Special Commission of Inquiry into Healthcare Funding

Statement of Dr Natalie Rainger

Name: Dr Natalie Rainger

Occupation: Consultant Otolaryngologist and Head & Neck Surgeon (ENT)

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

A. My Roles

3. I am a Visiting Medical Officer (**VMO**) Otolaryngologist and Head and Neck Surgeon (**ENT**) based in Orange.

4. I am contracted by the Western New South Wales Local Health District (**WNSWLHD**) as a VMO in the Department of Surgery within the Orange Health Service.

5. I also work in private practice at Bloomfield Medical Group, Orange, and at the Dudley Private Hospital, Orange.

6. I am a conjoint lecturer at the University of Sydney, Rural Clinical School.

7. I am an accredited supervisor of training with the Australian Society of Otolaryngology Head and Neck Surgery (**ASOHNS**). ASOHNS with the Royal Australasian College of Surgeons (**RACS**), provides a nationwide Training Program for future Otolaryngology Head and Neck Surgeons.

B. The Service

8. I completed placements at the Orange Health Service while a medical student, intern, resident and six months as a Registrar. I relocated to Orange and commenced working with the Greater Western Area Health Service (**GWAHS**) (the predecessor to the WNSWLHD) as a

consultant approximately 10 years ago. I was attracted to relocating to and working in Orange as I had grown up in a rural area.

9. There are currently four consultant ENT surgeons working within the Orange Health Service, soon to be three as one of our colleagues is retiring. All of us work under VMO contracts. Up until approximately 12 months ago, there were only two resident consultant ENT surgeons. We currently also have a registrar undertaking their ENT training, and I am the accredited supervisor for that registrar. We also have an unaccredited registrar working in the Department.

10. Despite being located predominantly at the Orange Health Service, we have district-wide contracts meaning my colleagues and I am able to provide services at public hospitals throughout the WNSWLHD. In addition to Orange, the service generally treats patients from within the WSLHD from Forbes, Bathurst, Cowra, Parkes, Mudgee, and Dubbo, and we also see patients from the Far West Local Health District, for example, from Coonamble and Bourke. The on-call ENT service for the Western and Far Western NSWLHD is provided solely by the ENT surgeons in Orange.

11. All of the ENT surgeons in the Orange Health Service are contracted as VMOs on fee-for-service contracts for the surgical work they undertake. Our public patients are generally seen for outpatient appointments in our private rooms, and we bulk bill a significant proportion of these consultations/outpatient treatments through Medicare. There is also a long-standing personal arrangement with the Aboriginal Medical Service, where those patients are bulk billed and not charged any fee personally.

12. I estimate that on average I spend a third of my time in my private rooms seeing public and private patients, a third in private operating rooms and a third in public operating rooms.

13. As part of my public practice, I conduct surgical lists and attend public hospitals and clinics at a number of locations within the WNSWLHD. We tend to ask patients to attend on us in Orange, because ENT practices and surgery are equipment-heavy, making it difficult to travel and perform these services. Despite this, we do regular outreach trips, and conduct operating lists at peripheral sites such as Cowra, Forbes and Bathurst. In addition to Orange, I currently conduct public surgery lists in Cowra, and I have previously conducted surgical lists in Dubbo and Forbes. This is to help smaller communities retain their medical services.

14. In my experience, if we do not visit these satellite hospitals as specialists, local GPs will deskill and leave those communities. GPs need to be supported by specialists in regional areas. With this support, GPs can be confident that if their patient needs specialist care they will be able to access advice and care for their patients in a timely manner, and within the area. While it can be onerous driving long distances, often in the dark, and operating at these sites less efficient, this is very important to people in local communities and those providing care in those communities.

15. In addition, the service provides on-call ENT coverage from the Blue Mountains through to Bourke and up to Gunnedah. When on-call, I can be required to provide urgent advice to other clinicians over the telephone, attend the Orange Health Service to carry out emergency procedures, or attend on a patient via air as part of an emergency retrieval team.

C. Workforce Challenges

16. For most of the first 10 years of my engagement with GWAHS/WNSWLHD, I was one of two (or three) VMO ENT surgeons at the Orange Health Service. As such, my colleague and I had a predominantly 1 in 2 on-call roster. In 2021, due to my colleague being away I was doing a 1 in 1 on-call.

17. In comparison, the minimum on-call roster for ENT surgeons in metropolitan facilities ranges from approximately 1 in 7 to 1 in 16. A 1 in 4 roster has been identified as being arduous and unsustainable by the college. We are below this minimum requirement.

