Submission No 271

INQUIRY INTO HEALTH OUTCOMES AND ACCESS TO HEALTH AND HOSPITAL SERVICES IN RURAL, REGIONAL AND REMOTE NEW SOUTH WALES

Organisation: The Royal Australian and New Zealand College of Ophthalmologists (RANZCO)

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RANZCO The Royal Australian and New Zealand College of Ophthalmologists
THE LEADERS IN COLLABORATIVE EYE CARE

11 December 2020

The Hon Greg Donnelly, MLC
Chair of Portfolio Committee no. 2 - Health
Parliament House
Macquarie Street
SYDNEY NSW 2000

Dear Hon. Donnelly,

RE: Inquiry into health outcomes and access to health and hospital services in rural, regional, and remote New South Wales

The Royal Australian and New Zealand College of Ophthalmologists (RANZCO) welcomes the opportunity to respond to the Parliamentary Inquiry on *Health outcomes and access to health and hospital services in rural, regional, and remote New South Wales.*

RANZCO is the medical college responsible for the training and professional development of ophthalmologists in Australia and New Zealand. Our mission is to lead eye care by setting and improving standards, providing lifelong education, promoting research and innovation, and advocating on behalf of patients, their communities, and our members. We recognise that delivering on our commitment to best practice and patient outcomes requires a diversified collaborative approach to ensure balanced methods of mitigating issues that affect the overall patient experience and outcomes.

RANZCO continues to work on providing the best possible training and education of the ophthalmology workforce while recognising that we have a key role to play in tackling some of the long-standing issues confronting the medical workforce. These issues include responding to an ageing rural ophthalmology workforce, ensuring that communities in rural and regional areas have access to quality specialist eye care, redressing the inequities faced by Aboriginal and Torres Strait Islander peoples in eye health, developing holistic and challenging training posts for our future workforce and proposing solutions to workforce maldistribution.

The terms of reference of the Inquiry provides an opportunity to examine these concerns in much detail. As such, this submission is structured to focus on the following parts:

1. Response to NSW Parliament Legislative Council terms of reference 1a, 1b and 1d: Health outcomes and patient experience
2. Response to NSW Parliament Legislative Council terms of reference 1c: Access to health and hospital services
3. Response to NSW Parliament Legislative Council terms of reference 1e Planning systems and projections:
4. Response to NSW Parliament Legislative Council terms of reference 1g: An examination of the staffing challenges and allocations that exist in rural, regional, and remote NSW
5. Recommendations to the Portfolio Committee no. 2 - Health

1. In response to NSW Parliament Legislative Council terms of reference 1a, 1b and 1d: Health outcomes and patient experience

The Bureau of Health Information (BHI) reports that health outcomes and access to health and hospital services are largely affected by age, remoteness, and aboriginality in New South Wales (2016). In the first instance, residents of remote areas experience higher mortality rates and higher death rates from chronic diseases with a marked gradient of increasing chronic disease mortality from cities to remote and very remote areas in NSW. In the second instance, differences in experiences of hospital care between Aboriginal and non-Aboriginal patients were more pronounced in hospitals in rural areas than those in urban areas.

Burden of eye disease in regional NSW:

Regional populations in NSW have more than 3.5 times the rate of persons identifying as Aboriginal and/or Torres Strait Islander compared to urban areas. On 30 June 2016, over one-third of all Aboriginal and Torres Strait Islander people lived in Major Cities of Australia (298,400 people), compared with around three-quarters of the Non-Indigenous population (17,013,400). NSW has the largest population of Aboriginal and Torres Strait Islander people in Australia.

Indigenous Australians living in regional areas experience worse eye health outcomes than non-indigenous Australians living in the same areas. The National Eye Health survey (2016) reports that the prevalence of blindness and vision impairment in Indigenous Australians is three times that of non-Aboriginal Australians. The prevalence of vision impairment in Indigenous Australians was more than double in outer regional areas compared to inner regional areas. Indigenous Australians aged 50 - 59 years have almost twice the prevalence of vision impairment than non-Indigenous Australians of the same age (8.23% vs 4.42%). This gap increased to a four-fold higher prevalence in those aged 60 - 69 years old (16.85%) in Indigenous Australians vs 4.37% in non-Indigenous Australians. Vision impairment in non-Indigenous Australians did not vary significantly between regions of different remoteness.

