Special Commission of Inquiry into Healthcare Funding

Statement of Professor Jennifer May

Name: Professor Jennifer May

Occupation: Director of the University of Newcastle of Rural Health

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.

3. I am the Director of the University of Newcastle Department of Rural Health. As part of this role, I oversee the Rural Health Multidisciplinary Training Program in Northwestern New South Wales, the Tablelands and on the North Coast. I have held this position since August 2016.

4. I am also the Betty Fyffe Chair of Rural Health. I have held this position since 2018**.**

5. I am currently a General Practitioner **(GP)** and have been engaged with a local not-for-profit GP Practice, Peel Health Care, since 2004.

A. Workforce challenges in rural and regional New South Wales

6. In the last 20 years, the General Practitioner workforce in New South Wales, particularly in rural areas, has been decreasing. This is evident in the increased GP wait times indicated by the Australian Bureau of Statistics (ABS). Annexed hereto and marked **"A"** is an extract from the ABS detailing GP waiting times in 2022-23 financial year. Further, reports of lack of access from patients and experience locally of having reduced numbers of GP registrars on the training program in New England North West. Further, Australian General Practice Training (AGPT) registrar numbers fell between 2017 and 2020 but are now increasing. Annexed hereto and marked **"B"** is a copy of the Royal Australian College of General Practitioner's 'General Practice Health of Nation 2023' which reflects those numbers.

7. At the same time, there has been an increase in the number of doctors pursuing specialist training in other, non-general practitioner specialties.

8. An example of the impact of the reduction in the medical workforce in rural areas can be seen in Moree over the last 20 years. In 2005, Moree had 17 resident doctors, 16 of whom were appointed as Visiting Medical Officers (VMOs) to work at Moree Hospital. Of those 16 clinicians, there were seven GP obstetricians, five GP anaesthetists and three GP surgeons. These clinicians were also responsible for covering a 24-hour on-call emergency department roster.

9. Currently, Moree has ten resident doctors, including six VMOs appointed to work at Moree Hospital. Of those six clinicians who are VMOs, there is one GP obstetrician, one GP anaesthetist and two GP surgeons. As such, Moree Hospital is heavily reliant on locum clinicians to fill vacancies and maintain rosters. This has also impacted services as these clinicians are responsible for covering a 12-hour on-call emergency department roster. In order to meet the clinical requirement, there is an increasing reliance on locum with a significant increase in cost.

10. There are some practical barriers to certain specialist clinicians practising in rural and regional parts of New South Wales. For example, many non-general practitioner specialties cannot readily practice outside larger regional centres as they require access to appropriate infrastructure and allied health and nursing expertise to deliver care and to work at a full scope of practice. For example, an ophthalmologist cannot practice to full scope or practice without access to a hospital to provide surgical services and without significant infrastructure to diagnose and treat patients. They can and do, however, work in a hub and spoke model where they can provide services within a catchment if supported to do so. Depending on specialty, the spoke activities include consultations and some procedural work using district hospitals and GP anaesthetics. For example, cataract lists occur in Moree hospital and endoscopy and general surgical lists in Gunnedah.

11. It is well recognised that attracting and retaining clinicians is particularly difficult in rural and regional areas in New South Wales. The reasons for this are multifaceted and include professional, social and locational factors. Professional factors include possible remuneration, expected scope of practice, anticipated work hours including on-call and professional isolation. Social factors relate to proximity to family, cultural and community connection, opportunities for partner employment and expectations of education and family

lifestyle. Locational factors encompass both physical amenities, proximity to capital city (cultural opportunities) and rural lifestyle. In rural and remote locations there is often a high-level of visibility for health care professionals and their families. This is a double-edged sword being important for connection but problematic if some anonymity and personal boundaries are preferred. Those factors can make recruitment and retention of clinicians in those areas challenging. Individual practitioners who have choice in where they may practice, will weigh up these factors differently depending on their own lens, their life stage and whether they are under obligation to go to rural areas, such as International medical graduates on the moratorium.

12. In my view, the current health workforce, particularly the General Practitioner workforce, is challenged to meet the needs of the New South Wales population having regard to current distribution patterns, population growth and increasing service demand related to an aging population. This is particularly the case in rural and regional areas where the scope of practice is higher. For example, Moree's ten resident clinicians cannot, in my view, effectively continue to provide health services to a population of around 7,000 where the current care required involves the delivery of specialist procedural services like anaesthetics and obstetrics, emergency care and office based general practice care.

13. Health workforce shortages in hospitals such as Moree also lead to an increase in financial costs to provide medical services and locum services that are episodic can impact on the effectiveness and efficiency of service delivery. Time taken for orientation and travel and lack of continuity mean that locums may not take the same load as resident clinicians.

