Special Commission of Inquiry into Healthcare Funding

Outline of Evidence of Professor Lenert Bruce

Name:	Lenert Bruce
Occupation:	General Manager of Wagga Wagga Base Hospital; Executive Director for Medical Services for Murrumbidgee Local Health District

1. This is an outline of evidence that it is anticipated that the witness will give to the Special Commission of Inquiry into Healthcare Funding.

2. I am the Executive Director for Medical Services for Murrumbidgee Local Health District (**MHLD**), where I am responsible for strategic oversight of medical services in the District. I have held that role since 2020. From April 2023 I have also held the role of General Manager of Wagga Wagga Base Hospital (**WWBH**).

3. Part of my role as Executive Director involves providing advice and support to the broader executive team regarding provision of medical services, including outpatient clinics. The majority of specialist outpatient services within MLHD are provided in private rooms and only a small proportion of these services are provided by MLHD clinics. The MLHD clinics are based at WWBH and Griffith Base Hospital, however some surgical disciplines undertake private outreach to rural communities (urology and general surgery), and there is an oncology outreach clinic at Young Health Service.

Workforce

4. MLHD experiences a number of challenges in attracting medical doctors and graduates to work at its facilities. The main challenges are the remote geographical location of MLHD and the level of on-call responsibilities. Medical staff can also experience social and professional isolation.

5. MLHD has been successful in recruitment, but there is a degree of natural attrition. This can cause challenges for MLHD in keeping up with demand for services, for example increasing surgical services since COVID19, and overall increased activity at WWBH.

6. Generally speaking, this workforce shortage needs to be addressed by considering both the demand for medical services, and the supply of doctors to provide those services. In my view, the solution is not solely through increased funding of the medical officer workforce.

<u>Premium labour</u>

7. In my present role, I am not responsible for day-to-day staff rostering. However prior to holding my present positions, I was the Clinical Director of the Anaesthetics Department at WWBH for approximately 10 years. As part of that role, I was responsible for, and had oversight of, the preparation of staffing rosters for senior and junior medical staff.

8. In general terms, rosters would be prepared by first allocating permanent staff to fill shifts. Premium labour would only be engaged if all local staff had been deployed, and it was necessary to keep a health service operating. It is very rarely necessary to utilise

registrar locums in Anaesthetics. We do use provisional fellows who work independently with remote supervision.

9. The cost of premium labour is much higher than the equivalent cost of employing a doctor of mid-level seniority, namely third year residents (PGY3) and career medical officers. This can make locum roles more attractive to this cohort of the workforce when compared to permanent employment. Work flexibility is another attraction of locum roles.

10. Furthermore, the price of premium labour can fluctuate. For example, post-COVID19, there was an increased demand for anaesthetists. That in turn increased the demand for premium labour anaesthetists, which meant it was more expensive to access them.

11. The majority of specialist locum medical officers engaged currently at Wagga Wagga Base Hospital are in the areas of Emergency Medicine and Anaesthetics. Other disciplines are less reliant on specialist locums. MLHD also uses locums in the Emergency Departments (**EDs**) at some of our District Hospitals; Young and Deniliquin Health Services rely on premium labour to cover their EDs.

12. In an ideal scenario MLHD would have enough permanent medical officers that it would not be necessary to recruit premium labour. There are benefits to having staff with local knowledge of the area, who are familiar with the facility and local context, and whose strengths and limitations are known. That said, the practical reality is that it will likely always be necessary to utilise some level of premium labour to cover planned and unplanned leave. Using premium labour also has the benefit that the locums can share knowledge and ideas with local staff and it can even be an effective recruitment strategy.

13. MLHD is strategic in how locums are deployed. For hospitals that have low volume ED-presentations, we will elect to support that community with virtual care rather than through an on-site locum doctor. Cross-cover between hospitals, such as Finley, Berrigan and Tocumwal, can also reduce locum requirements.

<u>MLHD initiatives</u>

14. Opportunities to address the demand on the MLHD medical officer workforce include:

    a. Investing in primary healthcare to improve the general health of the MLHD community. Although the primary care and hospital systems are separate, they are also co-dependent in that an effective primary care system can reduce the need for patients to present to hospital in the first place. For example, in New Zealand, there is a greater alignment between the primary care and hospital-based system. As a result, there are a significantly lower number of ED presentations per year/1000 population compared to Australia and MLHD.

    b. Expansion of scope of practice of other health care providers, where appropriate – for example nurse practitioners and extended skill paramedics.

    c. Alignment of medical officer utilisation to consumer health care needs, and in a related manner repurposing of services that are underutilised.

15. An initiative adopted at MLHD is the Rapid Access Clinic (**RAC**) at WWBH. This is a General Practitioner led multidisciplinary service where low acuity presentations are diverted from the ED where appropriate.

