Special Commission of Inquiry into Healthcare Funding

Statement of Dr Michelle McRae

Name: Dr Michelle McRae

Occupation: Dermatologist

1. This statement sets out the evidence that I am prepared to give to the Special Commission of Inquiry into Healthcare Funding as a witness.
2. The statement is true to the best of my knowledge and belief.

A. My Role

3. I am a dermatologist at Pinnacle Dermatology in Orange.

4. I am also a clinical lecturer for the University of Sydney.

5. I am also currently the Senior Director of Training for the Australasian College of Dermatologists (**ACD**) in NSW.

6. I am also the Chair of the Rural and Regional Services Committee of the ACD, a position I have held since 2019.I have also held roles on other committees of the ACD including the NSW Rural Task Force.

B. The Service

7. Whilst being located in Orange, Pinnacle Dermatology ("the service") provides dermatology services to patients across the region of western and far western NSW, including to patients in Lithgow, Walgett, and Broken Hill. Patients may travel up to three or four hours to attend a consultation at the service.

8. At the service, we accept all patients. To accommodate this, I conduct my private rooms similar to a public clinic and have a tiered payment structure to ensure that all patients have access to dermatology services. If I had not modified the service in this way, some of my

patients would not have had access to the service, and thus specialist dermatology care.

C. Workforce challenges generally

9. There are currently approximately four full-time equivalent ('FTE') dermatologists across regional and rural NSW. Aside from me, west of the Blue Mountains there is one dermatologist in each of Albury/Griffith, Wagga Wagga and Tamworth. This reflects a substantial shortfall in the provision of dermatology services in the area. As a reflection of this shortfall, I currently have a 12-month wait list, although I triage every week and there is some degree of flexibility in my list for more urgent appointments.

10. In the absence of significant change (of which some initiatives are set out below), I believe the shortfall in dermatology services in rural areas is structurally entrenched. That is because a critical mass of consultant dermatologists is required to train rural dermatologists, however, there is a challenge to attract and retain such dermatologists. In my view, that is because there are a lack of rural trainees in dermatology who can progress to a senior role in a rural environment and become settled rurally. In that way, I see the issue as cyclical. Further, those that have trained in non-rural areas are largely unwilling, or insufficiently incentivised, to move rurally as they become settled in the geographical areas (ie. metropolitan) where they have trained. Constraints in funding play a role in this shortfall, in that there is a lack of funding for consultant and training positions in regional public hospital and therefore rural training positions may simply not be available. These factors are set out in more detail below.

11. I am particularly concerned about the shortfall and its impact on the future provision of services in these areas as the other rurally located dermatologists west of the Blue Mountains are all over the age of 60 and are therefore nearing retirement age. Despite some initiatives that are being introduced, discussed below, there does not currently appear to be the public investment to enable a sufficient level of renewal to sustain the current service in the area, let alone, to increase the service to an adequate level to address the current shortfall.

D. Training Pathway

12. The training program for dermatology involves 4 years of full-time equivalent training in accredited training positions. Trainees rotate through positions and are required to complete assessments and other requirements that ensure they are skilled and safe to practice in order to be eligible for fellowship.

13. Training is conducted only in paid positions accredited by the College's National Accreditation Committee (NAcC).

14. Of the 116 training positions nationally, 36 are in NSW across 19 training sites.

15. There are 23 NSW Government funded training positions, however, these are hospital based and, as such, are only offered in Newcastle and Sydney.

16. A third of ACD training positions in NSW are funded by the Specialist Training Program (STP) via the Commonwealth government. It is noted that the Commonwealth offers around $110,000 per year per STP placement, however, where the STP placement involves a trainee working in a public hospital in NSW, the relevant award requires that the trainee be paid approximately $140,000 per year. The shortfall is covered by the Local Health District.

17. The STP positions require a minimum of 0.5 full time equivalent (FTE) training to take place in a private or rural setting. The rural positions attract rural loading funding to assist with the cost of travel, accommodation, relocation and any other training related costs.

18. The majority of STP training positions are affiliated or managed by a public hospital so that trainees can maintain their workplace entitlements. There often issues or delays surrounding access of the rural loading from the hospital as currently STP funds can only be paid to one site/person to then be distributed. And departments are having to negotiate with hospitals regarding the wage shortfalls, particularly if the registrar is a 3rd or 4th year registrar. For example, I am currently the sole dermatology supervisor in Orange, and have a full-time registrar affiliated with Concord Hospital.

