Special Commission of Inquiry into Healthcare Funding

Witness Outline

Name: Dr Ai-Vee Chua

Occupation: General Practitioner in Western New South Wales Local Health District

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

A. My Role

2. I have been a general practitioner ('**GP**') in Dubbo, New South Wales since 2002. I first came to the region for a 6-month GP registrar placement and, given the high level of need for GP services in Dubbo, decided to stay.
3. My husband (who is a fellow GP) and I own our own practice, which has 11 other doctors working with us. We also employ 5 practice nurses and administrative staff, and provide rooms for a dietitian and mental health nurse.
4. My roles external to our practice include: Senior Clinical Editor for Western NSW HealthPathways, Western NSW representative on the RACGP NSW/ACT Faculty Council; Northwest NSW representative on the AMA NSW Council; Chair of the Western NSW Primary Health Network's ('**PHN**') Western Clinical Advisory Council.

B. Challenges in Collaboration Across Healthcare Sectors and Between Health Administrators and Clinicians

5. In my experience, the current Commonwealth-State funding system can lead to fragmentation in healthcare, with limited collaboration across our primary and secondary healthcare sectors in health planning and delivery. Within the healthcare sectors there is also inadequate collaboration between healthcare administrators and clinicians; this is particularly evident in the limited engagement with General Practitioners in health needs assessment, and clinical service planning and delivery in Western NSW, despite General Practitioners being well placed to identify gaps and solutions for health services in our local communities.

6. It is not uncommon for Primary Health Networks to erroneously be considered to represent the voice of primary care and General Practitioners and/or to have governance over General Practices. In Western NSW, this has led to a lack of true primary care representation within the Western Health Collaboration and
7. Possible solutions to this include:
    a. Establishment of a General Practitioner advisory council, to assist Western NSW PHN and Western NSW LHD in service planning and evaluation, quality and safety, and other matters that would benefit from local General Practitioner input
    b. Inclusion of General Practitioners in LHD Clinical Councils; an example of this occurs in Hunter New England LHD
8. I think it is important to facilitate strong communication and a willingness to collaborate between local GPs and the LHD, particularly in our smaller towns where GPs may function as the core medical workforce in the local hospital. I believe our LHDs play an important role in retention of GPs in those towns by flexibly working with them to support their needs to ensure they stay in those areas.

C. Challenges with Pilot Project Funding

9. Part of the problem relating to funding relates to how pilot projects are funded. Pilot projects are funded on a short-term basis, for example one to three years. The funding is inclusive of the planning and clinical recruitment phase, leading to limited periods for service implementation and delivery. There is also difficulty in attempting to recruit workforce for these short-term projects, given the lack of income stability and certainty.
10. An example of this is Western NSW LHD's ADHD & Behavioural Management virtual service project, which seeks to address the extended wait times for children with behavioural issues to see a paediatrician for a diagnosis and treatment. The pilot was funded for three years, however given the time required for robust consultation and planning, the actual period of

service delivery will only be around 15 months. There has been significant recruitment challenges, no doubt impacted upon by the nature of short-term funding.

D. Workforce Challenges in Western NSW

11. Ensuring we have sufficient workforce, including GP and non-GP specialist doctors, nurses, pharmacist and allied health professionals in both the community and in hospitals, is a challenge.
12. Within Dubbo, lack of timely access to public services due to insufficient workforce contributes to poorer health outcomes and exacerbates the inequity faced by our vulnerable populations. Examples of this include access to falls prevention programs, specialist outpatient services such as psychiatry, cardiology, paediatrics and chronic pain clinics, and orthopaedic surgery.
13. A possible solution may be to ensure that public outpatient clinics collaborate with GPs to reduce unnecessary utilisation of appointments and to reduce service block to new patients. This would require clarity of referral pathways (as can be provided by Western NSW HealthPathways if adequately funded), and good communication to enable GP coordination of patient care as per specialist advice.
14. At present there appears to be a government focus on expanding the scope of practice of our nursing, pharmacy and paramedic colleagues. However, there has not been Medicare support for maintaining the scope of practice for GPs. This has particularly impacted on GPs and patients in rural areas. For example, MBS item changes in 2020 led to a reduction in rebates for patients having their ECG tests at their GP practice; currently the rebate of $17.25 does not go anyway close to covering the costs of nurse and GP time, and equipment and consumables required to perform this essential service.

15. The high levels of remuneration provided by Local Health Districts for locum services is a financial incentive for doctors to undertake intermittent work as locums rather than as a permanent staff specialist, permanent GP VMO or as a GP in private practice.

E. Training in Western NSW

16. University rural clinical schools need to ensure good exposure (of sufficient length and quality) to rural General Practice. Exposure to hospital medicine alone will bolster the non-GP specialist workforce in our large towns, but will not assist with bolstering the medical workforce in our smaller and more remote towns that are dependent on GPs to provide medical services both in the hospital and community.
17. Western NSW has an ageing GP workforce, with a number of GPs that are at or past the age of retirement. Unable to find other GPs to take their place, these GPs are continuing to work due to concerns that they will leave their communities without medical care once their retire. There is an urgent need for progressing rural GP training at a medical student, junior doctor and GP registrar levels before our experienced GP workforce retires.
18. Although in-person training is best practice, there may be situations where trainees could be supervised remotely. Part of this remote training could be done by rural GPs in other towns.