New South Wales

# Special Commission of Inquiry into Healthcare Funding

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**Name:** Department of Rural Health, University of Newcastle

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**DEPARTMENT OF RURAL HEALTH**

THE UNIVERSITY OF NEWCASTLE AUSTRALIA

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Special Commission of Inquiry into Healthcare Funding
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To Whom It May Concern

Thank you for the opportunity to provide a submission in response to the inquiry into health funding.

I write as the Director of the University of Newcastle Dept of Rural Health, supporting the Commonwealth funded Rural Health Multidisciplinary Training Programme (RHMT). This programme has a solid evidence base in supporting students and health professionals to aspire to and remain in rural areas where appropriate. The area we support incorporates the Upper Hunter, New England region and the lower and mid North Coast. With six larger sites with accommodation and teaching support, the programme continues to try and consolidate workforce initiatives and works in collaboration with Local Health Districts (LHD) to ensure as much synergy as possible.

I am based in Tamworth. I remain a practising GP and GPVMO at Tamworth Hospital and have been fortunate to have opportunity to further academic studies and have written on health workforce policy both generally and specifically pertaining to the rural context.

As such the main key areas that align to our expertise relate to important trends in workforce scope and distribution, with matters including funding and service models to ensure equitable access to both primary and specialist medical services to the people of NSW. This may be useful for the committee to consider to what extent the current processes and policies will be sufficient to meet the ongoing challenge.

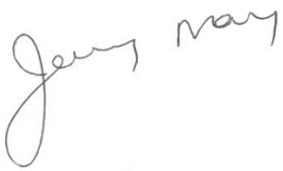
Important for the committee to consider is; *To what extent does the current structure of NSW Health align with its current and future remit to deliver health care in NSW?*

Clearly the roles of planning, delivering, and funding for service delivery differs with geographic location but has the commonality and important overall state systems approaches that support the important work.

With a workforce lens there could be an argument that where different models of care are required, health services or LHD units or networks should be of differing sizes and more locally distinct. Again, with a workforce lens, the responsibility for training and maintaining that workforce with key skills (allied health, medical and nursing) depending on location and population size should be based on the best scaled organisational unit in order to deliver that, understands economy of scale, career trajectory and sustainable service and planning

I have chosen to respond to points A, F, G and H which are attached.

Yours sincerely



**Professor Jennifer May AM PhD FRACGP FACCRM**
Betty Fyffe Chair of Rural Health and Director
University of Newcastle Department of Rural Health
[redacted]

***A. The funding of health services provided in NSW and how the funding can most effectively support the safe delivery of high quality, timely, equitable and accessible patient-centred care, and health services to the people of NSW, now and into the future.***

The first observation is that the quantum of funding spent on health funding will need to increase. Internationally the proportion of GDP spent on health continues to climb with expectation of the need for ongoing rapid growth rates in funding at all levels within the health system. [Health expenditure and financing (oecd.org)]

The proportion of the increase in spend that should be borne by Commonwealth and state is clearly core to this discussion. The enclosed figure simply demonstrates the complexity of funding sources. Whilst the diagram is old (2013-4) the extent to which NSW Health needs to invest upstream from hospitals is clear if it needs to control demand for hospital services.

