**Submission No 571**

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

**Organisation:** Regional Medical Specialists Association (RMSA)

**Date Received:** 20 January 2021

**1. From Associate Professor Balaji Bikshandi, Intensivist:-**

My views would concentrate on the intensive care services in regional/rural NSW. At present the resource discrepancy between metropolitan and regional/rural intensive care systems are enormous. Metropolitan centres exploit this deficiency and utilise various classification systems to paralyse the operations of very many regional/rural hospitals by depriving them of the ability to care for the critically ill. The retrieval service being a major beneficiary of this arrangement, quite happily approves of this and aids in perpetuating this schema. Essentially this makes the local health district (lhd) model a big joke! Every lhd is subservient to the metropolitan ICU masters and is never 'local'!

Add to it the invented classification of intensive care units by the agency for clinical innovation which was designed with a view of stifling regional/rural specialists doing basic life saving work while their metropolitan counterparts could spend resources on over utilising valueless therapies such as adult Extracorporeal Membrane Oxygenation, unnecessary tracheostomies and trans oesophageal echo cardiographys.

Metropolitan ICUs will not let a self sufficient intensive care service to develop by duly qualified specialists holding the fellowship of the college of intensive care medicine in rural and regional centres.

This leads to persons without specialist qualifications assuming positions of Intensive care directors and becoming subservient slaves to their metropolitan masters. This bring individuals without any Australian experience from abroad under the pretext of specialist unavailability but in effect it is a lie.

A specialist who is duly qualified and trained in Australia to provide their services in regional/rural Australia requires at least ten times of skill and proficiency. But they stand to be unfairly treated and criticised by the arm chair politicians in the "referral" centres in the city ICUs. Somehow such critical individuals are beyond reproach despite their much lower experience in comparison to the specialists who provide their services to regional/rural ICUs.

The current COVID crisis very well exposes this disparity as politically motivated and self centred. Not a single regional centre received an onsite PCR machine and if they did, it was held at ransom by a city centre far away (which will be within the lockdown zone!).

A strong plan needs to be in place to boost visiting medical specialists in intensive care to provide services to regional/rural Australia. The requirement for 24 hr services will mean a few staff specialists is a ridiculous idea. It only serves to save pennies at the cost of lives. Such specialists be protected from the metropolitan inexperienced Intensivists in every way, specifically from politically motivated unfair criticisms and setups.

BALAJI Bikshandi

**2. From Associate Professor Stephen Flecknoe-Brown, Haematologist, Port Macquarie:-**

(Part 1)
1A) and 1B) Health outcomes in NSW – comparison between rural and metropolitan areas ENDORSED.
1.C) Access to health and hospital services
The value of medical specialists living and working in rural and remote NSW is not given much attention here. They are needed to service the needs of rural and regional hospitals; around the clock.
Although the proportions of General Practitioners per 10,000 population in Outer Regional NSW is about half that in Inner Metropolitan areas, the proportion of medical specialists is one tenth, and falling.
A report from the Royal Australasian College of Physicians in January 2020 showed that trainee numbers in rural & remote Australia were less than the number of practising physicians by a significant proportion, while numbers of trainees based in metropolitan areas continued to grow, outstripping the supply of vacancies for fully-qualified physicians. Yet still the imbalance continues.

(Part 2)
I'm pretty confident that we would all support a call for more medical training to be based in rural sites so that we 'grow our own' rural specialists. This includes medical schools, junior doctor placements and vocational training.

The Commonwealth's Integrated Rural Training Pipeline for Medicine (https://www1.health.gov.au/internet/main/publishing.nsf/Content/integrated-rural-training-pipeline-medicine) is the model, but must be supported by state-run public hospitals.

How can the NSW Government support this?

1. Raise the profile and funding of hospital Medical Education Units in rural hospitals;
2. Requiring these Medical Education Units to support and supervise *all* junior medical staff not enrolled in formal College-supervised training, with proper funding for them to take on this extra work-load;
3. Improving support for those rural hospital specialists in charge of specialist training;
4. Creating and funding the role of 'Academic Dean' in each rural hospital designated by the NSW Health Education & Training Institute (HETI) as a Primary Allocation Centre for interns, and
5. Developing formal agreements between rural hospitals and their associated Medical Schools to ensure availability of Academic Titles for medical staff at Level D (Associate Professor) or Level E (Professor) level. Recognising the unique features of rural hospital practice, the teaching commitment of rural specialists should be given a higher priority for these appointments than research by the Universities.

