Submission
No 60

THE IMPLEMENTATION OF PORTFOLIO COMMITTEE NO. 2 RECOMMENDATIONS RELATING TO THE DELIVERY OF SPECIFIC HEALTH SERVICES AND SPECIALIST CARE IN REMOTE, RURAL AND REGIONAL NSW

Organisation: AMA NSW

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The Australian Medical Association of New South Wales provides its submission to NSW Parliament regarding the Inquiry into the implementation of Portfolio Committee No. 2 recommendations relating to the delivery of specific health services and specialist care in remote, rural, and regional NSW.

Please contact Isabella Angeli, Policy Officer at AMA (NSW), if you have any further questions at

The Australian Medical Association of NSW, (''AMA NSW''), is grateful for the opportunity to make a submission to the Legislative Assembly Inquiry chaired by Dr Joe McGirr.

AMA (NSW) is a medico-political organisation that represents more than 8,000 doctors-in-training, career medical officers, staff specialists, visiting medical officers, specialists, and general practitioners in private practice. AMA (NSW) is the registered industrial body representing Visiting Medical Officers in NSW. Through its provision of Workplace Relations services to Visiting Medical Officers, Staff Specialists, Doctors-In-Training and General Practitioners, AMA (NSW) has a unique understanding of the pressures felt by those providing medical services in regional areas.

This submission has been prepared based on information provided by Chairs of Medical Staff Councils, AMA (NSW) Councillors, as well as feedback from AMA (NSW) members.

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The implementation of Portfolio Committee No. 2 recommendations relating to the delivery of specific health services and specialist care in remote, rural, and regional NSW

Please note for simplicity AMA (NSW) has used the term *regional areas* to collectively recognise services that are provided in remote, rural, and regional NSW.

Introduction:

1. All people across NSW, irrespective of where they live, or their social or economic circumstance, should have access to high quality healthcare. Roughly one third of the state's population lives in regional areas. That's more than three million people in regional, rural, and remote [1] areas. Unfortunately, people living in rural and regional communities have experienced difficulties in accessing health services, including the full range of non-GP specialist services. Despite the Rural, Regional and Remote Health Inquiry, there appears to have been no improvements in health services and in fact, reports of a deterioration in the workforce, funding and services available to rural, regional and remote communities.

2. We have identified several factors impacting on regional health services:

   (a) The recommendations of the Inquiry into Rural and Regional and Remote Health were poorly targeted and failed to consider the delivery of medical services.

   (b) There appears to be a growing disconnect between doctors and Local Health Districts (LHDs) in some areas.

   (c) The critical budgetary issues impacting NSW Health are disproportionately impacting regional LHDs.

   (d) Because of the above factors, new consultants are not choosing regional positions over work in metropolitan areas.

   Together, these factors present a grave and time-critical risk for the delivery of health services in regional NSW.

3. AMA (NSW) is deeply concerned about the lack of progress in addressing the declining specialist workforce in regional NSW. This is an issue about which AMA (NSW) has been advocating for many years. In 2013, AMA (NSW) facilitated a regional specialist workforce forum in Wagga Wagga to tackle the shortage of medical specialists in regional areas of NSW. The forum devised practical strategies to expand clinical services for patients outside metropolitan areas.

4. AMA (NSW)'s submission has been prepared with input from Medical Staff Council (MSC) Chairs at Dubbo, Bourke, Walgett, Mudgee, Scone, Gosford, Lismore, Grafton, the Hunter region, Port Macquarie, Tweed, Bega, and Queanbeyan Hospitals. Additionally, feedback has been provided by AMA (NSW) Councillors and members, who live and work in regional areas or who have done so previously. The feedback provided and observations made to AMA (NSW) through the consultation process have been instrumental in identifying the four most critical areas of need; *workforce, budget, training, and culture.*

[1] https://www.healthstats.nsw.gov.au/topic-overview/Regional%20health

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Workforce:

5. In regional areas it is difficult to maintain organisational stability or foster growth due to an inability to recruit or retain doctors. The shortage of doctors in regional areas places inordinate strain on the existing workforce, leading to the implementation of unfair, onerous, and often unsafe rosters. This perpetuates a cycle of burnout and dissatisfaction among doctors, resulting in the departure of doctors working in these locations but also serving to deter others from seeking positions in regional locations.

