Special Commission of Inquiry into Healthcare Funding

Statement of Nathan Oates

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1. This statement made by me accurately sets out the evidence that I would be prepared, if necessary, to give to the Special Commission of Inquiry into Healthcare Funding as a witness. The statement is true to the best of my knowledge and belief.

2. This statement is provided in response to letters of 28 June 2024 and 19 July 2024 issued to the Crown Solicitor's Office, and addresses the topics set out in the 28 June 2024 letter relevant to my role.

A. INTRODUCTION

3. My name is Dr Nathan Oates. I am the Director of Prevocational Education and Training at South East Regional Hospital (**SERH**) in Bega, Southern NSW Local Health District (**SNSWLHD**, **the LHD**), a Visiting Medical Officer (**VMO**) Anaesthetist at the Hospital and Lecturer at the Rural Clinical School, ANU School of Medicine and Psychology (**ANU SMP**). A copy of my curriculum vitae is exhibited to this statement (**MOH.0010.0459.0001**).

B. ANU SCHOOL OF MEDICINE AND PSYCHOLOGY

4. The ANU SMP Rural Clinical School has campuses in Bega, Moruya, Cooma, Goulburn, Young, and Cowra. I work in the Bega campus, and intermittently provide teaching for students at each of the other campuses. At Bega I supervise and teach the students rotating through Acute Care (anaesthesia and ICU) throughout the academic year and provide teaching on resuscitation and trauma management during intensive teaching blocks twice a year.

C. PREVOCATIONAL EDUCATION AND TRAINING

5. My role as the Director of Prevocational Education and Training (**DPET**) comprises approximately 1 day per week of work. I commenced in this role in October 2019. In this role, I plan, deliver and evaluate the prevocational training program at SERH, with the

aim of ensuring a high quality and sustainable program that meets the Australian Medical Council's (**AMC**) National Standards for prevocational training. I also seek to ensure that SNSWLHD trainees are meeting their learning objectives, and that the training program is relevant to our local context.

6. SERH has 9 Post Graduate Year (**PGY**) 1 and 2 Junior Medical Officers (**JMO**s) in accredited positions. All of the current PGY 1 and 2 JMO positions rotate from the Australian Capital Territory (**ACT**). Interns are able to remain at SERH for the entire year of their internship, as distinct from a single 3 month duration rotation. The year long program is similar in intent to the NSW Health Rural Preferential Recruitment (RPR) scheme, however as the JMO program is accredited by the ACT (Canberra Region Medical Education Council, **CRMEC**) and staffed through the Canberra Health Services positions are not advertised on the NSW Health recruitment portal, and there are no references to the program on any HETI resources. These are the locations that future junior doctors will look to for information on JMO positions in rural NSW.

7. CRMEC and HETI are the organisations providing support and oversight of the JMO program at SERH. The relationship between SERH and these organisations is complex, with logistical, accreditation, workforce, contractual and financial challenges of a cross-border arrangement with the ACT. There are also substantial benefits to this arrangement which will be outlined below.

8. For the SNSWLHD JMO program, CRMEC plays a similar role to that of HETI for NSW. CRMEC is responsible for accreditation of all JMO terms, ensuring the programs meet AMC requirements. CRMEC also provide networked support for clinical supervisors and the JMO administration team in SNSWLHD. CRMEC are accredited by HETI.

9. The SNSWLHD relationship with HETI in regards to the JMO program is not well defined, but provides a much broader support network than is available through CRMEC. This is invaluable in the DPET role, where the rural context can often feel quite isolated. As a NSW hospital, SERH is invited to participate in the state DPET network meetings. Our JMOs are also eligible to apply for some HETI scholarships, such as the Rural Medical Trainee Scholarship. Several training positions at SERH are funded through HETI, and the John Flynn Prevocational Doctor Program is administered through HETI.

10. The advantages of PGY 1 and PGY 2 JMOs from the ACT include proximity to the ACT, that the Canberra Hospital is the tertiary referral hospital for the Coastal Network of

SNSWLHD, and the relationship of the LHD with the ANU SMP and the continuity this provides with rotational JMOs from the ACT.

11. Logistical challenges of this arrangement include ongoing issues with JMO positions at SERH and other sites in the LHD not being filled, and that the rotational program is different to NSW (ACT has a 4-term year, whereas NSW has a 5-term year).