My full submission also made several recommendations to enhance governance skills and practice in rural LHDs and ensure that administration and LHD Boards have meaningful clinician input.

**3. From Dr Nicholas Stephenson, Radiologist in Wagga Wagga:-**

The draft submission Luke sent does not include nearly enough emphasis on the medical workforce shortages that regional, rural and remote Australia face. It is critical this be emphasized and discussed more, if health outcomes are to be improved. This includes shortages of GPs, GP Proceduralists, Rural Generalists and [non-GP] Medical Specialists. To that could be added shortages of Nurses and Allied Health practitioners.

The fact that in my region of NSW more than 70% of the GP workforce is overseas trained is an inditement of the 'system'. It is recognised that the states are responsible for their respective jurisdiction's medical and health workforce. The Commonwealth has funded a massive increase in medical graduates numbers, has invested in rural clinical schools, new rural medical schools, new training pathways, rural entry criteria, etc. Unfortunately the states and territories have not updated their postgraduate training pathways, such that far too many specialists are trained in metro for metro and far too many GPs are not trained to be 'bush doctors' (although in that regard the Commonwealth stands guilty of appointing Synergy to manage GP training, rather than the two relevant Colleges). I also accept that the medical profession and many of the Colleges have not updated their training systems so as to provide appropriately trained doctors for all Australians.

With regard to 'bush doctors', it must be recognised that doctors in rural and remote communities need a very different knowledge and skill set to suburban GPs - to be able to provide emergency care in Emergency Depts, etc. Medical Specialists are essential to train GPs with these skills and knowledge as well as back them up in the regional hubs of the rural and remote communities.

Evidence from all over the world shows that the best way to get newly trained doctors to choose to live and work rurally is to train them rurally. This matches the Commonwealth's approach.

One example of how the states could do better is the trial occurring in the Riverina, where the Murrumbidgee Local Health District is this year appointing GP Trainees on a 4 year salaried training program (incl approval from the Commonwealth to use Medicare funds when the Trainees are working in GP practices) so as to give them a structured path to 'bush doctor' (aka GP Proceduralist, Rural Generalist), rather than the trainees having to negotiate moving between hospitals and GP practices themselves during their training period. Critical to the success of that is the availability of locally resident medical specialists who will provide alot of the specialists skill training these doctors will need.

I would also like to emphasize the importance of locally resident doctors (and other health practitioners), not visiting practitioners. When discussing 'workforce', we should concentrate on the locally resident workforce, because they are the ones who are available 24/7, who are invested in upskilling their peers and fellow practitioners, working as a valuable team member with the other local/regional staff and investing generally in the community in everything they do. Please see my discussion paper for more justification of this. In this regard, I wonder if the table on Palliative Care practitioners relates to locally resident practitioners, visiting practitioners or a combination of both. It seems dodgy. I

know the shortage of Oncologists is a major barrier to cancer care, in addition to shortages of support services.

The above problems are not partisan and all NSW govts and the NSW bureaucracy have failed to adequately plan and manage their medical workforce.

Regards, Nick

Dr Nick Stephenson

**4. From Dr John Flynn, Physician in Armidale:-**

(Part 1)
I have been a rural Physician for 40 years, and have never known the rural situation to be worse than it is at the moment. The two main culprits as far as my practice is concerned are the New England Local Health District and the RACP.

(Part 2)
Regarding the NSW Legislative Council Inquiry, the issues with rural medical services are large and complicated, involving not only the State Government, but also the Commonwealth Government, the Colleges, and the University Medical Schools. As the State Government is primarily responsible for the conduct of rural hospitals and their associated services, I believe that we should concentrate on this area. Here on the Northern Tablelands, the main issues are:

1. *A reluctance to employ Specialists*. For example, we have only three General Surgeons, who are expected to provide 24 hour cover, 365 days of the year. Last year, we had a VMO Surgeon appointed, but the LHD refused to give him any routine operating time – it just wanted to cover the "on-call" roster, as this was cheaper than employing locums; needless to say, he left. We have two aging Obstetricians who are having trouble in maintaining their "on-call" roster, and there is young female Obstetrician who is married to a local grazier and who wants to maintain her skills, but the LHD refuses to employ her. Recently, we had a young Paediatrician who wanted to come to Armidale, but again was knocked back by the LHD.