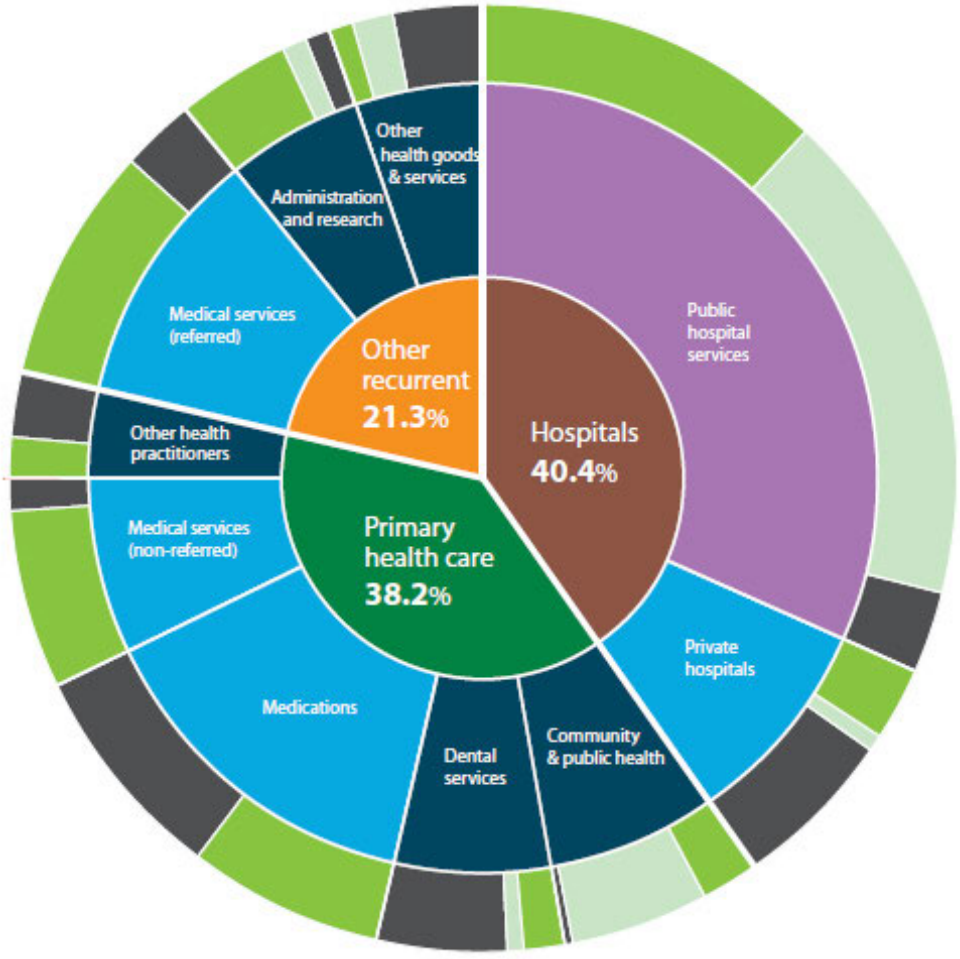


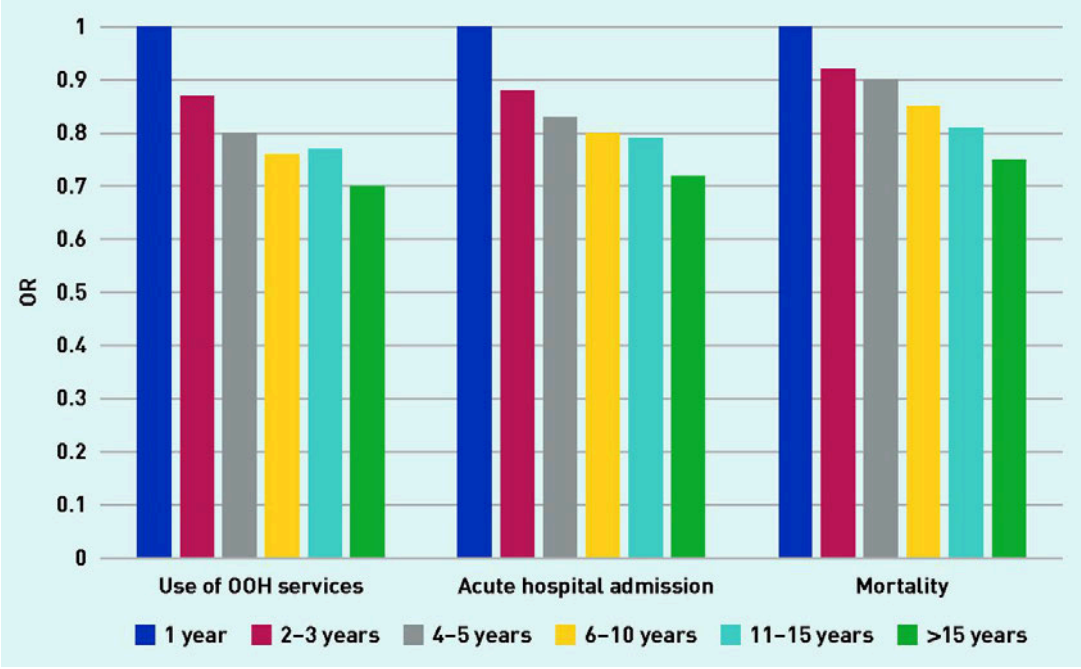
**Figure 1 Health services—funding and responsibility, 2013–14**

https://www.aihw.gov.au/reports/australias-health/australias-health-2016/contents/health-system

