Special Commission of Inquiry into Healthcare Funding

Outline of Evidence of Professor Mark Arnold

Name: Professor Mark Arnold

Occupation: Chief Medical Officer, Western New South Wales 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.

My role

2. I am the Chief Medical Officer (**CMO**), for the Western New South Wales Local Health District (**WNSWLHD**). I have held that role since January 2022. I have lived and worked in Dubbo since January 2014.

3. My role is focused on strategic oversight, leadership and direction of the medical workforce within WNSWLHD. I ensure service-wide medical collaboration across areas including service planning and implementation, stakeholder relationships, people management, learning and development, medical professionalism and research. I am also responsible for voluntary assisted dying and the research office. A copy of my CV is at **Exhibit A**, which sets out my roles within WNSWLHD in further detail.

4. The CMO role is a new position, replacing the prior Executive Director of Medical Services role. It was established in June 2022. It is not a common role within the NSW public health system, however it was created in WNSWLHD to ensure leadership and direction in the operation of the whole health service. WNSWLHD is the largest District by area in NSW, with the population within the WNSWLHD geographical footprint at 247,000 square kilometres and over 276,000 residents.

5. As the CMO I report directly to the Chief Executive of WNSWLHD. Part of my role includes provision of support to the Director of Medical Services and General Managers of each of the facilities within the District, however they do not report to me. I am not involved in operational management of the medical workforce, such as rostering and recruitment, and my role is more focused on strategic oversight, the maintenance of professional standards, and interdisciplinary cooperation.

6. I was awarded a Bachelor of Medicine/Bachelor of Surgery from the University of Sydney in 1983. I am a Fellow of the Royal Australasian College of Physicians. I hold a Masters and PhD in bioethics.

7. I remain a practicing rheumatologist within WNSWLHD, notionally at 0.25 FTE. I am an accredited supervisor for rheumatology. I have had various roles with the Royal Australasian College of Physicians, I am a National Examiner, and I sit on the Adult Medicine Clinical Examination Committee. I have worked with various medical regulators, continue to work with the Professional Services Review, and have been involved in human research ethics at the University and National Health and Medical Research Council level.

8. Due to my long involvement in professional regulation, I am often involved in the provision of advice and assessment of standards of practice, and the NSW Health MCCC process (Managing Complaints and Concerns about Clinicians) when necessary.

9. I was previously the Head of School of the University of Sydney School of Rural Health based at Dubbo and Orange for about 10 years.

Medical workforce

10. I am not involved with the recruitment, retention or rostering of medical officers on a day-to-day level. Rather, my role is to develop professional strategies across WNSWLHD to support the LHD's strategic plans on medical workforce recruitment and retention.

11. Although there are fundamental workforce issues related to workforce maldistribution – in terms of absolute numbers and specialist coverage by discipline - between metropolitan and regional NSW, WNSWLHD has been quite successful in its recruitment of high-quality clinicians to the area. I have been working in Dubbo since 2014 and the breadth and depth of services we can now offer is far better than what it was in 2014. Whilst there may be workforce difficulties when looking at individual facilities, when looking at WNSWLHD as a whole, there has been an improvement in the breadth and depth of medical workforce coverage. However, many gaps in specialist coverage by discipline remain across WNSWLHD (for example in Geriatrics and Endocrinology).

12. Part of my role includes engagement with Universities as a strategy to recruit and retain medical practitioners early in their career. The Universities that are active in WNSWLHD are:

    a. The University of Sydney: WNSWLHD has had a longstanding relationship with the University of Sydney for about 23 years. The University of Sydney has a rural clinical school based at both Dubbo and Orange, which gives medical students the opportunity to live and study in these areas. The School now has an end-to-end full program delivered in Dubbo.

    b. University of Western Sydney: The University of Western Sydney runs a Rural Medicine Program based at Bathurst.

    c. University of Western Sydney and Charles Sturt University: The University of Western Sydney and Charles Sturt University run a joint program for the Rural Medical School in Orange.

13. Regular meetings are held by WNSWLHD with the Universities to coordinate medical programs and placements across WNSWLHD. Meetings are held between each of the Universities individually and WNSWLHD in addition to the joint meetings. These meetings ensure that all students have the necessary access to hospitals, that the three programs do not adversely affect one another and that there are reasonable demands on WNSWLHD supervisors.

14. I am also the contact point for WNSWLHD for all College accreditations. During accreditation, the Colleges will liaise with the Chief Executive and myself. I will then notify the relevant Heads of Department on what is required and work with them. Part of my role has also included working towards securing more trainee positions.

15. There are issues with the accreditation and placement process which contribute to recruitment and retention issues for vocational trainees in WNSWLHD.

16. The Health Education and Training Institute (**HETI**) are responsible for accrediting a particular facility for junior medical officer (**JMO**) roles (post-graduate years 1 and 2 [**PGY1** and **PGY2**], aka prevocational trainees), based on whether appropriate training can be provided consistent with the relevant National Medical Board/AHPRA guidelines.

Within WNSWLHD, Orange Health Service is eligible for rural preferential recruitment, and we usually fill the available trainee positions at that facility. Dubbo Health Service fills half of its intern placements via rural preferential recruitment and the other half through rotations from Royal Prince Alfred Hospital. However, Bathurst Health Service does not have intern accreditation. If a medical student wants to undertake prevocational training at Bathurst Hospital, they must be appointed at Blacktown Hospital and then – if possible – rotate to Bathurst. If Bathurst Health Service was accredited for PGY1 and 2, I estimate around 8-10 JMO positions could be accommodated.