2. *A reluctance to allow Specialists to practice their specialty*. I was trained as a nephrologist, but am not allowed to practice as such – I might generate costs - however the LHD provides a fly-in-fly-out nephrologist who, at considerable cost to the LHD, visits Inverell from Newcastle. I have a son who is a gastroenterologist in Tamworth, but he is having trouble in obtaining endoscopy lists; this has resulted in a fly-in-fly-out gastroenterologist from Sydney, who persuades patients that their endoscopies are urgent and that they need to travel to Sydney for them; meanwhile, both Armidale and Tamworth have poorly utilised Theatres.

3. *A reluctance to provide appropriate support services*. Armidale is the Rural Referral Hospital for the Northern Tablelands, and up until ten years ago had a very good, functional, and necessary ICU, but this was closed and the funding redirected to Newcastle. We now have a Close Observation Unit, but the LHD will not admit to this, and has directed that the "Intensive Care Unit" signs remain in place, despite the fact that we are no longer staffed or equipped to provide this level of service. This has significant ramifications not only for the Physicians and Surgeons, but also for their patients and their families. It has also led to significant delays in our being able to transfer patients out for intensive care, as potential receiving units say "*We know that you have an ICU; therefore look after your own patients*". In winter, Armidale is not infrequently closed to air traffic, meaning that critically ill patients are unable to be retrieved; sooner or later we will have a death, because we are unable to treat them. In years gone by, hospitals like Glen Innes had a small Pathology Laboratory that was able to do common basic tests; these laboratories have now been

replaced by “point of care” tests, which seriously limit the Hospital’s ability to manage acutely ill patients.

4. *A reluctance to provide Specialist Medical Support to the smaller GP hospitals on the Northern Tablelands*. Over the last few decades, we have seen a decline in the number of “home grown” GPs who are prepared to practice in rural areas. One of the reasons for this is the perception pedalled by the University Medical Schools that you cannot practice an adequate standard of medicine unless you are fully supported by a raft of Subspecialists. This is nonsense, but the reality is that young GPs are afraid to go into rural areas if there is little or no specialist support readily available. Decades ago, I used to do regular Physician clinics in Glen Innes and Walcha, but these have now been stopped – to the detriment of GP capabilities in these towns. I believe that, these days, this sort of support is vital to the attraction and retention of good young GPs, but it is not possible while the LHD limits the number of Specialists who are available locally to provide such support – “Unless you nourish the vine, it will wither”.

5. *A reluctance to employ Medical Superintendents*. Once upon a time, we had a full-time Medical Superintendent for the hospitals on the Northern Tablelands, and this worked well, but some twelve years ago, it was decided by the LHD that the position be reduced to half-time. Not surprisingly, this did not work, but rather than reinstating the position full-time, it was abolished altogether, and replaced by an “Operations Officer”, who is a Nurse. Things are now working even less well, if this is possible! We desperately need Medical Leadership.

6. *A lack of Clinical Governance*. Decades ago, Armidale Hospital had an effective Medical Staff Council (MSC), but it was shut down some 15 years ago by a Nurse administrator – “*I’m not going to have Doctors telling me what to do*”. When she left (she was of course promoted in the system) we resurrected the MSC, but successive administrators have taken no notice of it, but allow it to exist, as it helps them when it comes to the Hospital being accredited. The lack of respect for the MSC and the denial of a Medical Superintendent means that Clinical Governance exists in words only, much to the detriment of effective and efficient clinical services, patient safety, and morale.

7. *Lack of support for Medical Education and Training*. Armidale Hospital is accredited by the RACP for both Basic and Advanced Physician training, and has a Director of Physician Education (DPE), as required by the College. The DPE position receives financial support from outside the LHD, but this is diverted by the LHD for other purposes, and does not filter through to our DPE. As for undergraduate training, I am an adjunct A/Prof at both the University of New England and the University of Newcastle; Armidale Hospital, however, refuses to recognise this, and I have been threatened with dismissal if I spend more than four hours per week in teaching.

I make these comments as a Level 1 Staff Specialist who has been trying to practice medicine in an austere environment for 40 years. I have also had 45 years in and out of the military, have had 17 operational deployments, have served in four war zones, have served with other armies, and finished up as the ADF’s senior Physician and Colonel Commandant of the RAAMC in NSW.

## 5. From Dr Michelle McCrae, Dermatologist in Orange:-

I am the chair of the Regional and Rural Committee for the College of Dermatologists and we have made a submission on behalf of the College.