Regional, rural and remote populations have a higher percentage of persons older than 40 years of age than urban populations. In 2019, people aged 60 years or over made up 19% of Sydney's population, compared with 27% in the rest of New South Wales.

From an eye health perspective, age is the single largest contributor to diseases of the visual system with the incidence and prevalence of the five most common causes of visual loss and consequently, the rate of visual impairment and blindness, steadily increasing from 40 years of age onwards. The majority of these highly prevalent, sight-threatening, diseases are chronic and require ongoing regular follow up - such as glaucoma, macular degeneration and diabetic eye disease to reduce the risk of irreversible visual loss.

Summary points:

Residents of remote areas experience higher morbidity and higher death rates from chronic diseases with a marked gradient of increasing chronic disease mortality from cities to remote and very remote areas in NSW.

Aboriginality is the single biggest risk factor for vision impairment and blindness in regional NSW. Mechanisms to expedite services for patients identifying as Aboriginal and/or Torres Strait Islander should be considered.

From an eye health perspective, age is the single largest contributor to diseases of the visual system.

2. In response to NSW Parliament Legislative Council terms of reference 1c: Access to health and hospital services

Poor access to timely specialist eye care can result in permanent visual impairment and blindness. Visual impairment impacts on the individual with the potential to lead to loss of independence, increased falls (odds ratio of X2 with a visual acuity of worse than 6/12 – Blue Mountains Eye Study 2014), depression and reduced functional ability. At a population level, there is an impact on the delivery of public health resources. Not only does visual impairment impact on morbidity, but its impact on the risk of mortality has also been reported (Bruce, BMJ, 2016). Untreated and irreversible visual impairment has a high social and economic cost.

Barriers to access:

Access to travel for care locally and flow-on effects to regional economies where care is not available locally:

Visual impairment and blindness have a greater impact on persons living in regional, rural and remote areas due to increased travel distances and limited and frequently absent public transport services. Persons disabled by visual impairment and blindness cannot drive and are more dependent on caregivers to transport them to and from appointments which in turn results in loss of time spent at work for caregivers. Where services are not available within the local area this loss of productivity is magnified, with money which would otherwise be spent locally being used to travel away from the area to access and pay for the service elsewhere. There is a cumulative economic impact on regional, rural and remote areas when a significant proportion of the population needs to travel for care.

Transport disadvantage is experienced by specific sub-groups in the population, for example, families with young children, people with a disability and Indigenous Australians. Transport disadvantage is also common in specific geographical locations such as outer-urban (or "fringe") areas, rural and remote Australia.

Rural and remote areas of Australia have low levels of public transport access. Some remote areas have relatively low levels of vehicle ownership. In particular, transport options for Indigenous Australians in remote communities and communities located in fringe urban areas are very limited. A significant proportion of Indigenous Australians living in remote areas have no access to public transport and one-third have no access to a car.

Summary points:

The need to travel for care is a significant barrier to accessing ophthalmic services in regional NSW particularly for patients identifying as Aboriginal and/or Torres Strait Islander.

There is a substantial social and economic cost to regional communities when a significant percentage of patients need to travel away from their local area to access medical services.

Regional ophthalmology services and service availability:

Ophthalmology services are largely outpatient-based (80% of ophthalmology services) with most surgeries (20% of ophthalmology services) being done using a day surgery model.

For the most part, NSW Health does not fund the outpatient services in regional NSW - funding the surgeries once a patient is listed on the public waitlist in the region from private rooms. There are some exceptions to this such as in Dubbo and Broken Hill which both have public clinics and no resident ophthalmologists. Services in these areas are supplied by regular outreach.

The burden of supplying outpatient services in regional NSW thus largely falls upon regionally based private ophthalmology practices which are under increasing pressure with regional workforce shortages and increasing regional population which is an older population on average than in urban areas and has a higher burden of disease. The ophthalmologists in these private practices are typically working under severe workforce pressure with many fewer ophthalmologists per 100,00 people than their city counterparts.

Such regional private practices generally provide for the entire community – often bulk-billing patients that can't afford to pay a gap, the onus being on the patient to disclose a financial need for bulk-billing, in some cases at significant cost to the practice. Many of these services, such as intravitreal injections and the ongoing treatment of established glaucoma are required to be provided regularly to patients with chronic ophthalmic conditions and without these services, irreversible loss of vision could ensue.

