (as ambulances cannot be sent out to new calls if they are ramped) and longer time under the care of paramedics (includes assessment and immediate treatment, transport and the time ambulances are ramped) means that their condition can worsen significantly before they are assessed and treated by doctors.
- Later review within the episode of care can mean that the condition becomes more severe, less easily treatable and that more complications occur. This can in turn lead to longer hospital stays exacerbating the issue of bed block.
- Poor patient experiences occur when paramedics are, in essence, being asked to do the work of Emergency Departments within a confined space and with limited equipment.
- Poor patient experiences occur when patients are offloaded from the ambulance but there are no beds in the Emergency Department. An example of this situation reported by an RDAT member exemplifies the issues:

  A patient of mine was 'ramped' in the corridor of a major ED. They were still on an ambulance monitor but had been offloaded to the care of the hospital, but there were too few nurses and inadequate space to monitor them appropriately, and they experienced a significant episode of hypotension and altered conscious state secondary to bacterial infection (sepsis), which required an escalation in their care to a resus[citation] cubicle. This also meant removing a patient currently in the resus[citation] cubicle to the corridor until an appropriate bed space could be found for them.

(ii) ambulance response times and availability

Ambulance ramping increases the poorer access to ambulances already being experienced by rural people. Ambulances are taken out of rural areas for longer, markedly worsening availability, slowing response times and increasing the likelihood of poorer health outcomes.

RDAT understands that there have been significant issues with Ambulance Tasmania availability in response to community calls. This is due to an increase in Ambulance Tasmania utilisation, staff (paramedic) shortages and longer lengths of time being 'ramped' at hospitals.

RDAT members have observed that all urban ambulances can be ramped simultaneously at major hospital Emergency Departments leaving no community cover, except for urgent 'P0' and 'P1' cases. This means that paramedics are rushed to handover their current patient to either another crew or the hospital, clean and restock their vehicle and respond to the time-critical call outs.

The impact on ambulance response times is particularly exacerbated in rural areas, where there is often only one paramedic for an entire rural region. With no rendezvous crews available trip times are significant and creates management of paramedic fatigue issues.

In areas where there are no GPs people are more likely to call for an ambulance. Ouse, in the Central Highlands is in a district where there are no GPs, no District Hospital and a downgraded community centre. It has been reported that a single case from Ouse can take over 6 hours to return to the area and be ready to respond to the next case.

Often these solo paramedics work without volunteer support. This means that rural communities must wait for a crew to become available from the city to respond to a primary call-out from the community to a major hospital or to rural interhospital transfers retrieval requests.

RDAT understands that interhospital transfer times from rural Emergency Departments to large Emergency Departments have also increased significantly in the past few years. This has meant that rural hospitals are taking on a large burden of risk that they are not resourced for as they care for critically unwell patients for longer. RDAT urges the Committee to further inquire into this issue.

(iii) wellbeing of healthcare staff

Ambulance ramping was occurring prior to the advent of the COVID-19 pandemic but has become even more problematic. The pandemic placed an increased burden on health systems, highlighting shortfalls and inadequacies, including in relation to the health workforce. Workforce shortages became even more apparent as the demand for medical and other health professionals increased to care for those contracting COVID-19 and were exacerbated by necessary furloughing rules.

Ongoing COVID-19 admissions combined with hospitalisations due to deferred care (throughout the pandemic), influenza outbreaks, and other causes (such as injuries due bushfires and flooding), means that demand for services can be unrelenting and those who remain experience low morale. This is exacerbated by the increased pressure that ambulance ramping places on ambulance services and on overcrowded, under-staffed and under-resourced hospitals.

Health professionals continue to experience considerable physical and mental burdens and suffer significant moral and professional injury from working in these sub-optimal conditions. They come to work to provide high quality and safe healthcare but are demoralized by providing care that is just 'enough' to get patients through, in a system that prevents them from striving for and providing 'excellent' health care.

The persistent moral injury from not being able to perform to the best of one's ability and seeing adverse outcomes for patients and colleagues has contributed to the burn out of health professionals and seen them leave for other areas of work within the health system (Urgent Care Centres for example) or leave the system altogether.