However I would like to support and add to Nick's comments, especially:
When discussing 'workforce', we should concentrate on the locally resident workforce, because they are the ones who are available 24/7, who are invested in upskilling their peers and fellow practitioners, working as a valuable team member with the other local/regional staff and investing generally in the community in everything they do.

There is a critical shortage of Dermatologists outside of metropolitan Sydney. Unfortunately I am now the only full time Dermatologist (and only female) west of the Blue Mountains (Orange). The closest are Canberra (5), Griffith (1), Wagga (1) and Tamworth (1) – with the 3 of these regional Dermatologists close to retirement. I cover an area of over 350 000. We have a small group of FIFO to Dubbo and Orange however with COVID Dubbo completely stopped. Those that FIFO don't triage – so they don't end up dealing with any urgent or serious/complicated cases, which places even more strain on my services. I have a 9 month waiting list and work full time. I have an interest in genital dermatology. The female Dermatologist in Wagga retired last year and now a good number of her patients have been referred to me in Orange for long-term followup.

As Nicholas stated, there is overwhelming evidence that the those who train rurally are more likely to be retained rurally. The numbers are greatest for JMOs (31-35%) followed by medical students. Increased attention needs to be placed on training and supporting those who wish to train in regional areas. Despite an increase in JMO positions in regional NSW areas, demand outstrips supply and we are losing access to potential doctors. I was fortunate to have great mentors and be well supported during my JMO training.

I am pleased to see the trial in Murrumbidgee. It is not just about developing the contacts to work as a valued team member of the medical and greater community, but it ensures we attract those with the personality, integrity and commitment to work in these geographical areas. It has been shown multiple times that regional doctors work longer hours than their metro counterparts. It would definitely be easier to work in the city, not worry about fee structures or different socioeconomic concerns, referring complicated patients to the tertiary referral hospital, and living in a different suburb to where I practice. There is also the need to support those who are early career doctors – it is very difficult to set up a solo practice without a bit of experience and hence confidence. Unfortunately by the time most develop this they are well established in the city environment – both medically and socially, and have developed a certain mentality about rural practice.

Unfortunately, I would love in be involved more in my LDH, but until recently due to prompting from other colleagues, there has been little interest in the 7 years I've been back in Orange. I am unable to find any Dermatology KPIs for NSW Health and have flagged this with our college. Most rural dermatology training positions are STP/ITP funded, which are heavily private practice based. This places an added burden on any regional supervisors who decide to apply to supervise/run a position. Having completed a full year of regional training

as well as FIFO training, and previously supervised rural registrars fulltime for 3 years, I have come to the realisation that it is too hard to train registrars rurally without the input of local health services and the medical community support that it provides. Not only does it exclude dermatology registrars from learning opportunities and development of those important medical and social contacts, it excludes them from registrar accommodation assistance (it is very hard to find affordable rentals in our area).

In addition there has been a major push with telehealth implementation. Unfortunately a lot of decisions regarding telehealth have been made by those who don't experience it on a daily basis. Many areas have very poor infrastructure despite NBN. Many don't have the up to date equipment to utilise access. Even larger regional cites such as Bathurst and Orange have had large sprawls of housing and the nodes/infrastructure have not been maintained or increased to deal with the increase in population. As a result the bandwidth is strained and on multiple occasions telehealth consults were abandoned for telephone discussions.

It is by no means a complete response - my biggest concern is the end outcome of services to those already disadvantaged by distance and access.

*1A) and 1B) Health outcomes in NSW – comparison between rural and metropolitan areas*