B. Potential solutions to workforce challenges

Recruitment and retention initiatives

14. There is evidence that clinicians who have a historical connection with regional areas, such as growing up in such a region and having a childhood or family connection to it, are often attracted to returning to those areas to practice. Other clinicians who elect to practice in rural and regional areas have often had previous positive experiences in those areas during training or other work opportunities. The Rural Health Multidisciplinary programme which commenced in the early 2000s has provided significant evidence about the impact of rural origin and positive rural exposure on recruitment of Australian trained medical graduates.

Annexed hereto and marked **"C"** is an article titled 'The pathway to more rural doctors: the role of universities' which summarises the role of universities in rural training.

15. In my view, exposing doctors to rural practice during training and for longer periods is one measure that may complement "grown your own" initiatives. Although there are a number of barriers to the expansion of regional training, including the preference of trainees to remain in urban locations and challenges with supervision, recruiting and supporting trainee registrars to work in rural, regional and remote areas in NSW would give them exposure to rural health services and may assist in permanently attracting and retaining clinicians in such areas. Opportunities such as this have shown benefits in recruitment and retention of staff in regional areas. Expanding regional training opportunities also has the long-term payoff of increasing critical mass and longer-term retention. Enhancing positions with opportunities for teaching and research has been shown to be moderately effective through the rural clinical school programme. The distributional challenge within our medical workforce is not being solved by current policy settings.

16. To support the system, training needs to occur outside of acute hospitals to ensure that we are training the whole workforce we need. Further, access to specialist training with quarantined places in non-metropolitan locations has merit. In those positions, trainees who are based rurally, they "in-reach" into metropolitan hospitals for those aspects of their training requirements that cannot be met in a rural location, rather than trainees being based in metropolitan locations for the majority of their training which is currently commonly the case. Some Commonwealth policy settings have offered this model through the provision of funded specialist training positions (STP funding).

17. Further, there have been recent positive gains in attracting doctors to general practices which can be seen with the development of a new "rural generalist" pathway. The rural generalist pathway is awaiting Australian Medical Council endorsement as a "specialist qualification". The Commonwealth is working with the jurisdiction to support rural generalist training. There is early evidence of an increased subscription to this programme.

The National Medical Workforce Strategy

18. In seeking to develop a health workforce that delivers efficient, equitable, and effective healthcare to the people of New South Wales over the long term, I believe that the National Medical Workforce Strategy 2021-2031 **(the National Medical Workforce Strategy)** should

be supported and many of the actions implemented. Annexed hereto and marked **"D"** is a copy of the National Medical Workforce Strategy.

19. The National Medical Workforce Strategy has five thematic areas and three cross-cutting themes. Collaboration between the stakeholders in training, recruiting and retaining the health workforce (including the Commonwealth and state and territory governments, universities, training institutions and specialist medical colleges) is a necessary part of implementing any workforce blueprint.

20. Importantly the themes that emerge from the National Medical Workforce Strategy are:
    i. Collaborating on planning and design;
    ii. Rebalancing supply and distribution;
    iii. Reforming training pathways;
    iv. Building the generalist capacity of the workforce; and
    v. Building a flexible and responsive workforce.

21. These themes also recognise the need to consider the importance of building the Aboriginal and Torres Strait Islander medical workforce and improving cultural safety, adapting to, and better supporting new models of care and improving doctor wellbeing in implementation of the five thematic areas.

Engagement of the medical workforce in regional locations

22. In my view, the engagement and deployment of the medical workforce in regional locations should be approached flexibly depending on the needs of the particular location. For example, contracts with clinicians could include both staff specialist salaried appointments and VMO contract options. Clinicians have different appetites for appointments which may depend on their own personal circumstances and life stage. The capacity to work in private practice for individual clinicians is likely in the health systems interests if the clinician is able to provide on-call or other supports to the public system.

23. VMO contracts can benefit the community as providers who choose this type of employment and who often also provide services in the private sector. The loss of viable private hospitals in regional settings will be deleterious to the health system as a whole and would significantly increase the demand on the public system. The private hospital system can also

provide operating times for procedural clinicians without the challenge of providing emergency services.

24. Further, in my view, there needs to be an increased focus on workforce planning to manage and incentivise the distribution of the health workforce to ensure local levels of services in rural areas. Whilst forward planning based on future predictions cannot be absolutely precise, the levels of workforce need can be predicted with a reasonable degree of certainty. For example, we do have an understanding of what reasonable after-hours and on-call obligations for consultant clinicians looks like.