The concept of rationing of services and prioritisation of funding further towards prevention, early diagnosis or rapidly increasing treatment options will need to be debated at length. As can be seen from Figure 2 usage can be controlled with effective general practice and prevention services. What is also clear is that the impact of the absence of those services will not be seen immediately but there is a significant time lag from the withdrawal of prevention and early diagnostic services to the impact on hospitalisations and increasing cost of care.

The current environment is characterised by reducing levels of service to socioeconomically and geographically disadvantaged group. Access reduction can be seen in the form of large copayments for some services, and the lack of appropriate and local primary care services that, in the past have had proven prevention and cost benefit. A recent Norwegian article demonstrates the synergistic effect of relational continuity on mortality with evidence of a causal relationship. As will be discussed in Section F, the maintenance of this ongoing model of general practice is absolutely in the interests of many health service that will need to absorb the downstream increase in services required. Multiple strategies will need to be employed if the cost base of health is to be kept to less than 10% of GDP. ae3016b9-en.pdf (oecd-ilibrary.org)

**Figure 2 Associations between continuity measured as years with the same GP and odd for use of out of hours care, hospital admissions and mortality during 2018**




Continuity in general practice as predictor of mortality, acute hospitalisation, and use of out-of-hours care: a registry-based observational study in Norway. Hogne Sandvik, Øystein Hetlevik, Jesper Blinkenberg and Steinar Hunskaar British Journal of General Practice 2022; 72 (715): e84-e90. Continuity in general practice as predictor of mortality, acute hospitalisation, and use of out-of-hours care: a registry-based observational study in Norway | British Journal of General Practice (bjgp.org)

***B. The existing governance and accountability structure of NSW Health***

There is no doubt that attention to governance and accountability within government should be a high priority. Clinician engagement has often been highlighted as key to ensuring productive and safe care within our health system and yet it seems it has been hard to achieve. The Garling report and the more recent NSW Rural Health enquiry were both signposting the importance of a clinical culture and a safe workplace environment characterised by respectful communication and shared vision. More recent workplace health and safety legislation has highlighted the need for culture and capacity to be reasonable and negotiated. This will promote new discussions on what is "reasonable" in an environment where some staff are regularly working 60 - 80 hour weeks in both clinical and non-clinical roles. The need for clarity around roles and responsibilities and clear well documented escalation strategies remain key to whatever structures are most fit for purpose.

Importantly, financial transparency and accountability are highly prized by both communities and stakeholders and should be considered.

One of the clear challenges inherent in our current governance and accountability structures is rural classification. Commonwealth programmes use Modified Monash for health workforce distribution.

https://www.health.gov.au/topics/rural-health-workforce/classifications/mmm

As I understand it, NSW Health uses LGA's, hospital classifications, LHD and PHN boundaries and sectors. For clinical service planning and workforce mapping the "Heads Up Tool" developed by the Commonwealth is very helpful at delineating GP catchments and is searchable by MM.MM is also used for the allocation of Distribution Priority areas and delineates places where bonded students and others under Commonwealth workforce programmes may practice's adoption of MM in addition for rural workforce mapping may better reflect the supply of health practitioners.

Demand modelling however is still an inexact science with multiple indicators required to identify community need. The following table identifies the useful linkages that can be utilised to training and funding.