18. In 2021 I contacted all five or six graduates in NSW who had recently completed the ENT training program and requested their assistance in the WNSWLHD, however, each of these graduates declined. From speaking to these graduates, the lower pay, longer patient wait lists, and strenuous on-call arrangements in the WNSWLHD were the reasons why they were not interested in coming to Orange.

19. In the past 12 months, WNSWLHD has recruited two ENT fellows in Orange. As such, we currently have four consultant ENT surgeons and have had a 1 in 4 ‘on call’ roster. However,

one of my colleagues is retiring in July 2024 which will result in a 1 in 3 on-call roster. The two fellows who joined the WNSWLHD in the past 12 months also grew up in rural areas.

20. For ten years, I also provided services in Dubbo and Forbes. Over the past 10 years, WNSWLHD has employed two ENT surgeons in Dubbo. However, an overseas ENT surgeon who was employed permanently in Dubbo recently left the WNSWLHD and the second ENT surgeon in Dubbo will also be leaving at the end of 2024. As a result, our service is assisting in providing services in Dubbo.

21. The current number of ENT surgeons in the WNSWLHD is still much lower than is required for the per capita size of the population. Data accumulated across Australian states displays a normative trend of 1.89-2.3 ENT surgeons per 100000 population. Therefore to cover the population of Western and Far Western LHDs ideally we should have at least 6-8 ENT Surgeons.
22. WNSWLHD is increasing in patient volume, and we are busier due to COVID-19 and growth in rural areas as people left the city to relocate to regional and rural areas. The staffing levels in the Department have not increased to meet this demand. For example, for a non-urgent issue, a patient would previously have to wait 12 months for an appointment with an ENT within the WNSWLHD. As a result of the recent recruitment of two fellows, the wait list initially shortened, however, it is growing again, in part because I am now seeing more Dubbo patients. Our current wait is 6-8 months for a non urgent consult in rooms or clinics.

23. In my view, while cities are becoming more saturated with specialist clinicians and ENT positions are becoming more attractive, it remains difficult to attract and retain staff in western and far western NSW.

24. I believe that critical mass is key to attracting specialists to relocate and work in western and far western NSW. For example, if a specialist position is established in a rural area, in my opinion there needs to be at least two positions in the same area as it will be more attractive for clinicians to relocate knowing they have other colleagues in the area to share the on-call load with, they will not be professionally isolated and will have the benefit of collegiate support, have a shared workload and can meet current professional standards including participation in MDT meetings and M&M meetings.

25. An acknowledgement of the benefits to be gained from having numerous specialist positions in rural areas is the reason that specialist services for WNSWLHD are predominantly provided from Orange rather than from Dubbo, as there is more of a concentration of specialists in Orange than Dubbo. Therefore Orange functions as the demographic centre of the state where a majority of specialist services, not only ENT, are provided from.

26. In my view, RACS now sees the value of rural trainee positions as medical practitioners receive more operating experience than their peers at the same stage of their training in Sydney. Exposure to rural training positions also encourages trainees to return to rural areas long-term. This will also help to increase the numbers of rural and regional specialists.

D. Remuneration Issues

27. When I was first engaged by GWAHS as a consultant, I was open to becoming a staff specialist. I provided GWAHS with a cost model and a list of equipment required to provide outpatient services; however, GWAHS was unwilling to fund the required equipment, and I was re-offered the VMO position that was originally offered to me. The effect of this arrangement was (and is) that I bore the cost of the equipment, and I consult with public patients in my private rooms (as discussed above), rather than in a public clinic.

28. As stated above, I perform my public surgical work on under the terms of a fee-for service VMO contract. My on-call work is currently also provided on a fee-for service basis. The only public work that is provided on a sessional basis is any work I perform in public outpatient clinics. As I describe below, a public clinic is being established in Orange, but is not yet operational.

29. When I am on-call, I often provide phone consultations via V-Care to other clinicians who are located in other rural areas, such as general practitioners. I talk the clinician through what to do and they can often stabilise the patient over the phone until the patient is re-located to Orange, or I arrive at the location. However, as I am on a fee-for-service contract for my on-call work, if I only provide a phone consultation, I do not receive any payment. Under the VMO Contract, I am only paid if I attend the hospital and provide a medical service. Another situation where I will not receive payment is when I complete the pre-operative work at the hospital for a procedure and the procedure does not proceed for some reason.