6. Not only are regional areas short of specialists, but they are also short of interns and doctors in training (DITs). As an example, a Medical Staff Council Chair told AMA (NSW) that in their regional hospital, of the 14 intern places allocated to the hospital, only two places have been filled.

7. Another MSC Chair indicated their hospital is down 20 interns for 2024. They believe they will face the same issue next year because hospitals in nearby Queensland are paying $30,000 above what NSW pays for an intern to work regionally.

8. The use of locums remains a common reality in regional NSW. Locums are and will always be an important adjunct to the medical workforce, providing much needed short-term cover for doctors in regional areas when they wish to take leave. That said, the increasing reliance on locums as business as usual is concerning to AMA (NSW) and to doctors working in regional areas, not simply because of cost but because of the challenges this presents to continuity of patient care.

9. To attract a locum, is it often necessary to provide preferential terms and condition which are then not available to locally based doctors. Doctors living and working in regional communities may then be required to undertake more onerous on call hours and difficult shifts than locums who may leave their placement early or not attend at all with very little or no notice.

10. While AMA (NSW) acknowledges the need to use locums to meet workforce shortages, long-term, he patients of NSW need and deserve resident doctors serving their community. The NSW Government is in discussions about the creation of a National Locum Rate. Whilst we support mechanisms to address locum arrangements, without addressing the underlying factors driving doctors to become locums, these measures will not be effective.

Budget:

11. On 19 September 2023, the Minns Government delivered its first health budget of $30.9 billion. This was a mere 0.87 per-cent increase on the budget delivered in 2022-23 by the Perrottet government. Comparatively the 2022-23 budget was a 9.2% increase to the overall health budget from the previous year. This makes the most recent NSW health budget, an effective cut.

12. The Minns budget has not and will not meet the growing demands for health funding. Population demand in NSW is currently sitting at 2%, normally 1.5%. When combined with aging total demand, this increases to appropriately 2.5% for 2024. Given producer price indexes in Australia are 5.5% for medical services, as per the Australian Bureau of Statistics, and demand is 2.5%, it implies the health budget must increase by 8% to maintain the same standard of services from the previous year.

13. Budget cuts appear to have disproportionately impacted regional LHDs. As discussed above, the issue of extensive use of locum services places significant budgetary pressure on LHDs due to their rates being at times higher than permanent doctors.

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14. Activity-based funding for regional LHDs exacerbates constraints and limitations by basing funding solely on the volume and complexity of services provided, often failing to account for the unique challenges and higher costs associated with delivering healthcare in regional areas.

15. This issue is further compounded by hospital exit block, where patients cannot be discharged due to a lack of available community or home-based care options for the elderly and other marginalised groups. This ties up hospital beds and increases workload for existing doctors. Additionally, because of budgetary pressures, AMA (NSW) has been advised that administration officers are being pulled from services, leading to some services and clinics having to be cancelled and in other cases, doctors being left to fill both roles. This is not only impacting the workforce, but these budgetary cuts are impacting patient care.

16. AMA (NSW) has also been advised that the financial pressures in regional hospitals are such that even in LHDs with adequate number of doctors, services are being cut, including delaying of emergency surgical work. We note in some instances this has resulted in patients with fractures having their care delayed by days or even weeks.

17. Addressing these budgetary constraints through increased funding allocations and targeted incentives for regional doctors is crucial to ensure adequate workforce levels and maintain quality patient care.

18. *'If you are offering the same rates in Sydney as you are for example in Broken Hill, you are going to stay in Sydney.' –* ***MSC Chair***

Training:

19. Pathways for career progression may not be available in regional areas and this is a major disincentive for doctors working in these areas. The heavy reliance on locums in regional areas makes the provision of supervision for DITs more difficult. AMA (NSW) has been informed that some locums either do not have the desire or the relevant qualifications to supervise DITs. A shortage of supervisors directly impacts the hospital's capacity to offer accredited training positions for DITs.

20. Regional hospitals also tend to have fewer senior registrar positions, meaning the DITs require additional support by consultants. Depending on their level of experience, DITs may not be rostered to work nights or if they are, must work under direct supervision, which increases the telephone calls and call backs taken by consultants.

