15 December 2023

Ms Robyn Kruk AO
Chair, COVID-19 Response Inquiry
C/-Department of Prime Minister and Cabinet
PO Box 6500
Canberra ACT 2600

Dear Ms Kruk

The National Rural Health Alliance (the Alliance) welcomes the opportunity to make a submission to the COVID-19 Response Inquiry. The Alliance is the peak body for rural health in Australia.

The Alliance comprises 50 Members[1], and our vision is for healthy and sustainable rural, remote and regional (hereafter rural) communities across Australia. The Alliance is focused on advancing rural health reform to achieve equitable health outcomes for rural communities, the 7 million people residing outside our major cities. Our members include health consumers, healthcare professionals, service providers, health and medical educators, researchers, medical and clinical students and the Aboriginal and Torres Strait Islander health sector.

I would like to take the opportunity to raise a few key points for you to consider in your deliberations for this Inquiry. I note you are looking for concise submissions, hence I will limit our response to key themes the Alliance has noted from our members and other stakeholders. Our rurally focussed content relates collectively to the following terms of reference for this Inquiry:

> *Key health response measures (e.g. across COVID-19 vaccinations and treatments, key medical supplies such as personal protective equipment, quarantine facilities and public health messages).*
>
> *Broader health support for people impacted by COVID-19 and/or lockdowns (for example, mental health and suicide prevention support and access to screening and other preventive health measures).*

Personal Protective Equipment

- At times, personal protective equipment (PPE) was in short supply during the pandemic, and more was needed for rural students. Universities were forced to access their own PPE. Universities did not have access to distributors and, therefore, bought PPE that was not always approved in the clinical setting or did not fit appropriately. Many general practices could not access extra PPE for students, and it was expensive to buy.
- All students and staff needed to undertake mask fit testing – that is, determination of the mask that fits best on the face to protect COVID-19. There were delays in students being fit tested as some universities did not have facilities and had to rely on the acute care sector for testing. Some students missed placement due to delays with testing.
- Pharmacists also experienced PPE supply issues.
- **In future pandemics, timely and affordable access to PPE by all health professionals in all parts of the health sector, including students, should be considered.**

COVID-19 vaccinations

- Aboriginal and Torres Strait Islander Health Practitioners and the RFDS played a vital role in the vaccination program during the pandemic. The utilisation of these health practitioners to provide vaccination in communities was key to the high uptake and protection of Aboriginal and Torres Strait Islander communities, particularly in remote areas.

[1] Please see www.ruralhealth.org.au/about/memberbodies for details

- **The reduced workforce in rural locations means that in a pandemic or other disaster situations, all health professionals must be able to work to the full scope of practice. Policy settings and program guidelines must ensure health professionals with the relevant training - such as nurses, nurse practitioners and pharmacists - can deliver appropriately and equitably funded services that fall within their scope and have access to adequate supplies. It is essential that regulatory or bureaucratic barriers in this context do not constrain practice.**

Rural Medical and Health Student Placements

- During the pandemic, Universities and hospitals cancelled short clinical placements for medical students. Teaching of rural content was completed online. This resulted in students needing more clinical exposure to rural practice. Whilst the physical placement itself is not essential, it does give students *valuable insight into rural practice* (what a rural general practitioner (GP) does compared to urban GPs) and an understanding of the depth of knowledge all health practitioners need to work in rural communities, especially during a time of great health stressors. These placements also provide training in how rural healthcare workers work in multidisciplinary teams and rely on each other's skill to provide best-practice care. Short placements are extremely important, as this is a time when students consider undertaking longer placement placements in their later years of study, indeed a future career in rural Australia.
- Medical students in years four and five tended to stay onsite in rural locations during the pandemic, with their placements extended. They became more embedded into healthcare teams that were sometimes short of staff. Some medical students worked as part of the surge workforce on weekend.
- Overall, many medical students on rural placements fared better, as most were transitioned to longer placements, whereas their urban colleagues were often refused placement opportunities. Students required more social support, particularly when they were prevented from going home to see family and friends because of lockdowns.
- Feedback suggests that while medical students may have fared better, nursing and allied health student placements in rural locations may have needed to be better supported.
- **The learnings are that well-supported students across all health disciplines can benefit from, and be of benefit to, rural communities during a pandemic. Policy settings should support health students of all disciplines to have their rural placements continued during pandemic situations.**

Staffing Issues

- Rural hospitals have limited staff, and often experience workforce shortages. During the pandemic, it difficult than usual to fill rosters. Contributing factors included the movement of staff back to metropolitan areas and the limitation of staff movement on a transient basis, both due to border restrictions and lockdown policies, along with the furloughing of available staff due to COVID-19 exposure and illness itself.
- Many nurses worked extra shifts and or double shifts. Locum doctors were in short supply, and, as with all locum arrangements, there can be increased tensions with local staff about the daily rates earned by locums compared to existing and local health professionals. This was exacerbated during the pandemic.
- This is amplified in rural areas where there is a maldistribution of workforce, and evidence clearly demonstrate that selecting rural students and/or providing positive rural training experiences makes rural practice exponentially seven times more likely.
- Some medical and health staff living and working close to the borders of states and territories faced issues of being able to cross the borders or facilities for work. Federal, state and jurisdictional agreements and understanding need recognition and management before any future pandemic or disaster.
- Workforce and staffing issues are an area that requires recognition, careful consideration and collaboration between federal and state governments and communities to ensure any unintended consequences of policy decisions are managed appropriately and in a timely manner.
- **The pandemic taught us the importance of "growing your own" workforce – both for Australia as a whole and in rural areas specifically. Due to international border restrictions, Australia could not rely on recruiting health professionals from other countries. It became clear that ensuring health professions are an attractive and supported field of study and practice for Australians is vital for our future.**

Telehealth

- The ability to offer subsidised telehealth options was a major advancement during the pandemic.
- The Alliance is pleased to see that telehealth is now more readily available for rural people via Medicare but notes that telehealth options should remain a supplement to, not a replacement for, face-to-face services in rural locations.
- Great agility was shown by health professions and health service funders (including the MBS and private health insurers), to convert services to telehealth where appropriate and provide funding support.
- **Further work should continue to improve telehealth and virtual healthcare provision by rural health professionals, improving access to services while ensuring metropolitan providers do not "cream" easier online services that would otherwise be provided by local and main rural health providers. This would disjoint the patient journey and record keeping, leaving the more difficult and after-hours care for the rural practitioner.**

Definition of essential workers

- Early in the pandemic, there was some confusion about whether allied health professionals were considered essential workers, which created considerable issues.
- **In future pandemics the implications of policy settings on the entire health workforce should be thoroughly considered. This requires close collaboration between the Australian government and state/territory governments.**

Consequences of delays in access to non-emergency care

- Post-pandemic, the Royal Flying Doctor Service reported retrieving a higher proportion of high-acuity patients. Inadequate access to primary healthcare during the pandemic is thought to have deteriorated some rural people's health status.
- The negative consequences of reduced access to care should be thoroughly considered in future pandemic planning, especially in rural areas which already have existing inequities in access and health status.

Thank you for your consideration of these key points. I would be happy to provide further background or information required. I can be contacted at [redacted] or [redacted]@ruralhealth.org.au.

Yours sincerely,

Susi Tegen
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