12. The JMO workforce at SERH is not yet sufficient for the current role delineation and work profile of the hospital. Gaps in the JMO workforce exist in obstetrics/gynaecology, intensive care, emergency department (**ED**), and psychiatry. A Rural Acute Care Senior Resident Medical Officer (**SRMO**) program that has recently been approved includes positions for all of these departments with the exception of psychiatry. This program has been made possible through the John Flynn Prevocational Doctor Program and is in the process of recruitment for the 2025 training year. This is discussed further below.

John Flynn Prevocational Doctor Program

13. The John Flynn Prevocational Doctor Program (**John Flynn Program**) is a Commonwealth funded training program for PGY3 doctors and above. It was introduced to fund rural primary care rotations for hospital-based doctors in rural areas.

14. SERH currently hosts 2 positions funded by the John Flynn Program. These intern positions are based in local General Practices, and spend one day per week with the medical teams in SERH. Interns from the ACT rotate through these positions, with 4 rotations per year allowing 8 JMOs annually to gain experience working in general practice within a rural setting.

15. Feedback from JMOs on this program has been excellent and was presented as a report last year by a CRMEC representative to the Confederation of Postgraduate Medical Education Council Prevocational Forum. For SERH, the funding of these programs also contributes to the JMO program more widely, and is a positive influence on the training culture within the Bega Valley.

16. A further 6 positions funded by the John Flynn Program have been approved by SNSWLHD executive, as part of a Rural Acute Care SRMO program scheduled to start in the 2025 training year. These positions will be accompanied by a further 6 SRMO positions that are currently filled on an ongoing basis by locums. The Acute Care SRMO program gives PGY 3-5 JMOs four rotations during the course of the year, with a program designed to meet workforce need in obstetrics/gynaecology, ED, and ICU; creates an

attractive job proposition with excellent training opportunity; and promotes rural general practice and rural generalist pathways.

17. For the Acute Care SRMO program, the John Flynn Program funding has enabled rotations in anaesthetics that are supernumerary to the hospital medical establishment. Anaesthetic rotations are the most sought-after rotation in critical care, and the inclusion of these rotations is a significant drawcard to the program and will likely be instrumental in recruitment.

D. ANAESTHETIST WORKFORCE AT THE HOSPITAL

18. I have been working at SERH as a VMO anaesthetist for 8 years, and work in the clinical role 3 days per week. From December 2018 to mid 2020, I was the Local Anaesthetic Coordinator, following the departure of the Director of Anaesthetics at the time. During that time I maintained the department roster, organised and oriented locums in conjunction with medical workforce, escalated issues, and was involved in organising perioperative processes in SERH.

19. All anaesthetists in SERH are on VMO contracts. These contracts are better suited to the rural environment than the existing NSW Health Staff Specialist contracts. Staff Specialist contracts do not take into account and pay for the burden of on-call in rural hospitals, nor account for the lack of registrars and other features of the Staff Specialist contracts that are available to doctors working in larger centres but rarely to those in the country. VMO contracts allow for a sufficient number of staff for the on-call requirements, and for a reasonable employment arrangement for those staff. At SERH we have 8 anaesthetists, some of which only work one day per week, but all of whom contribute approximately one day per week to the on-call roster. The on-call roster would be unreasonable in our context with if we had 8 Staff Specialists on fractional appointments as those working a single day in anaesthetics each week would be required to do an on-call shift for every clinical shift worked in order to cover the roster. Under the Staff Specialist determination, they would not be given an additional pay loading for this, despite effectively doing a 1:1 on call ratio. The Staff Specialist award requires ‘reasonable’ on-call duties, but does not specify what this constitutes. Other jurisdictions (such as the ACT) specify pro-rata on call for fractional appointments, and time off in lieu (**TOIL**) for onerous hours. Although this is approach is more fair, a pro-rata and TOIL arrangement in a small team, with 7 days of on-call to cover each week is also not workable for sustaining a service, or for an appealing job prospect. The VMO contract pays an on-call rate, and pays for recalls. This makes a weekly day on-call a reasonable

prospect for those of the team that are only working a single day in anaesthetics each week.

20. There are a total of 5 specialist anaesthetists, 3 General Practitioner (**GP**) anaesthetists and a GP anaesthetic registrar which comprise the anaesthetics workforce at SERH. This is insufficient to meet the current workforce requirements of SERH as every member of the anaesthetic workforce works part-time in anaesthetics. The anaesthetists at SERH are involved in a wide variety of roles in other health services including general practice, pain medicine, Aboriginal and Torres Strait Islander Health, motorsport medicine, clinical teaching and academic appointments. These additional roles contribute to the attractiveness and viability of working in the country, by providing variety and the opportunity for special interest. At present, SERH usually requires 1 locum anaesthetist to maintain clinical services. The Director of Anaesthetics lives in the United Kingdom and spends approximately 6-10 weeks each year in Australia. Although this arrangement is different to most hospitals, it has been invaluable to SNSWLHD.