As the public health service is typically not paying for outpatient services, despite them being essential, they are to some extent hidden services and not part of the local health service budget with no establishment as there are no FTE payments. NSW Health typically pays a fee-for-service amount for each operative procedure performed on a publicly listed patient but does not pay for on-call services that ophthalmologists in each area deliver.

With increasing workforce pressure regionally, an ageing regional workforce, an ageing population and ongoing population growth regionally, regionally based private ophthalmologists are under increasing pressure and this may result in some being forced into early retirement should their workload become unsustainable.

There remains a large community need for such services and without them, patients would be forced to travel for services to city areas which in turn costs regional areas as money is spent travelling for service rather than regionally and caregivers often lose income when accompanying their relatives for such services.

Summary points:

The current model of care for ophthalmology in regional NSW does not allow for access to public ophthalmology outpatient services as NSW Health does not routinely fund outpatient services in regional NSW with few exceptions.

Regionally based ophthalmologists in NSW are typically working under severe workforce pressure with many significantly fewer ophthalmologists per 100,000 people than their city counterparts.

With increasing workforce pressure regionally, an ageing regional workforce, an ageing population and ongoing population growth regionally, regionally based private ophthalmologists are under increasing pressure.

Lack of transparency for patients and referrers concerning waitlists for care:

A barrier for access to inpatient services is the lack of transparency for patients regarding inpatient waitlist wait times. There is also frequently no or limited information available to patients regarding outpatient waitlist wait times should there be an outpatient waitlist available to be placed on.

There are different waitlists for each hospital or LHD and frequently patients are on multiple different waitlists in different LHDs to access the earliest service.

There is a focus on elective surgery waitlist data when in many districts there is a long wait to get a clinic appointment to be put on the surgical waitlist. The length of time spent waiting for a clinic appointment to be assessed and be placed on the elective surgery waitlist is frequently not taken into consideration when assessing how a public health service (hospital or district) is performing concerning providing accessibility to elective surgery.

Because waitlists are not centrally managed there is no mechanism to provide equitable access to patients across the jurisdictions in NSW.

Whilst some data on waitlists is available to the public on some public health services' websites in some states and territories, it is difficult to find and understand and therefore does not help patients or their referrers to make informed decisions about their care.

Summary points:

Current management of inpatient and outpatient waitlists in NSW does not allow mechanisms to provide equitable access to patients across and within LHD in NSW.

Outpatient services in regional NSW are invisible to the public health sector with no public service and no waitlists.

The size of the problem of accessing regional ophthalmology services is not well defined by the current data available. In particular:

- It is unclear what percentage and what overall number of patients in each LHD need to travel for their ophthalmic care and what average distance and how often they need to travel.

- The multiple impacts on patients and their caregivers and the economic cost of patients travelling out of the area for their care is not available.
- It is unclear how many patients do not access ophthalmology services they need at all or are delayed in accessing them and for what reasons as there is no universal referral pathway and no public outpatient services and there are no waitlist data available.
- It is unclear how many patients don't access services when they need them as they don't wish to ask for what they consider charity by enquiring if they can be bulk-billed.
- It is unclear what percentage of patients end up with a gap at times that causes them financial stress (as they are embarrassed to admit their financial circumstance and ask for fee relief from the private ophthalmology service).
- There is a lack of transparency around waitlist wait times.

3. In response to NSW Parliament Legislative Council terms of reference 1e Planning systems and projections:

RANZCO has not to date been invited to collaborate with NSW Health to develop a plan to meet the needs of residents living in rural, regional, and remote NSW.

4. In response to NSW Parliament Legislative Council terms of reference 1g: Examination of staffing challenges and allocations in rural, regional, and remote NSW

The ophthalmology workforce in NSW

Size and age of the ophthalmology workforce:

RANZCO has 1008 Fellows working in Australia, of which 378 are based in NSW and 15 in the ACT. Our workforce data reveals that the workforce is ageing, and this is a concern, particularly in regional and rural areas. No Fellows or Trainees in NSW identify as Indigenous despite NSW having the largest indigenous population in Australia.