***Thinking about Workforce characteristics by MM -JM 2022***

| | Type of Funding Model | | Training opportunities |
|---|---|---|---|
| MM1 (capital cities) | Standalone discrete primary and secondary care services | Market based funding models- MBS funded general practice/Chronic care allied health/NDIS<br>Self/PHI/State funding for hospital services(ABF) | Unlimited for all professions and specialities |
| MM2<br>Sometimes labelled large regional | Standalone discrete primary and secondary care services | Market based funding models- MBS funded general practice/Chronic care allied health/NDIS<br>Self/PHI/State funding for hospital services(ABF) | Training for most professions – with focus on clinical placements some models may be hub and spoke |
| MM3<br>Often Labelled regional | Combination of discrete private primary and secondary services supplemented with state funded/NGO ACCHS models | MBS funded general practice.<br>24/7 specialist services and allied health services available through state hospitals (ABF Hospital) supplemented with block funding<br>Private FFS models for community care | Training for most professions with focus on clinical placements–some models may be hub and spoke. Generalist training and practice highly relevant here |
| MM4<br>Considered rural | Acute care beds and ED<br>Co-located state-run allied health services/ACCHOs | Block funded specialist services (FIFO or hub and spoke)<br>GP VMO or salaried model with on call rosters for ED and procedural specialties<br>Scattered private FFS Allied health with some block funded allied health services | Some training options usually allied to more metropolitan programme<br>EN/AIN training in place |
| MM5<br>Considered rural | Acute care beds and ED<br>Co located state run allied health services/Some ACCHOs | Block funded specialist services (FIFO or hub and spoke)<br>GP VMO or salaried model with on call rosters for ED and procedural specialties (Hospital non-ABF?)<br>Scattered private FFS Allied health with some block funded allied health services | Some training options usually allied to more metropolitan programme<br>EN/AIN training in place |
| MM6-considered remote | NGO /State owned infrastructure | Salaried models with MBS cash out/supplement or RFDS | Clinical placements as part of hub and spoke training |
| MM7<br>Considered very remote | State owned infrastructure with fly in fly out service provision | Salaried models including for outreach services like RFDS | Clinical placements as part of hub and spoke training |

***F. The current capacity and capability of the NSW Health workforce to meet the current needs of patients and staff, and its sustainability to meet future demands and deliver efficient, equitable and effective health services:***

***G. Current education and training programs for specialist clinicians and their sustainability to meet future needs***

Importantly these questions should address not only current workforce need but the planning and vision in place to manage the future.

### *Implementation of Recommendations from the National Medical Workforce Strategy (NMWS) and the National Nursing Strategy*

- NSW is in a prime position to lead and work with other stakeholders to realign medical training and ensure its future focused. The Health Workforce Taskforce has taken up many of the specific topics however an implementation plan in complement with the Commonwealth would identify key projects and act as a blueprint for change with the similar approaches to then be adopted by the nursing strategy.

### *Maldistribution of the medical workforce linked to:*

- Reappraising where training positions are allocated to locate training positions in rural areas wherever possible requires combined and sustained work between employer led training networks and college accreditation and support functions. At present there is significant difference. Figure 1 is taken from a review paper by Mathew McGrail and demonstrates the variety of specialist college approaches to selection in 2021 .A streamlined and targeted approach to selection, accreditation and support could be considered by NSW Health in conjunction with the specialist colleges.

- Historically metro centric College training pathways have supported training positions. Positive rural exposure and incumbency remain the best predictors of rural return and are variably reflected in college and employer selection and appointments.

- There remains a status problem with generalsim and currently there is predictive intent with medical student aspiration and desired career outcomes skewing the generalist/specialist divide.

- There is a reduction in available training concurrent with the reduction of status of generalism (both general practice and generalist specialist)

- Lack of coordination between colleges and the jurisdictions in responding to projected deficits in medical workforce and demographic demand changes.