21. SERH is likely to have an increased workforce shortage in coming years. It is likely that 3-4 out of our 8 anaesthetists will retire or move away in the next 3-4 years. We have advertised for specialist anaesthetists for 4 years without successful recruitment, and have had many instances where clinical services are unable to be delivered as planned because of insufficient anaesthetic staff. Reason for lack of interest of specialists in working in hospitals such as SERH that have been given include less variety of work available in the country, lack of private work opportunities, burden of on-call, lack of on-site registrar, and other factors related to living in the country such as work for their partner and available schools.

22. There is a regional need for increased surgical and therefore anaesthetic services, demonstrated by the number of patients leaving SNSWLHD to have procedures in the ACT and southern Sydney region. SERH has the capability to do far more surgical work than it is currently doing, within its role delineation. Examples include general surgery, orthopaedics, urology, ear nose and throat, and gynaecology surgical services. For example, although we have 3 colorectal surgeons working in SERH, a substantial volume of colorectal surgical work from the region is still going to the ACT and to Sydney. The urology service provided is helpful, but there is data from 2021 that this meets just over 30% of the community demand. In SERH, the urology service only functions when the surgeon is in town every fortnight. In order to accommodate the additional workload, SERH would need to have additional ward capability and operating theatre time. If additional surgical services were offered at SERH it would be a more attractive workplace

for specialist staff, and contribute to a sustainable workforce model for anaesthesia and surgical services. The primary barrier that is cited is funding for these services.

23. SERH is accredited with the Australian and New Zealand College of Anaesthetists for 3-month rotations, however we currently lack the funding for these trainees. The one GP anaesthetic registrar in the team is funded through HETI, and although we can continue to take registrars in this space, we do not always have jobs available for them at the end of their training.

24. SERH recently applied for Specialist Training Program Funding from the Commonwealth government in order to address these challenges and take on specialist trainees.

E. WORKFORCE CHALLENGES AND OPPORTUNITIES

25. Similar to other rural areas, attracting and retaining a quality medical workforce is very challenging at SERH. The resultant use of locums for key workforce positions is very expensive, and leads to pressure to cut other essential health services.

26. Strategies to recruit and retain a quality medical workforce need to be long term and take into consideration the formative and pivotal experiences that influence individual decisions about career direction and workplace location. There is a growing body of evidence for improving rural and regional workforce across the following areas: medical school exposure, prevocational and vocational training opportunities, and sustainable workforce models. SERH is working toward addressing each of these. High quality training is an essential part of providing a positive experience for medical students and prevocational doctors in the country. Simulation based education is an expected part of a high-quality training program.

(i) Training and Education

27. The ANU SMP runs a week-long rural immersion program in the Bega Valley for first and second year medical students. The aim of each of these programs is to provide a memorable experience and introduce students to aspects of work and life as a medical practitioner in the country. As part of the first year rural immersion program, students spend one day involved in an emergency services showcase. This day is run in conjunction with local emergency services – NSW Ambulance, the Rural Fire Service, State Emergency Service, Volunteer Rescue Association. A traumatic incident, such as a road traffic accident, is simulated and this is linked to the Simulation Centre. The rural

immersion programme for second year students also includes a day with simulation, with a paediatric theme.

28. At this stage, it is difficult to quantify the impact of the one week rural immersion program and research is currently being undertaken. I have observed and gathered anecdotally that it has encouraged more medical students to want to come to Bega to do their student placement and consider it to be an important point of contact for students who will return on placement in their third year.

29. The ANU SMP also offers 12 students a year-long placement in Bega through the Rural Clinical School. There are further opportunities for short placements in fourth year, including the Acute Care program that I supervise. Many students have provided strongly positive feedback on the times spent in Bega, and a substantial number have returned for PGY 1 and 2 terms after graduating from medical school. The Simulation Centre at SERH enables simulation of a wide variety of clinical situations, including some of the high stakes situations that occur infrequently, in a safe learning environment. It is a key part of training at the Hospital and is particularly useful for interprofessional training (across different disciplines and professions within a hospital). The Simulation Centre is an innovative way to deliver quality teaching to junior medical staff and other junior staff. It provides educational benefits to doctors who are early in their careers and the ability for them to evaluate their performance after a training event. Funding the Commonwealth was received by the ANU SMP for the construction of the Simulation Centre in 2020. There is no ongoing funding available for the ongoing running of the simulation centre, which substantially reduces the opportunity to use this facility to its potential.