The 2018 Australia's Future Health Workforce – Ophthalmology report, which presents long-term, national workforce projections for doctors to 2030, recommends an increase in the intake of new trainees of three per year from 2019 to address an impending workforce shortage. This report also identifies a maldistribution of ophthalmologists with most working in urban locations, a higher than average reliance on international medical graduates, an impending critical shortage of paediatric ophthalmologists and Indigenous trainees and a lack of funded training positions in the public sector.

Summary points:

The ophthalmology workforce in NSW is maldistributed, being mainly urban based, is lacking in Fellows who identify as Indigenous and is facing an imminent overall workforce shortage.

Barriers to increasing overall trainee numbers:

There are significant barriers to increasing overall trainee numbers in NSW as is required to avoid the impending shortage of ophthalmologists projected by Australia's Future Health Workforce – Ophthalmology report. State funding for registrar FTE and supervisor FTE (FTE in public publics for VMOs and SMOs) continues to be stagnant in urban areas. Any recent past increase in registrar training positions in regional, rural and remote NSW have been largely funded by STP funding and this is also currently stagnant with no projected increases in the near future. The Federal Government caps the percentage of posts which can be paid for by STP funding to 7% overall - which ophthalmology is well over.

Additionally, ongoing investment in public hospital infrastructure and equipment to increase ophthalmology services is largely absent with new hospitals and outpatient departments being designed and constructed without consideration of including a public ophthalmology outpatient department – for instance in Gosford which serves a population of 400,000 people. There are also no ophthalmology outpatient departments in Nepean Hospital and Wollongong Hospital despite both these areas servicing large outer urban populations (300,000 and 500,000 respectively) and the surrounding regional areas. Some large public hospitals have chosen to close their ophthalmology department at very short notice (St Vincent's Hospital in Sydney). Westmead Children's Hospital is only able to continue maintaining its current level of service and continue training from all over NSW (including future regionally enhanced pathway trainees) in paediatric ophthalmology as many of its consultant staff are working for free as honorary appointments.

Establishing new training positions for Ophthalmology in some of the larger Public Hospitals has proved difficult in recent years. Public Hospitals like the John Hunter Hospital, Nepean Hospital and Campbelltown Hospitals, hospital administrations place a higher premium on service delivery rather than training. Therefore, training does not appear to be a KPI at these institutions and suffer from sufficient budgetary allocation as a result. The data shows that the percentage of ophthalmologists participating in service delivery in Public Hospitals across Australia is declining. At some point, this will create a deficiency in the functioning of the Public Hospitals, who require ophthalmology input, not just for routine elective surgery, but for the trauma and emergency cases that present to Accident and Emergency Departments, as well critical care in Intensive Care Units, Neurology, Neurosurgery, Endocrinology, and Neonatal Intensive Care Unit.

This funding crisis in public ophthalmology has a significant flow-on effect on regional services and patients. Ophthalmology, like many specialties, works on a hub and spoke model with referral onwards to the hub for presentations that require more specialized care. For example, Tamworth Rural Referral Hospital and Armidale Rural Referral Hospital are the hubs to a network of 12 other district hospitals across the north-west slopes and plains of NSW. Tamworth Rural Referral Hospital and Armidale Rural Referral Hospital, in turn, should both be spokes of a hub, based at John Hunter Hospital in Newcastle being in the catchment area of this large urban hospital. The further development of the currently woefully inadequate ophthalmology department at JHH is chronically blocked by a refusal to increase funds to the service despite JJH servicing a catchment population of greater than 750,000. Regional patients in this catchment unable to access ophthalmology services in their area will frequently need to travel through to Sydney for these services – where public services, in turn, can be difficult to access if they cannot afford to pay for private care.

Sydney hospitals ophthalmology departments have long public waitlisting lists for care, particularly where their catchment area includes a large proportion of patients with lower socioeconomic indices, e.g. Liverpool. This is in a large part to the stagnant funding environment described. As there is little increase in available FTE and other funding for ophthalmology in the public sector, with a growth in the number of ophthalmologists in NSW and NSW's resident population the only available outcome is an increase in private compared to public service delivery. Currently, just 16% of ophthalmology services in Australia occur in the public sector. Many ophthalmologists are interested in working in the public sector, however. As most of the public work on offer is very part-time, around 40-45% of ophthalmologists do some public work – i.e. are employed in the public sector at least part-time.

Summary points:

There is a lack of growth in expenditure on ophthalmology services by NSW Health across the state.

Key performance indicators tracking public FTE and expenditure on ophthalmology are not available.