(iv) Emergency department and other hospital functions

The Emergency Department is the 'front door' of the hospital and has the ability to provide observation and monitoring, advanced and critical care. Emergency Departments are currently not able to function to full capacity due to the significant pressures of access block. As previously discussed, the limited flow through Emergency Departments means that there are delays in commencing treatment of patients, finding appropriate clinical spaces to review and re-review patients, as well as adequately monitor them for preventable deterioration.

A significant number of patients are referred or transferred to the Emergency Department as it is only space within the hospital that can provide care for the undifferentiated and acutely unwell patient. RDAT recommends that the Committee should examine whether there are other areas within the hospital that can be appropriately resourced to bypass Emergency Departments and provide acute care to patients from the community and/or on referral from GPs e.g. Acute Medical Units, Acute Surgical Units.

Other hospital functions are directly impacted by large numbers of inpatients in the Emergency Department, including creation of separate teams who only see inpatients within the Emergency Department. This means that when patients are taken to a ward they have to 'start again' with a new team including a new consultant. Other issues include less access to specialist nursing skills like oncology, orthopaedics and paediatrics, and doctors and other professionals needing to cover multiple areas of the hospital simultaneously and responding to patient issues in segmented areas, rather than looking after a cohort of patients in one place.

(c) the adequacy of the State Government's data collection and reporting for transfer of care delays

RDAT believes that the data reporting on ambulance response times and transfers is inadequate for rural settings. Current metrics make it unclear if the median emergency response time includes rural and remote responses or just urban areas. The data would suggest that rural areas have been excluded as feedback from members and their communities is they can wait hours for an ambulance in a rural and remote location. RDAT suggests that the Department of Health dashboard includes rural and remote Ambulance response times.

On the ground clinicians report that they are unable to ascertain from Ambulance Tasmania approximate transfer times for rural Emergency Department patients and no clear order of priority for their patient. This creates uncertainty about how the situation is being managed and how long the local rural health service will need to care for the patient prior to transfer. Rural doctors also hold a significant burden of decision making in asking for an ambulance transfer as they know it removes the local ambulance and crew from the community, leaving a community-based emergency uncovered. RDAT suggests that clear communication is developed so that local clinicians are aware of their status in the priority que for transfer and when assets have been allocated with an expected time of arrival.

Similarly in the major Emergency Departments there is difficulty in planning for a surge of ambulance arrivals to an Emergency Department and patient flow resources should be allocated to planning for patients' arrival into the Emergency Department (and hence the need for movement within in the Emergency Department) prior to their arrival to prevent transfer of care delays. Having a critically unwell patient arrive without the appropriate clinical space can be avoided if there was enough clear communication between Ambulance Tasmania and the hospital (not just the

Emergency Department) to ensure that flow through the Emergency Department and the hospital allowed a smooth transfer of care.

(d) the State Government's response to transfer of care delays and its effects to date, and the efficacy of these measures;

The efficacy of the 2016 Patients First Initiative that specified 19 actions to manage demand on Emergency Departments and improve patient flow through the hospital is difficult to assess without access to formal evaluation reports. However, media reports from five years later indicate dissatisfaction with progress[10,11].

RDAT is unable to make comments about the Governments implementation of the *Review of Ambulance Tasmania Clinical and Operational Service Final Report May 2017*[12] report due to the short time frame for submission. We do note, however, that often rural doctors and District Hospitals are 'left out' of the conversation around patient flow, despite multiple acknowledgements that part of the solution is better utilisation of rural acute, subacute and aged care beds.

(e) measures taken by other Australian and international jurisdictions to mitigate transfer of care delays and its effects

Ambulance ramping is an acknowledged problem in other parts of Australia and internationally. It is a major indicator of health systems that are under stress and has prompted various inquiries. There is widespread acknowledgement that whole-of-system reform is needed to address the causes of ambulance ramping.

Federal action would appear warranted given the scale of the ambulance ramping problem, and that it is symptomatic of structural issues within the health system. This action must be integrated with state responses to mitigate against duplicative effort and wasted resources.