(ii) Models of care

30. Team structures and models of care in the country are crucial to the success and failure of recruitment and retention of medical staff. My view of this has been influenced by a number of factors, including from the perspective of senior doctors that have left our LHD, from my role in the anaesthetic department at SERH, from my roles on committees in the LHD, and through working on a workforce project whilst participating in the Leading for Innovation program through NSW Health. A number of years ago there was no process in place for following up after senior doctors resigned. As deputy chair of our Medical Staff Council, I was tasked with speaking with each specialist that had left SERH. Common themes from these staff included rostering (including on-call), professional support (the size of the team), job variety, and access to specialty-specific aspects of their job (for example, clinics). These conversations led me to form the view that there

are specific factors that determine the attractiveness and sustainability of medical jobs in the country.

31. For each team, the specific details of what constitutes an attractive and sustainable job is different. On-call arrangements provide a good example of this. Factors contributing to on-call burden include frequency of on-call, clinical workload, and the JMO staffing of the team. A position that has frequent on-call periods, with a high clinical workload and no registrar or ward JMO, will not be a sustainable job. When I first started at SERH in 2016, as an anaesthetist I would also cover our ICU overnight. We did not have any junior medical staff in the ICU. I was on-call every 4-5 days, and would regularly be required to stay back until 2am and was rostered to start again at 07:30am. This was unsustainable. We now have a registrar overnight in ICU, and are on-call once every 7 days. With our current workload, this is now sustainable. However, in order to have a one in 7 day on-call, we need 8 anaesthetists employed to work at SERH. The design of the team, workload, and contracts needs to take into account the number of staff needed to maintain on-call rostering.

32. Contracts are also very important. NSW Health Staff Specialist contracts are designed around a metropolitan environment, and for a number of reasons do not function well in the country. Factors include the on-call burden in the country, influenced by the frequency, intensity, and presence or absence of registrar staff on the team. In a previous work location Staff Specialists in a tertiary hospital were on-call about once every 3-4 weeks, with a registrar covering as first on-call. In SERH it is usually about 4 times as frequent, without a registrar. The Staff Specialist award does not give any additional allowance for the difference in on-call burden, and a prospective employee will take this into account with decisions on work location. Other aspects of Staff Specialist contracts such as non-clinical time, access to secretarial support, TESL (training, education and study leave) are not available in the rural environment as they may be in a metropolitan centre.

33. In my view, another opportunity for change in models of care is related to the role of Rural Generalists. Regional environments should incorporate and cultivate the skills of Rural Generalists more broadly in the hospital context. This would require substantial work on strategies for Level 4 facilities to provide the required level of service and run an on-call roster with a mixed staffing model, incorporating Rural Generalists. This approach currently functions within the Emergency Department and Anaesthesia Department, but needs to be addressed in the ICU, paediatrics, general medicine and some of the surgical specialties.

(iii) Funding

34. The way that SERH is funded does not match the need for services, and there seems to be little to no ability for the system to accommodate to the changes required for the hospital to achieve the Level 4 status intended when the hospital was opened in 2016. The activity based funding (ABF) often seems to be directly or indirectly responsible for this. In some circumstances, the required services are not going to achieve the level of activity required for sustainable funding, or are unable to leverage the economies of scale available to a larger hospital to achieve this. Obstetric services are a good example of this. Approximately 260 babies were delivered in SERH last year, which does not make full use of the maternity ward on almost any given day. Despite this, the service must have a certain level of medical and nursing staffing and will therefore be very expensive to run when viewed through an activity-based lens. The service is geographically essential, and for the foreseeable future will never appear to run efficiently.

35. When services such as obstetrics are expensive through an ABF model, there are consequences for development of other services in which there is substantial community need. Examples of community need for surgical services have been given above, and there are other examples in the medical specialties that could be given. The medical staff at SERH are informed that there will be no consideration of any new services, or expansion to existing services until the ABF targets for the hospital and the LHD are met. This is an unachievable task for services such as obstetrics, and has been an obstacle to development of services that are needed by the rural community, and creating the sustainable staffing models in SERH that will contribute to a sustainable medical workforce.

Nathan Oates

Witness: Lauren Celle

8/08/24

Date

8/8/24

Date