There is a lack of further investment in the growth of ophthalmology workforce in NSW despite an impending workforce shortage.

Increasing the number of Trainees and Fellows who identify as Indigenous:

In response to the AMC review, RANZCO has increased our focus on recruiting Indigenous trainees who may be better able to serve their communities. A points system in the selection process has been introduced to facilitate an increase in the number of Indigenous trainees in Australia; Indigenous applicants are automatically accepted into the interview stage of the process. RANZCO is also working closely with the Australian Indigenous Doctors' Association (AIDA) to generate interest in ophthalmology with young doctors and exploring ways to reach and encourage undergraduates to consider ophthalmology as a career path.

Improving the distribution of the ophthalmology workforce:

Most ophthalmologists in NSW work in urban locations.

The 2017 RANZCO Workforce Survey has shown that Fellows with experience studying in rural and remote areas (defined as at least five years of secondary and or tertiary studies spent outside Australia's major urban centres) are twice as likely to regularly practice in rural or remote areas compared with their colleagues who have not studied in rural or remote areas (44 percent and 22 percent, respectively).

In terms of actual rate of work in rural or remote areas, Fellows who studied in these areas spent on average 35 percent of their clinical practice time in rural or remote areas, compared with just 15 percent of Fellows who did not study in these areas.

This survey data is confirmed by available published evidence with doctors with a rural background being almost three times more likely to indicate a preference for rural practice compared with doctors with an urban background, (Aust Journal of Rural Health, 2005).

This data strongly indicates that having more trainees based in rural or remote areas is a priority in improving the distribution of specialist workforce in the future.

RANZCO recognises that positive rural training experiences are essential to building a future workforce. Some of the factors that lead to a positive rural education experience include:

- Positive perceptions of a rural and regional training practice
- Supervisor availability and training
- Adequate clinical exposure and case-mix
- Access to appropriate infrastructure
- Provision of administrative and financial support
- Dedicated time and support for teaching and learning
- The opportunity to participate in CPD
- Social networks and supportive environments for family members of the trainee and
- Attractive lifestyle and incentives.

RANZCO actions to date include:

- Promoting rurality in trainee selection processes
- Providing the opportunity for rural clinical rotations in city-based training
- Developing a CPD program that can be done remotely and does not rely on city access and
- Informally supporting locum services for rural ophthalmologists.

Further to the above, RANZCO has considered in depth how our training program can be responsive to the workforce shortages in rural and remote areas.

Summary points:

Doctors with a rural background are almost three times more likely to indicate a preference for rural practice compared with doctors with an urban background.

Positive rural training experiences are essential to building a future workforce.

Current ophthalmology training models and regional training in NSW:

Two of RANZCO's six Vocational Training Networks in Australia are in NSW and have been in place for many years. These are the Sydney Eye Hospital and Prince of Wales Hospital Networks. Each trainee is part of the network for the first four years of their training. Both are urban-based models with some regional terms. There is difficulty adding additional terms, even in urban areas, onto these existing networks due largely to the stagnant funding of registrar and supervisor FTE by NSW Health at the district level and an ongoing lack of additional investment in facility and equipment.

The regional terms currently incorporated in these networks have unfortunately not resulted in a high enough percentage of Fellows choosing to work in MM2-7 after obtaining

Fellowship to address workforce maldistribution. This is despite the average trainee spending more than 6 months in regional Australia.

It is thought that this is largely due to the foundation training commencing in urban areas encouraging trainees to put down roots there, the majority of the training experience of urban-based trainees being in urban areas and the regional rotations not being long enough for the trainees to make long term connections in the regional area the training post is based.

It is important, however, to continue to offer urban model trainees' regional terms as this does result in some choosing to work in MM2-7 post Fellowship. Consideration is being given on how to maximise this (longer regional terms for instance). Removing current regional terms from existing networks would be likely to reduce the number of fellows who choose to work in MM2-7 post-graduation.

Summary point:

The current model of urban-based training with some regional terms is not sufficient to address workforce maldistribution.

The Regionally Enhanced Training Network:

In response to the ongoing maldistribution of the ophthalmic workforce, the RANZCO Workforce Taskforce has designed a Regionally Enhanced Training Network (RETN) with 3 inaugural training pathways proposed – one of which is in NSW and the ACT. Initially, the proposal has been presented to the Federal Department of Workforce for consideration and consultation.