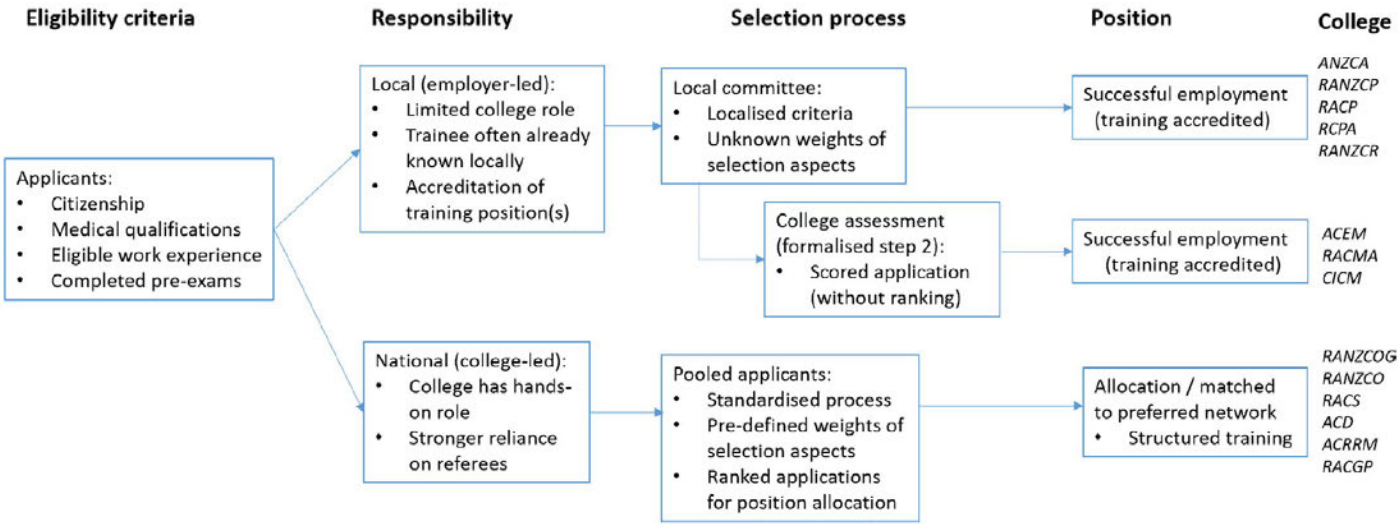



**FIGURE 1** Overview of the process of medical specialty selection by Australia's colleges

McGrail, M., O'Sullivan, B., & Gurney, T. (2021). Critically reviewing the policies used by colleges to select doctors for specialty training: A kink in the rural pathway. *Australian Journal of Rural Health*, *29*(2), 272-283.

### *Understanding the rising number of non fellowed clinicians*

- There is clear need to recast approaches to vocational medical training and understanding the reduction in FTE across the medical workforce, a new approach to hospital non specialist registrars is likely important.

- Reviewing the current NSW governance and regulatory framework around these doctors considering CPD and possible career trajectories and supporting different approaches to verification of scopes of practice.

- Understanding remuneration imbalances for doctors in hospital practice v those with community roles and articulation of skills escalation and recognition (junior and senior) within this group.

### *Comprehensive approaches to postgraduate training that meet population need and are geographically distributed and recognition that when people move to rural areas they have to move away if their job changes*

- A pleasing response to the Commission of inquiry has been work on recruitment with financial bonuses and caps on positions reviewed. The planning of ongoing increases in workforce in the health system commensurate with need and population growth will need to be sustained and proportionate.

- The next important focus in tandem is that of staff retention which will require a multitude of strategies that prioritize place-based health service delivery. There is a current imbalance in

financial renumeration and non-financial benefits for clinicians who live in rural with the balance shifting towards temporary employment (locums).

- One option will be to review medical training models utilizing networks funded and staffed and based in areas of greatest need within reach to specialty units to allow trainees to complete college requirements. (This is the direct opposite of how networks are currently constituted)

- As mentioned earlier the state jurisdictions are key health employers and often sets the pay threshold and expectations. Impacts in aged care, the disability sector and the community sector health workforces will be felt if there are major pay discrepancies. Within medicine, trainee salaries and consultant salaries and funding streams need a collegiate rethink with the opportunity to focus on ways of working within a salaried model that promote integration. The addition of research and supervisory roles into workforce roles is important to ensure the sustainability of the health services where integration is clearly important.

- All parts of the health system need to revalue generalism with remuneration and career options allowing movement and skills maintenance for those with broad efficient generalist scopes of practice to work in multiple rural and regional centre locations

### *New Models of training, not just for medicine but all health professional training progression including:*

- Assistants in Medicine and Assistant in Nursing options for students and consideration of Earn and learn on the job;
- Supporting existing health professionals with skills escalators to work at a higher scope where the workforce is highly distributed to allow skills transfer within a strict credentialing framework;
- Supporting all advanced practitioners in this domain by four key pillars of clinical practice, leadership, research and education.
- Skills escalators with Master s programmes in primary care and also skills escalation for nurses and allied health practitioners into medical course (Edinburgh) -allowing training in place for the first 2 years with 2 years subsequent post graduate clinical placement.
- Integration of international medical graduate pathways into supportive supervisory arrangements and credentialling across the prevocational and post vocational health system.

Thank you for this opportunity to provide preliminary information. Further information and referencing can be provided or expanded upon if required.