16. The expansion of the RAC can reduce ED demand. Low acuity presentations can be diverted to RAC. Between January and December 2023, 3034 patients were diverted

from the Wagga Wagga Base Hospital ED. Since it was first implemented, the operating hours of the RAC have been expanded, and more recently it was expanded to include paediatric patients. Proposed future stages of expansion include integration between the RAC and HealthDirect (patients can access RAC without presenting to the ED), and expansion to include referrals from aged care facilities and community pharmacies.

17. To increase the **supply** of doctors who work within MLHD, there are a number of strategies which could be adopted.

18. First, there is a need to attract medical students by expanding training beyond large hospitals. Most of the training provided to medical students and junior doctors is within large hospitals. As a result, there is less awareness of the opportunities available to provide care outside of the hospital context, and in particular community health and general practice in rural areas. Rural clinical schools play a significant role in addressing this.

19. Secondly, while the NSW centralised model of Junior Medical Officer (**JMO**) recruitment has advantages, it can be improved by allowing a JMO to stay in a location if a vacancy existed. I am aware of a case in MLHD where a JMO requested to be placed in Wagga Wagga after completing their medical student training locally. Instead, they have been allocated to another location by the matching system and have been required to take up a role in a different LHD.

20. Thirdly, from my observations, MLHD is most likely to retain doctors if they are located within the district during their specialisation training. Whilst undergoing that training, doctors develop professional connections which increases the chance that they will settle in that area.

21. There are a number of strategies which could be adopted to increase the number of doctors who undertake their specialist training in MLHD or other rural areas, and in turn increase the number of specialists who settle in rural areas:

    a. Training positions should be specifically allocated to rural areas for their specialist training, and then rotate to metropolitan areas to undertake training in fields where that training is not available in rural areas.

    b. Rural areas would benefit if doctors had more generalist skills, so-called multi-skilled specialists. The majority of physician outpatient services in Wagga Wagga are delivered by a subspeciality model, while it provides high quality care it does impact patients with multi-organ disease. Rural areas benefit from doctors with generalist skills, as they can service a greater mix of patient conditions in inpatient and outpatient settings, reducing the number of doctors required.

22. Another successful MLHD strategy is the Rural Generalist Training Pathway, which commenced approximately three years ago. The program is a pathway for junior doctors to undertake their general practice training with certainty about their location, income and working conditions. It provides a structured training pathway to develop general practice skills as well as hospital skills to work in rural hospitals. The program has been a success and we have already had one of our trainees commence as a GP-Obstetrician in Young, where we previously had to provide locum cover if the resident doctor needed time off.

23. Virtual care is also a useful tool to assist with the workforce challenges which MLHD faces. It increases the supply of doctors who are able to provide services to MLHD, reduces the demand on local medical staff, and reduces professional isolation.

Examples of where virtual care has worked well to support in-person medical services include:

a. WWBH provides support to the ICU department at Griffith Base Hospital. By that system, a doctor based in Wagga Wagga can assist with assessing a patient who is physically admitted at Griffith. Another example is virtual cardiology services, which means a patient presenting with a heart attack can be reviewed virtually by a cardiologist at WWBH and receive appropriate and timely initiation of treatment equivalent to presenting to WWBH.

b. A facilitated consultation system, whereby a patient can attend a general practitioner's practice and have a video-link to a specialist. This can prevent the need for that patient to travel long distances (often to metropolitan Sydney) to attend that specialist appointment. This model is used in the Rapid Access Clinic at WWBH where patients with burns are reviewed in consultation with the specialist burns unit at Concord Hospital.

c. Outreach virtual care services. For example, MLHD has a geriatrics virtual outreach service.

24. Concurrent academic roles and a culture of training also adds to professional satisfaction for staff at MLHD.

Funding

25. A challenge for MLHD is the way in which healthcare is funded. There are challenges when the District undertakes more or less activity than allocated. The District does not have control over the demand for services (planned surgery), which can lead to an unfavourable budget.

26. Although funding new models of care can be challenging within ABF, effective models of care will drive efficient expenditure. An example of where MLHD has done this well is the day surgery joint replacement project. This service is now being expanded to manage patients who are not suitable for day surgery but are able to be discharged to Hospital In The Home (HITH) services after one or two days.

Data to assess health needs

27. MLHD uses a variety of data to determine how to allocate services and meet the health needs of the community. These include:

a. Community survey analysis (to inform individual facility Service Plans)

b. Population Health data from NSW HealthStats, and other sources

c. Population Projections (Department of Planning and Environment)

d. Admitted, Non Admitted, ED, sub and non-acute and waitlist data streams that feed into NSW Health data warehouses

e. Ministry of Health Activity Based Management Portal

f. Ministry of Health historical and projected activity data sets (FlowInfo, EDAA, and HealthApp)

g. Murrumbidgee Primary Health Network (MPHN) needs assessments.

h. Patient transfer data (where relevant), and

i. Data/ information that may assist with determining need from other organisations such as Ambulance NSW, Private/not for profit residential aged care providers (where relevant and available), social services information regarding need (where relevant).

28. MLHD will look to the volume and type of presentations to a particular hospital to determine workforce distribution, in line with internal guidelines on role delineations, supervision requirements and guidelines set by professional bodies.