30. There is also an administrative burden in the process of submitting payment requests via the VMoney system. It is time consuming and claims are often rejected, requiring resubmission. For example, as recently as this week I was unable to log claims in VMoney as it would not recognise the patient's MRN from Powerchart even though I had the MRN, patient notes and sticker all evidencing the MRN. Another example of the limits of the system is the hours I spent caring for a very ill patient who passed away before surgery; I was unable to make a claim because no surgery was performed. Additionally, as a VMO on a fee-for service contract, I am not paid for any of my time spent teaching junior medical staff.

31. In my view, based on the above experience, my position and those of my colleagues would be more fairly remunerated if we were retained as VMOs on sessional rather than fee-for-service contracts, at least for on-call work. I raised this with the WNSWLHD in 2021, but my request was refused at that time.

E. Training and Funding

32. In early 2023, we were able to establish a registrar position in Orange, being one of the first rurally accredited ENT training post in Australia. I understand that a position in Townsville is also being established.

33. To obtain accreditation for a trainee position (i.e. registrar), you must meet the criteria set by the RACS and the relevant Society or Association who delivers the training (in the case of ENT training this is ASOHNS). At the time we successfully applied for accreditation, the RACS criteria required a minimum of three consultants (An ENT surgeon to be the supervisor plus two other consultant ENT surgeons), as well as a public clinic in which the registrar can perform supervised work.

34. Many rural sites are not able to meet those requirements. I have raised this issue with RACS, and I am aware that my colleagues have also raised it, and it is my understanding that over time, RACS has developed a greater understanding of the importance of training posts outside of the city. In keeping with this, I understand that now there is an exception for rural or remote ENT training positions, such that only two consultants are required to be at the site (one supervisor and one other ENT surgeon).

35. The second condition that caused difficulty in obtaining accreditation and establishing an accredited registrar position was for the service to operate a public clinic.

36. The process of setting obtaining accreditation for a training position at our service was entirely locally driven. In 2017, I first sought accreditation and, although we had successfully obtained Specialist Training Program (**STP**) funding, we did not meet the RACS criteria, so we were unable to progress the application.

37. In 2021, I again attempted to establish a training position and again obtained STP funding. I attended a few meetings with the Director of Medical Services (**DMS**) of the Orange Health Service, Dr Sid Vohra and the General Manager of the Orange Health Service, Catherine Nowlan, who were willing to approve a new trainee position, but were unable to approve funding for the public clinic. Again, it was apparent that we would not be able to meet the accreditation criteria set by the College.

38. Sometime after my second attempt ASOHNS encouraged me to continue to work to try again.

39. On 13 August 2022, I sent a letter regarding the accreditation of our service, which was addressed to NSW Chief Health Officer, Dr Kerry Chant, to Associate Professor Kelvin Kong via email. Associate Professor Kong provided this letter to Dr Chant and within a week, our service was notified that we would receive a one-off payment of $375,000 to cover equipment costs for our public clinic.

40. Once we had received the approval for funding for the equipment, RACS provided us provisional accreditation and a registrar began working with the team in early 2023. Most of the equipment we purchased arrived in December 2023.

41. One of the next difficulties was trying to find an appropriate room for the clinic to operate from. ENT work requires certain special facilities, including piped oxygen, suction and a resuscitation buzzer due to some of the paediatric airway services we offer. Orange Health Service did not have a spare room that was suitable, so we have had to use a spare dental clinic space within the Health Service which is not fit for purpose, largely due to the presence of the large operating dental chair which has been unable to be removed.

42. After we purchased the equipment for the public clinic, for around six months, we negotiated with WNSWLHD about licence agreements for the VMOs and additional funding for our clinic. Following meetings with AMA(NSW), ASOHNS and Mark Spittal in Dubbo (12 April 2024) and the DMS (29 May 2024), the contracts for the clinic was approved. We now have sessional contracts in place for this clinic, however, surgical and on-call work remains on a fee-for-service basis.

43. Overall, the process to obtain accreditation took five to six years from when I first sought accreditation in 2017. However, once RACS became supportive of the establishment of a public clinic in Orange, this process took two to three years. Once the issue of funding for the equipment was resolved, the WNSWLHD was very supportive.

44. Currently, we have a 12-month provisional accreditation for the training position. In August 2024, a review conducted by the College will be undertaken to determine whether our service will be re-accredited.

Signature: 

Name: Dr Natalie Ranger

Date: 28 July 2024