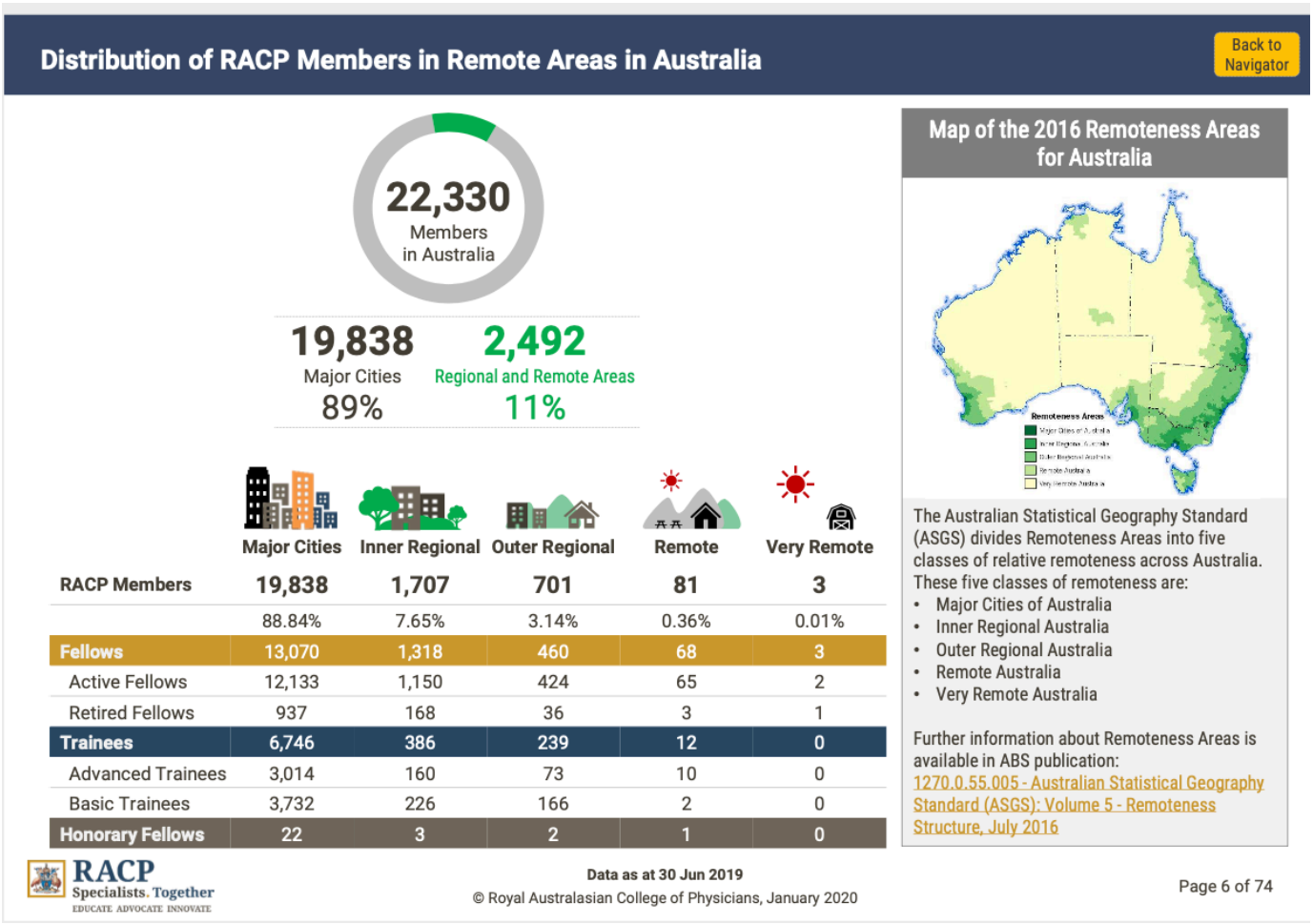
ENDORSED.

1.C) Access to health and hospital services

The value of medical specialists ***living and working*** in rural and remote NSW is not given much attention here. They are needed to service the needs of rural and regional hospitals; around the clock.

Although the proportions of General Practitioners per 10,000 population in Outer Regional NSW is about half that in Inner Metropolitan areas, the proportion of medical specialists is one tenth, and falling.

A report from the Royal Australasian College of Physicians in January 2020[1] showed that trainee numbers in rural & remote Australia were less than the number of practising physicians by a significant proportion, while numbers of trainees based in metropolitan areas continued to grow, outstripping the supply of vacancies for fully-qualified physicians. Yet still the imbalance continues.



**Distribution of RACP Members in Remote Areas in Australia**

Back to Navigator

22,330 Members in Australia

19,838 Major Cities 89%

2,492 Regional and Remote Areas 11%

| | Major Cities | Inner Regional | Outer Regional | Remote | Very Remote |
|---|---|---|---|---|---|
| RACP Members | 19,838 | 1,707 | 701 | 81 | 3 |
| | 88.84% | 7.65% | 3.14% | 0.36% | 0.01% |
| Fellows | 13,070 | 1,318 | 460 | 68 | 3 |
| Active Fellows | 12,133 | 1,150 | 424 | 65 | 2 |
| Retired Fellows | 937 | 168 | 36 | 3 | 1 |
| Trainees | 6,746 | 386 | 239 | 12 | 0 |
| Advanced Trainees | 3,014 | 160 | 73 | 10 | 0 |
| Basic Trainees | 3,732 | 226 | 166 | 2 | 0 |
| Honorary Fellows | 22 | 3 | 2 | 1 | 0 |