A number of states in Australia have already committed to significant investment in vehicle replacement and the training and recruitment of new paramedics. For example:

- South Australia committed $36.9 million on new vehicles and $124 million on the recruitment of 350 paramedics over four years[13,14].
- The 2022 New South Wales (NSW) *Inquiry into the impact of ambulance ramping and access block on the operation of hospital emergency departments in New South Wales* "made 12 recommendations aimed at relieving pressures within the NSW Health system with the intent of

[10] https://www.abc.net.au/news/2021-01-14/tasmanian-hospital-wait-times-and-ambulance-ramping-continue/13054868. Viewed 10 October 2023.
[11] https://independentaustralia.net/politics/politics-display/tasmanias-gutwein-government-patients-first-policy-puts-patients-last,15006. Viewed 10 October 2023.
[12] https://doh.health.tas.gov.au/__data/assets/pdf_file/0003/250905/RATCOSFR_v3_LR.pdf. Viewed 12 October 2023, Viewed 10 October 2023.
[13] https://www.premier.sa.gov.au/media-releases/news-items/biggest-ambulance-fleet-order-on-record-for-our-ambos. Viewed 9 October 2023.
[14] https://www.abc.net.au/news/2022-06-05/ambulance-funding-stop-ramping-more-paramedics-premier/101127486. Viewed 9 October 2023.

preventing delays in transfer of care.[15] Of the 12 recommendations, 10 are supported in full or in principle; one is noted and one is not supported.[16,17]

- The Victorian government has also committed to more support for the health system, including a $162 million package to improve Ambulance Victoria's operations. It has been reported that the Victorian Government initiative is based on the Leeds Teaching Hospitals NHS Foundation Trust, Leeds, United Kingdom model [18,19]

Whether these investments lead to a reduction in ambulance ramping remains to be seen. Clear strategic and operational planning that is sufficiently flexible to change what is not working and strong governance that includes robust evaluation mechanisms and transparent lines of accountability must underpin any consequent initiatives.

(f) further actions that can be taken by the State Government in the short, medium, and long term to address the causes and effects of transfer of care delays

RDAT recommends that the State Government strongly consider its role in investing in and bolstering rural primary care services to support Tasmania's decentralised population:

- Timely access to primary care is essential to prevent potentially avoidable hospital presentations and admissions.
- Rural health services can take the load off the larger Emergency Departments if they are appropriately staffed and resourced.

We acknowledge the work of the current Government in its investment in the Tasmanian Rural Generalist Pathway, the Rural Medical Workforce Centre and collaboration with the Federal Government on the Single Employer Model for GP Registrars. This moves Tasmania forward in helping recruit, train and retain rural doctors for our rural communities.

However, smaller rural and District Hospital Emergency Departments are currently underutilised. Investing in their physical, capital, technological and staff capacity, and ensuring that they are not bypassed during emergencies provides an opportunity to reduce the need to transfer patients to larger facilities, ambulance ramping, overcrowded Emergency Departments in larger hospitals and access block.

[15] https://www.parliament.nsw.gov.au/lcdocs/inquiries/2892/Report%20No.60%20-%20Portfolio%20Committee%20No.%202%20-%20Health%20-%20Ambulance.pdf. Viewed 9 October 2023.
[16] https://www.parliament.nsw.gov.au/lcdocs/inquiries/2892/Government%20response%20-%20PC%202%20-%20Ambulance%20ramping.pdf. Viewed 9 October 2023.
[17] https://www.nsw.gov.au/media-releases/reducing-pressure-on-public-hospital-eds. Viewed 9 October 2023.
[18] https://theconversation.com/ambulance-ramping-is-a-signal-the-health-system-is-floundering-solutions-need-to-extend-beyond-eds-187270 . Viewed 9 October 2023.
[19] https://www.nhsconfed.org/articles/what-latest-data-tell-us-about-ambulance-handover-delays?fbclid=IwAR1uGgNx1m--nlGgKtvI9qQu4Q6Y7lNVaafs3Dh0WyOoJb7eCEGIbYAbKeo. Viewed 9 October 2023.

District Hospitals need to be adequately resourced and staffed to ensure maximum utilisation. For example, to reduce the ambulance ramping that occurs as a function of increased emergency presentations[20], District Hospitals will require dedicated staff for emergency presentations. Currently the staff attending to emergency presentations in District Hospitals are taken away from the care of inpatients. As District Hospitals are not funded for the increased numbers of emergency presentations this means resources are being drawn from existing block funding for the facility further compromising the availability of other healthcare services.