The aims of the RETN are:

- To graduate comprehensive ophthalmologists with the skill set and desire to work in regional, rural, and remote Australia.
- To enable medical practitioners who have demonstrated commitment to rural health to undertake their specialist training in ophthalmology and pursue a career in a regional area.
- In the short term, the proposal aims work collaboratively with existing services on the ground to immediately increase the regional workforce by the placement of additional training registrars in regional areas and by bolstering the existing supervisory consultant workforce in these areas, where required, to provide for the necessary supervision requirements of these regionally-based trainees.
- In the long term, the proposal aims to improve the distribution of general ophthalmology services across Australia to deliver a sustainable, Australian-trained future medical workforce for regional, rural, and remote communities.

Regionally Enhanced Training Network (RETN) pathways are designed to specifically encourage the Fellows who graduate from them to choose to work in regional areas post-graduation with the fundamental goal of significantly addressing workforce maldistribution in a lasting manner.

Each RETN trainee would be based regionally in MM 2-7 regions for 60 percent or more of the total training time of 5 years which will ensure that this program meets its stated objectives and indeed the objective of the Integrated Rural Training Pipeline (IRTP) Federal Department of Workforce Initiative upon which it is modelled. More than 50 percent of postgraduate training spent in regional Australia is evidenced to increase the likelihood of the doctor working regionally post-Fellowship by a factor of 10 (J. Med Educ 2003).

Other key criteria which fit the IRTP Initiative are as follows. Trainees will be recruited via a rigorous selection process to ensure trainees are genuinely committed to working rurally in the long term. Trainees will undertake long-term clinical placements in regional Australia enabling them to maintain and build on their connections to rural communities throughout their training. Trainees will commence their training outside of the major capital cities to avoid them putting down roots in these cities.

Accreditation considerations, adequate training opportunities in the area, local engagement and support for having trainees in the area, working to place trainees in workforce poor areas where feasible and strengthening existing connections between jurisdictions were all key considerations in post-selection and pathway design.

Recruiting to these pathways trainees who have a passion for delivering ophthalmology services to regional communities after they obtain their Fellowship will be a key component to ensure success in addressing workforce maldistribution in a meaningful manner. RANZCO plans on engaging with additional stakeholders, including medical schools with a rural focus, to develop a strategy to recruit such trainees, commencing late 2020.

Factors that will be considered by the College to ensure selected trainees are genuinely committed to working rurally are rural upbringing and education of 5 years or more since starting primary school, rural bonding, rural medical school placements and post-graduate work in regional Australia.

A key consideration for trainees in designing regionally enhanced pathways is ensuring the pathways meet training requirements and give trainees an appropriate range and depth of experience within their training whilst having the opportunity to focus on areas more relevant to regional specialist practice.

Case study: A pathway designed along similar lines for General Surgical training has been set up in Western Victoria - the Southwest Surgical Training Program. This program has just graduated its first two general surgeons. They have set up to practice in Colac and Warrnambool.

Summary points:

In response to the ongoing maldistribution of the ophthalmic workforce, the RANZCO Workforce Taskforce has designed a Regionally Enhanced Training Network designed to address workforce maldistribution sustainably and meaningfully in regional, rural, and remote Australia.

One the of three inaugural RETN training pathways is based in workforce poor regions in NSW and Canberra.

Collaboration with NSW Health:

RANZCO would appreciate an opportunity to work collaboratively with NSW Health, Local Health Districts, and existing services on the ground to increase the regional workforce, regional training opportunities and in the implementation and development of the RETN.

It is anticipated that NSW would be able to support two RETN pathways in the future should the inaugural pathways and the program prove successful in meeting its aims. It is also likely that graduating two additional ophthalmologists per year in NSW, who have a high probability of setting up in regional, rural or remote NSW, would have a significant positive impact on addressing workforce maldistribution in NSW in the medium to longer term.

Funding for RETN registrar and some supervisor FTE has been sort from the Federal Department of Workforce. It is anticipated that some State funding of FTE may be required in addition to this and that State funding will be required to upgrade some facilities which currently train registrars to allow for additional, RETN, trainees. This is in part because registrars will be based in a Sydney teaching hospital for their third year to access subspecialty ophthalmology clinical and surgical experience. During this year registrars will extend their knowledge and skills with the aim of sitting the RACE (final fellowship exam) at the end of this year

Summary point:

RANZCO would appreciate an opportunity to work collaboratively with NSW Health, Local Health Districts, and existing services on the ground to increase the regional workforce, regional training opportunities and in the implementation and development of the RETN.