25. For example, in rural and regional areas, GP and non-GP consultants are more likely to be called in due to the reduced amount of registrar cover (if any) and the likelihood that the trainees may be less experienced. Working more than a one in every four days load on call, and for antisocial hours, is a challenge. This service requirement is often articulated as a reason for clinicians choosing not to work in regional areas where workforce shortage is present. When clinicians are nearing the age of retirement or indicating a reduction in participation in on-call rosters, in my view it would be prudent to seek to engage replacements at an early stage, rather than waiting until the vacancy arises. It is my belief that adopting this approach, where suitable candidates are employed when available, would reduce the long-term need for locum cover and provide opportunities to enhance service delivery. Where gaps in the roster must be filled, there is further pressure on resident clinicians and the need to employ locums. Both of these solutions may reduce attractiveness and make it more challenging to fill the long-term positions. That is particularly the case in relation to the regional centre GP non-specialist workforce, but also in rural locations where GPs providing procedural care like obstetrics and anaesthetics are a key part of the workforce. In my view, there needs to be an increased focus on longer-term succession planning.

International Medical Graduates

26. As part of the International Medical Graduates **(IMGs)** pathway, IMGs can be required to undertake work in rural locations. The challenge is that supervision or supernumerary work is required to support IMGs, rather than an immediate reliance on a workforce that does not have a strong understanding of cultural and geographic context. There are programmes as I understand in New Zealand where IMGs spend time orientating (6 months) to the work they are expected to do, which allows them to take on tasks in a graded way.

27. Obligatory strategies, such as issuing provider numbers to restricted locations or the current moratorium which impacts IMGs, whilst effective for the period of the obligation, are less effective than using attraction incentives in the long term.

D. Funding issues

Block funding

28. The Commonwealth Government provides block funding to each Local Health District **(LHD)** (and the equivalents in other states) for a number of different activities. This block funding is in addition to ABF funding, and is available for a range of services, including small rural hospitals, mental health services, highly specialised therapies as well as teaching, training and research. The allocations are publicly available in the Funding Reports produced by the National Health Funding Body. Annexed hereto and marked **"E"** are extracts from the National Health Reform public hospital funding National Report – July 2024.

29. In my view, there is a lack of transparency about how these important funds are utilised and the allocation that is apportioned to rural and regional settings. In Hunter New England, an LHD that spans urban, regional and rural locations, the allocation was $61.936 million in 2023-24. Greater transparency over the funding support of front-line clinicians would increase the confidence of rural communities.

Primary care

30. There is a clear need to support rural general practice and primary care in order to reduce the unnecessary usage of acute facilities. Recent collaborations around urgent care would appear useful in this shared approach. The opportunity to collaborate between the acute system and the community or commonwealth funded system allows consideration and identification of shared responsibility and opportunities for overall system integration.

31. In my view, there is scope for LHDs to support access to primary care, including GP services to a greater degree, including in rural and regional locations.

32. Extending work locations to have LHD-employed clinicians routinely attend community, aged care and primary care settings or work out of GP surgeries, is worthy of ongoing secure funding. If the viability of general practice activity falls further, LHDs will be challenged to

offset the demand on acute facilities. New data projects linking up acute hospital activity would benefit from interoperative extension to GP and aged care settings. Annexed hereto and marked **"F"** is an extract from a Lumos PowerPoint presentation which demonstrates that Lumos is requesting GP involvement in data sharing projects currently. Support for aged care will have the positive effect of reducing pressure on acute beds.

33. LHDs are impacted by the lack of prevention and GP services in smaller towns. In small rural towns the impact of a lack of prevention services operated through general practice has an impact on avoidable hospitalisations. Annexed hereto and marked **"G"** is an extract from the Australian Institute of Health and Welfare 'Rural and remote health' which demonstrates that the outer regions have 1.1 and 1.2 times the number of avoidable hospitalisations.

34. Salaried roles for GPs within LHDs in locations where there is not a viable local market for private general practice may assist in attracting general practitioners to those reasons, with the benefit of providing accessible primary care. In pursing such a model, salaried GPs could be included within the Staff Specialist award model.

35. In my view, this would also ensure greater attraction for Rural Generalists as there would be the continuity of employment within the LHD. Permanent secure funding that changes the status and career prospects of GPs, such as that afforded to staff specialists, also provides an option for those practitioners not having to become small business owners in order to enter practice in rural or regional locations, including not having to employ staff and needing to be compliant with the myriad of accreditation requirements associated with private general practice.

Service and workforce planning

36. Most LHDs are facing population pressure (an aging population) and changing consumer expectations and expanding health horizons. For example, whereas strokes were previously treated in stroke units, access to clot retrieval within a few hours is not increasing, despite now being viewed as best practice care. The challenge to deliver such a service is that it will require the expansion of retrieval services, tertiary capacity and frontline triage and diagnostic services.

37. I am aware that 1 in 5 medical graduates have not completed vocational training 13 years after they graduated. This group of medical graduates could be considered as part of the solution to some of our medical workforce gaps. Currently, many of them are in locum positions or waiting for training opportunities of their choice. A well-supported regional training programme targeted to those graduates may attract some of them to a rural generalist pathway.

Signature:

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Date: 27.8.24