RDAT emphasises that the solution to access block and better primary prevention is not further investment in siloed programs in the community (such as Urgent Care Centres, HealthCare Connect North, Nurse Practitioner Primary Care Clinics and Extended Care Paramedics). High quality well-funded General Practice can achieve this but has suffered from multiple assaults, including reduced funding, increasing MBS regulation and compliance requirements, greater patient demand and complexity of care, and lack of support from State and Federal Governments. The viability and sustainability of rural general practices are under threat.

General Practice provides cost effective and efficient care and it is the only part of the health system with evidence to support cost efficiencies in the hospital sector and decreased hospital admissions[21]. Other programs cost far more to implement and have poor evidence to support their utilisation. For example, a 2020 report into Nurse Practitioner Clinics in the ACT noted that the *average cost to taxpayers per service delivered by a nurse-led clinic is $162.21, compared to $38.22 for a standard Level B GP consultation*[22].

RDAT urges the Committee to consider:

- Immediate review of the average length of stay for common health conditions for admitted patients in the Tasmanian Health Service, benchmarked against other health jurisdictions. Causes of discrepancies in length of stay in Tasmania should be investigated.
- Investment in allied health teams to provide comprehensive care to patients during the episode of care.
- Investment in improved processes for providing discharge planning and transition of care back the community for example, through funding for general practice to take on patients who do not currently have a GP, patients who are vulnerable or patients who are being transferred to a Residential Aged Care Facility.
- Investment in 'Rapid Access Specialist Clinics' to provide advice and review of patients in the community and support GPs with their assessment and management plans for patients who are at high risk of deterioration and hospital admission

[20] Historically, Tasmania has had an ambulance utilisation rate lower than the national rate (see Figure 1). Since 2012–13, however, the utilisation rate has exceeded the national rate and the gap continues to widen. In 2015–16 the utilisation rate for ambulance services in Tasmania was 149.4 patients per 1000 people, compared to 136.8 patients for 1000 people nationally. p 11. https://doh.health.tas.gov.au/__data/assets/pdf_file/0003/250905/RATCOSFR_v3_LR.pdf. Viewed 9 October 2023.

[21] Bazemore A, Petterson S, Peterson LE, Phillips Jr RL. More comprehensive care among family physicians is associated with lower costs and fewer hospitalizations. Ann Fam Med 2015;13(3):206–13. doi: 10.1370/afm.1787

[22] https://www1.racgp.org.au/newsgp/professional/evidence-shows-no-benefit-for-more-nurse-led-clini. Viewed 12 October 2023.

- Tasmanian Government work with the Commonwealth Government to recognise and support the key role that rural GPs and Rural Generalists play in preventing the need for emergency call outs and in urgent care.
- Expansion of the scope of and support for rural District Hospitals.
- Immediate review of the role of the District Hospitals in providing acute and sub-acute care, including resourcing, workforce and access to multidisciplinary teams
- Properly equipping District Hospitals with the equipment and resources they require to asses and treat emergency patients such as Ultrasound machines, X-ray machines (including after hours), adequate and consistent pharmaceutical access.
- Review of the current process for renumeration of rural doctors who provide on-call and emergency work within District Hospitals, acknowledging the additional training and lifestyle burden that rural on-call services has on General Practice.
- Investment in the training, professional development, upskilling and clinical support for doctors in rural District Hospitals
- Support for rural nurses through training, skills maintenance, adequate remuneration and recognition of other rural area nurse qualifications such as Remote Area Nurses (RANs) and Remote and Isolated Endorsed Registered Nurses (RIPERNs)
- Support for multi-disciplinary teams in emergency departments and District Hospitals with Nurse Practitioners, Primary Contact Physiotherapists and Paramedic Practitioners.

Conclusion

Rural GPs, Rural Generalists and their teams in general practice and local hospital settings, can play a critical role in reducing transfer of care delays and consequent negative impacts, including poorer patient experiences and health outcomes, and avoidable deaths, if they are supported and resourced to do so.