19. However, as it is not advisable, and does not comply with the ACD accreditation, for trainees to train under just one supervisor for more than 6 months, this registrar will not stay in Orange beyond the 6-month period. If there are 2 or more supervisors, trainees can complete a 12-month placement. In my view, if trainees see their time doing rural training as

merely a 6-month rotation, they will be far less likely to choose to settle rurally at the completion of their training. However, we also need to negate this with increasing the number of Sydney-based trainees being exposed to rural placements.

20. If there were more dermatology supervisors in rural areas, trainees could complete much larger proportions (or hopefully all) of their training rurally, which I think would attract them to practise rurally longer term.

E. General Practice

21. It is noted that specialist training for dermatology is a distinct training pathway. GP trainees seeking advanced specialised competency in dermatology cannot currently do so through the rural generalist pathway, as dermatology is not currently included in the Pathway's Advanced Specialised Competency Standards, despite GPs seeing a large volume of dermatological issues in practice.

22. Due to the lack of investment in publicly funded dermatology services, medical students and junior medical officers, whose placements are largely in hospital settings, have limited or no exposure to dermatology. The same can be said of other hospital-based clinicians who may wish to pivot their careers but have not been exposed to dermatology.

23. I also note that the loss of rural generalists is a serious concern. Based on my experience working in the area, I believe there is a large shortfall in the availability and/or capacity of provision of care by GPs in western and far western NSW. As a result, I often find myself performing quasi-GP work in Orange.

F. Other factors impacting on rural dermatology

24. There are a couple of further factors which impact on the ability to attract and retain rural dermatologists.

25. First, there is a lack of financial and non-financial support for dermatology trainees to relocate and work in rural NSW, save for the STP rural loading funding referred to at [17] above. For example, dermatology trainees do not receive reimbursements or subsidies for their accommodation.

26. I believe the lack of funding is a reflection of the funding models in NSW Health, which place a significant emphasis on revenue or activity generated in a hospital setting, of which dermatology does not substantially contribute.

27. Another factor is that junior dermatologists cannot afford to open their own practice due to the cost and complexity of establishing a private practice in a rural area and, as a result, they do not relocate to rural NSW, rather, they remain working in Sydney in large practices.

G. Training Initiatives

28. To address the lack of dermatology supervisors in western and far western NSW, ACD is attempting to engage several fellows to the area to establish likelihood and sustainability of rural training. The ACD has secured funding under the Federal Government's Flexible Approach to Training in Expanded Settings (FATES) program to co-design and implement with local stakeholders (Western NSW Local Health District, Orange Aboriginal Medical Service, Western NSW Regional Training Hub, Sydney University School of Rural Health, private practice) a high quality sustainable training pathway for the region.

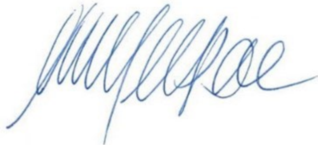
29. The aim of the project is to enable dermatology trainees from Western NSW to do most of their training locally. This will likely involve trainees completing one year of training in Sydney, one year in Orange and two years in Dubbo.

30. For the Dubbo portion of the training, it is expected that telehealth supervision will be combined with face-to-face supervisors. In my view, well governed telehealth services may assist in increasing access to dermatology services in rural areas. However, there are difficulties in relying solely on this form of care delivery, as dermatology often requires the physical examination of patients which cannot be done via a remote consultation. Further, in some rural areas there are challenges with IT and internet access. Virtual supervision alone, as contemplated by the above training scheme, also gives rise to similar challenges.

31. Nevertheless, by working to establish such training pathways to promote rurality, we may be able to establish a hub of rural trainees in Dubbo/Orange, which can be used as a model for other regional areas. Ongoing training in the region will rely on State Government investment at project completion in 2027.

32. It is noted that the ACD has had other projects funded under the same scheme in Darwin (a FIFO dermatology service) and Townsville (a dermatology screening service, linked to the Melanoma Institute in Sydney). The services and training delivery were able to be sustained due to State funding following project completion.

Signature:



Name: Dr Michelle McRae

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