Investment in public health infrastructure in regional NSW as a mechanism to increase health jobs:

Two case studies of Tamworth and Wagga Wagga illustrate that there is a strong connection between public and private investment in healthcare. An exploration of health employment data pre and post-development shows that investment in public health infrastructure leads to flow on growth in health jobs, across public and private sectors and healthcare settings (with growth in employment observed in both hospitals and other allied health services, and in public and private sectors).

Summary point:

Investment in regional health infrastructure drives increases in the health workforce in regional NSW.

5. Recommendations to the Portfolio Committee no. 2 - Health

1. It is recommended that the NSW government considers supporting the development of the RANZCO Regionally Enhanced Training Network (RETN) through hospital facility upgrades/refurbishment of eye clinics, procurement of additional equipment and salary support for Visiting Medical Officers in identified areas.

2. That measures to address the outlined shortfall in data which would define issues around access to regional ophthalmology services are taken.

3. That consideration is given to the current model of care delivery for outpatient services in regional NSW as a mechanism to reduce workforce pressure on regional ophthalmologists and increase the sustainability of their practices. Privatised outpatient services in both urban and regional areas have been successfully established using activity-based funding models in other jurisdictions in Australia. RANZCO would welcome the opportunity to work collaboratively with the NSW government to pilot such a model in workforce poor areas in NSW.

4. That a universal referral pathway in regional NSW is considered to enable access to services and provide clarity as to where these services are not available. Centralised referral services in some other states have been key in providing such clarity.

5. To consider the development of key performance indicators to track NSW Health expenditure on ophthalmology FTE, facility and equipment across different jurisdictions.

6. That NSW government work with RANZCO and other stakeholders to develop a plan to increase trainee numbers across NSW in line with the 2018 Australia's Future Health Workforce – Ophthalmology report.

7. To consider the case for waitlists to be centrally managed to allow inequitable access to services to be identified within a State or Territory and addressed. To consider what mechanisms could be designed and put in place to address inequity in access to medical services across jurisdictions.

8. To consider the case for providing transparency for patients and referrers regarding outpatient and inpatient waitlists so they can make informed decisions regarding access to their healthcare.

9. To consider whether NSW Health should recognise indigeneity and the high level of associated co-morbidity and put in place a mechanism across all inpatient and outpatient waitlists in NSW to prioritise access to services by patients who identify as Aboriginal and/or Torres Strait Islander.

10. To plan further investment in the coordination of comprehensive patient transport in all districts to bolster access to regional health services, particularly for Indigenous people. And that consideration is given to increase funding for Aboriginal Medical Workers to coordinate this care delivery.

11. That the NSW Government continues to invest in regional health infrastructural to drive the ongoing growth of the regional health workforce.

We believe that strong partnerships and cooperation across all points of the patient pathway lead to better health outcomes. Therefore, RANZCO is ready to work with NSW policymakers, NSW Health, our medical and health colleagues, and other stakeholders including the Federal government to address medical workforce maldistribution and improve eye health outcomes for regional Australians.

Yours sincerely,

Dr Diana Farlow
RANZCO NSW Branch Chair

Prof Nitin Verma AM
RANZCO President

Appendix

Modified Monash Category	Inclusions
MM 1	**Metropolitan areas:** Major cities accounting for 70% of Australia's population.
MM 2	**Regional centres:** areas that are in, or within a 20km drive of a town with over 50,000 residents.
MM 3	**Large rural towns:** Areas that are not MM 2 and are in, or within a 15km drive of a town between 15,000 to 50,000 residents.
MM 4	**Medium rural towns:** Inner and outer regional areas that are not MM2 or MM3 and are in or within a 10km drive of a town with 5,000 to 15,000 residents.
MM 5	**Small rural towns:** Remaining inner and outer regional areas.
MM 6	**Remote Communities:** All remote mainland areas and remote islands less than 5km offshore. Additionally, islands that have an MM 5 classification with a population 1,000 without bridges to the mainland.
MM 7	**Very remote communities:** Very remote areas.