Map of the 2016 Remoteness Areas for Australia

The Australian Statistical Geography Standard (ASGS) divides Remoteness Areas into five classes of relative remoteness across Australia. These five classes of remoteness are:

- Major Cities of Australia
- Inner Regional Australia
- Outer Regional Australia
- Remote Australia
- Very Remote Australia

Further information about Remoteness Areas is available in ABS publication: 1270.0.55.005 - Australian Statistical Geography Standard (ASGS): Volume 5 - Remoteness Structure, July 2016

RACP Specialists. Together EDUCATE ADVOCATE INNOVATE

Data as at 30 Jun 2019

© Royal Australasian College of Physicians, January 2020

Page 6 of 74

[1] RACP Member Statistics and Insights. January 2020 Royal Australasian College of Physicians.

## FURTHER INPUT FROM RURAL MEDICAL SPECIALISTS' ASSOCIATION

Although the Commonwealth has been addressing the shortage of medical specialists through its Integrated Rural Training Pipeline for Medicine, the states have a vital role:

1. Students in Rural Clinical Schools should be encouraged to have a close association with their training hospital. Programs engaging rural medical students should be a priority for rural hospitals hosting rural clinical schools or University Departments of Rural Health;

2. The intern (PGY-1) and PGY-2 years immediately after graduation set the scene for a young medical graduate to stay on in rural practice. Spending these years in a rural or regional hospital increases the probability of the graduate returning after completing specialist training by 20%[2]. Directors of Clinical Training and Offices of Medical Education should be supported to bid for and train increasing numbers of medical graduates in rural hospitals.

3. Offices of Medical Education in rural hospitals should also take care of the 'lost tribe' of medical graduates: those who have either not decided on which training program they wish to enter or those not yet accepted beyond PGY-3. These junior doctors should not be regarded as just workforce. They should be provided with the same supervision, assessment and regular feedback as those under the formal aegis of the NSW Health Education & Training Institute (HETI).

4. Rural and regional hospitals should be encouraged to enrich their opportunities to gain accreditation for additional specialist training places through the Royal Colleges. This requires an investment in leadership at both Departmental and institutional level. Medical graduates who have spent at least a year in a Rural Clinical School and completed more than half of their postgraduate training in a rural hospital have a 60% probability of returning to regional locations when they enter practice[2].

### 1.E, 1.F and 1.G) Funding across NSW hospitals and health services

Endorsed, but the drivers of this are complex:

1. Rural hospitals run smaller budgets than metropolitan hospitals, and so are intrinsically more vulnerable to sudden change in demand.

2. Good administrators in metropolitan hospitals are rewarded with ongoing employment. Good administrators in rural areas are usually 'climbing the career ladder' and move on as soon as a better opportunity presents. Mediocre administrators don't get better offers and so stay.

3. Governance in rural and remote hospitals is patchy. Some are excellent, but we have seen many examples of poor governance and executive performance in rural areas over the years.

### 1.J) Access to palliative care services

Endorsed, but again this is a function of where the specialists are trained.

---

[2] Denese Playford, Hanh Ngo, Surabhi Gupta and Ian B Puddey Opting for rural practice: the influence of medical student origin, intention and immersion experience Med J Aust 2017; 207 (4): 154-158. || doi: 10.5694/mja16.01322

## FURTHER INPUT FROM RURAL MEDICAL SPECIALISTS' ASSOCIATION

As long as specialist training programs are dominated by metropolitan centres, the shortages of palliative care physicians will remain and probably deteriorate. This also applies to pain control specialists, particularly in view of the opioid crisis, and radiation oncology, where corporate interests are gaining the upper hand.

### 1.L) Any other matters

Good governance of the system is critical to its resilience. Proper governance practice dose not come intuitively. There is an abundance of people in the metropolitan areas with governance experience, but this is not always the case in rural NSW. All the professions (not just medicine) have difficulty attracting practitioners.

#### Recommendations:

- All newly-appointed members to Local Health District (LHD) Boards should be provided with high-quality Governance training;
- Existing members have refresher courses each time their appointments are renewed.
- There should be a much better balance between clinicians and lay community members on rural LHD Boards, subject of course to provision of Governance training for incoming clinicians.
- The Chair of the Executive Medical Staff Council should be an invited observer at LHD Board meetings.