21. It is critical that doctors in training are supported and encouraged to live and work in regional areas. This can be facilitated with access to clean and safe accommodation, supervision, and financial incentives. AMA (NSW) also strongly supports Colleges establishing regionally based training positions. RANZCO has established a regionally based ophthalmology Registrar position in Broken Hill. While Colleges have an important responsibility, regionally based training only works where regional hospitals are able to provide adequate clinics, clinical work, and consultant workforce to supervise trainees.

Industrial Arrangements:

22. Modernaisation of industrial arrangements is a key issue for Visiting Medical Officers (VMOs) Staff specialists and doctors in training working in regional areas.

23. VMOs have told us of the significant issues with having claims paid or paid correctly, and the frequent dispute of claims despite the VMoney claim system being centrally managed.

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Further, when claims are paid, they may not be paid correctly, for example, regional loadings not being paid.

24. VMOs in regional areas are eligible to claim a professional support payment (PSP), an annual payment which is intended to recognise the impact of the more onerous nature of regional practice. The PSP was introduced in 2007 and has never been indexed. Many regional VMOs are not advised of the entitlement or have trouble in claiming it.

25. Staff specialists can claim TESL for the purposes of training, education, and study. Several MSC Chairs and Councillors, have informed AMA (NSW) that staff specialists in regional areas have overwhelmingly complained that they are not able to access TESL and feel it is being used as a whip.

26. An MSC Chair said they put in a request in January for June, and as of April it had not been approved. ''It is so difficult to access this aspect of our award, something that should be accommodated and accessible''.

Culture:

27. The culture of a healthcare workplace lays the foundation, establishing the ethos that guides clinical practice, patient care delivery, doctor interactions, and organisational effectiveness. It shapes the overall healthcare experience for both patients and doctors.

28. Put in simple terms by one AMA (NSW) Councillor, ''Decent treatment of doctors doesn't cost any money, but the lack of it has made it an adverse environment and one that's very antagonistic''.

29. Doctors report that some regional hospitals foster an anti-doctor sentiment by marginalizing doctors' voices and limiting their involvement in shaping medical services, leading to disillusionment and a feeling of lack of worth among medical professionals.

30. As one doctor stated, *''Culture eats strategy for breakfast, but I think that culture has a much broader appetite than that, and in particular culture eats staffing retention and that leads to staffing recruitment. If people know it's a toxic place, they don't even want to come, let alone stay.''*

31. The importance of fostering a positive and inclusive culture within the healthcare system cannot be overstated. The treatment of doctors is an area that can be turned around without cost. It would immediately aid in the workforce issues and improve patient care.

Maternity services, obstetrics, and paediatrics:

32. MSC Chairs and AMA (NSW) Councillors informed us that regional obstetric and paediatric services desperately require support. We were advised that most regional LHDs had issues attracting and retaining paediatricians and obstetricians.

33. *''When our obstetrician gynaecologist specialist left due to burn out, the district had no gynaecological services for over a year since they were our only gynaecologist specialist. Women in my LHD had to travel to Canberra, Sydney, or the Illawarra to access specialist gynaecologist services. There is a huge deficit in equitable access to care because we can't keep specialists here'' –* ***MSC Chair***

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34. *''We now have two resident paediatricians as we lost two earlier this year to another state, where their new positions are associated with significantly less on-call requirements and a higher payrate…the gaps are currently filled by locums but only partially. At times this means that new patients are being turned away from the paediatric outpatient unit and the follow-up of existing patients is delayed due to lack of capacity'' –* ***AMA NSW Councillor***

Conclusion:

35. It is imperative that this Committee listens to the voices of the doctors living and working in regional NSW to determine the sustainable and effective changes urgently required. Further, changes must not only be determined but actioned. Despite the recommendations made in 2022, remote, rural, and regional NSW communities are yet to see real change.

36. Doctors who serve these NSW communities are highly skilled individuals, who work long hours and are dedicated to their communities. The Minns Government must focus on measures that will make long-term real differences and commit to policies that:

- support the recruitment and retention of the medical workforce,
- relieve budgetary pressures,
- provide more opportunities to train medical students and doctors in regional areas and
- foster a positive culture that supports doctors to deliver medical services to local communities.

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