17. By 2026, it is estimated that there will be around 70 students in the area who are graduating from rural medical programs, however we will only have 30 or so positions available. Structurally, more intern placements are required at our facilities and in particular the peripheral sites such as Mudgee, Cowra, Forbes and Parkes could potentially accommodate JMO placements on rotation from the Dubbo and Orange Health Services.

18. There are additional impediments for students who wish to undertake their post-graduate medical training in the regions. The specialities that WNSWLHD can offer for training positions depends on the staff who are accredited by a particular College as supervisors, and whether a site is accredited by the relevant College at any given time. For instance, the surgical training options available in WNSWLHD are variable depending on the seniority of staff available and whether they are accredited to undertake advanced training. If a senior member of staff leaves WNSWLHD or retires, that can affect our capacity to train for some subspecialties.

Clinical trials

19. Clinical trials in WNSWLHD have been conducted for over 10 years, largely in the disciplines of oncology and haematology.

20. The Rural, Regional and Remote clinical trial enabling program (**R3-CTEP**) has established three rural/regional clusters, these being the Western, Northern and Southern – for which the WNSWLHD, Far West LHD and Nepean-Blue Mountains LHD constitute the 'Western Cluster'. The WNSWLHD is the lead agency. R3-CTEP derives from a Medical Research Future Fund (**MRFF**) grant which builds clinical trial capacity. Although WNSWLHD has the clinical support available for existing clinical trials, the R3-CTEP program brings, inter alia, standardised business rules and governance for clinicals trials in the three clusters to ensure consistency across all NSW LHDs. These standardised processes support clinicians and allows the Districts to comply with the directives of the National Clinical Trials Governance Framework, which is the benchmark for National Safety and Quality Health Service (**NSQHS**) Standards facility accreditation.

21. Presently the main disciplinary foci of clinical trial activity have been cancer and haematology. The objective of the R3-CTEP program is to broaden and deepen the range of disciplinary fields undertaking clinical trials, and to do so with standardised governance as set out above.

22. Further, the implementation of the Western cluster Clinical Trials Support Unit (**CTSU**) will assist in developing clinical trials in other disciplines. The objective of the CTSU is to ensure that clinical trials activity is sustainable following the end of the grant in 2027. To date, the CTSU has been able to facilitate clinical trials in intensive care and respiratory medicine. Other areas are currently being negotiated with trial sponsors.

23. Conducting clinical trials running in regional and rural areas is important to ensure equitable access to novel therapies across NSW. It also results in clinical trials that are more generalisable.

Challenges and opportunities

24. Running outpatient clinics is a challenge in WNSWLHD. Visiting Medical Officer (**VMO**)-run outpatient clinics are expensive. Without properly funded outpatient clinics, there are patients who have been in hospital and who are then lost to follow-up following discharge to primary care. Those patients may later return to hospital, however appropriately staffed and funded outpatient clinics would enable greater continuity of care and better support clinicians in primary care. Changes to the model of care used in NSW are required for this to occur. Outpatient clinics may be run by Staff Specialists or VMOs. The main challenges are allocating time for outpatient work as part of their substantive role in the case of Staff Specialists, and/or reduced income for VMOs if the LHD recoups a facility fee. Presently there is no capacity for General Practitioners (**GP**) or Rural Generalists to provide outpatient services in Health services aka 'Base Hospitals' (which do not have a section 19(2) exemption granted by the Commonwealth under the *Health Insurance Act 1973* (Cth)). Where there is not a section 19(2) exemption, Medicare benefits are not payable.

25. There is an existing and evolving failure of primary care in WNSWLHD. As a result, some of our smaller hospitals are reliant on section 19(2) exemptions so general practitioners can work as VMOs in rural and remote public facilities. Although this does provide a degree of coverage at the facilities, it does not solve the problem. Staffing some facilities (medical or nursing) necessitates the use of contracted locums at an unsustainable price point. The community in some facilities are reliant on WNSWLHD to be their de facto primary healthcare provider in the absence of adequate access to local primary care. The model of care at our facilities is not appropriate for primary healthcare.

26. Rural Generalists are GP specialists with advanced skills in certain disciplines, for example mental health, obstetrics, and anaesthetics. Training in these speciality areas is conducted by attachment to Health Services. Once qualified, these specialists at present are often not able to utilise their advanced skills in regional NSW (acquired through significant extra time in training pathways) as many facilities lack the infrastructure and staffing appropriate for the exercise of their advanced skills. NSW Rural Generalists have a narrower scope of practice than their Queensland counterparts where Rural Generalism is embedded in the Queensland model of care for Regional and Rural hospitals.

27. The Single Employer Model (**SEM**) aims to increase retention of GP trainees in regional and rural Australia by retaining trainees as NSW Health employees (with the advantages of, inter alia, long service, maternity and sick leave) rather than the financial insecurity associated with traditional GP training. SEMs have been implemented with success in South Australia and in the Murrumbidgee LHD. In WNSWLHD, the 4Ts (Tullamore, Trundle, Tottenham and Trangie) has been a successful program albeit at a significant cost. Implementation of the SEM in WNSWLHD has seen only a modest uptake of practices as a result of an effective financial impost to hosting practices when junior GP registrars are employed.