New South Wales

Special Commission of Inquiry into Healthcare Funding

Submission Number: 110

Name: Rural Doctors Association of New South Wales

Date Received: 13/11/2023

The Special Commission of Inquiry into Healthcare Funding review of the funding of health services in NSW.

Submission on behalf of the Rural Doctors Association of New South Wales

The RDANSW is a member organisation representing rural doctors and the health of rural communities. Our members provide care in rural hospitals and as GPs in rural towns. We are well placed to understand the challenges of providing health care in regional and remote NSW

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 RDA NSW believe that a substantial portion of the funding for health care services provided in rural, regional and remote NSW is now being spent on locum doctors to work in the hospital, rather than engaging in the services of local GPs. The RDANSW continues to be contacted by rural doctors who are no longer engaged in providing services in their local hospital due to reasons including not being paid appropriately. This can be in the form of rejected claims for patients seen, rejected claims for procedures carried out, changing item numbers. Ongoing refusal of payment, delayed payments and/or lack of understanding when claims processed can and usually lead to local GPs withdrawing their services from the local hospital. Some VMOs are reporting that VMO accounts are no longer processed in the local hospital and have been moved to the LHD where the roles are understaffed leading to delays in payment. The uncertainty of when payment will be made, and how many alterations will be made to the claims submitted is causing VMOs to reconsider their availability to work in the local hospital.

Where there are vacancies that are unable to be filled by local GPs in small rural hospitals then the hospital relies on hiring a locum at rates varying from $2000 per day to $3500, plus agency fees, accommodation, and vehicle expenses. Due to the locum doctor not having access to the patient's records from their usual GP, unnecessary pathology or radiology tests may be ordered.

The increasing reliance on the use of the virtual care in rural hospitals is leading to patients not attending their local hospital for treatment, or instead travelling to the emergency department in the next town or regional area to see a doctor face to face. This is adding extra pressure to larger hospitals and reducing the number of services delivered in smaller hospitals.

Lack of funding to properly staff hospitals leads to burnout of the workforce. Properly staffed hospitals function more efficiently, attract and retain staff and provide a happier and healthier work environment, with less sick leave and less turnover of staff and better patient outcomes.

Lack of funding to properly operate leads to people working below their scope of practice. For people with a broad range of skills, this is a disincentive to work in the hospital. Smaller hospitals need to be adequately equipped and staffed.

B. The existing governance and accountability structure of NSW Health, including:

i. the balance between central oversight and locally devolved decision making (including the current operating model of Local Health Districts);

Training for managing local hospital budgets does not appear to be effective and affects local decisions being made.
Lack of staff in hospitals due to budget constraints has a damaging effect of providing the right care, at the right time and the right place.
Rural hospitals are increasing their reliance on transferring patients to larger hospitals, going on COSOPs, or using a Virtual Rural Generalist doctor rather than engaging and using the services of local VMOs.
Increasingly locums being arranged is preferred as it is easier for hospitals to budget for rather than wait for a VMO to submit their claims which usually vary from month to month due to number of patients seen and procedures completed. Some LHDs are unwilling to renegotiate a Sessional contract with the VMO at an appropriate rate.
There appears to be little effort to find long term local solutions and the locum is an automatic response to staff shortages.

Locum agencies carry out the mandatory on-boarding checks, including working with children checks, police checks, document verification and completion and signing of hospital contracts Hospitals will only accept applications from the locum agencies for applicants where these have been completed.
The process for arranging contracts for a staff and contractors is too onerous for many local hospitals and so preference is given to outsourcing nurses and VMO doctors through using locum agencies. Use of agencies to arrange staff is having a damaging effect by creating uncertainty for the workers and impacting their ability to apply for loans and rental accommodation. Agency fees are paid and in many cases accommodation and vehicles.

E.g. VMO Physician who worked within 50km of a rural hospital was not offered a Rural Doctors Settlement Package VMO FFS contract as he lived near a large hospital. The VMO was unable to work at the large hospital due to their qualification requirements. The VMO had been offered a VMO FFS contract which they declined as their colleagues were paid under the RDSP FFS rates. As the VMO was not offered a RDSP FFS VMO contract at the hospital they then took locum work in other states such as QLD and ACT while the contract negotiations continued for more than 5 months.

ii. the engagement and involvement of local communities in health service development and delivery;

The Dept of health having better consultation with communities and involvement leads to better engagement to attract local doctors and healthcare workers. E.g. Councils may provide a house for the doctor for a period of time while permanent accommodation is found. Efforts can be made to help the new staff fit in to the local community. This leads to a better social environment for the doctor and staff.

iii. how governance structures can support efficient implementation of state-wide reform programs and a balance of system and local level needs and priorities;

iv. the impact of privatisation and outsourcing on the delivery of health services and health outcomes to the people of NSW;
The impact of privatisation and outsourcing on the delivery of health services and health outcomes is that each organisation has a different governance structure, different processes, different records system etc. which can lead to additional layers of bureaucracy and red tape which slows down the delivery of services and ability for organisations to work efficiently together.

v. how governance structures can support a sustainable workforce and delivery of high quality, timely, equitable and accessible patient-centered care to improve the health of the NSW population;

C. The way NSW Health funds health services delivered in public hospitals and community settings, and the extent to which this allocation of resources supports or obstructs access to preventative and community health initiatives and overall optimal health outcomes for all people across NSW;

The current, increasing rate of which NSW Health is employing locums to fill gaps in the rosters is leading to higher rates being offered as the dates that need to be filled get closer. Agencies are aware of this and some advise their clients to hold off accepting a role so that the rate offered is increased. In some cases, shifts will be cancelled close to the time so that the locum can accept another more higher paying role. The high rates are more attractive to some people leading to them no longer providing services in the local primary health care facilities, therefore in some communities this reduces access to preventative care.

D. Strategies available to NSW Health to address escalating costs, limit wastage, minimise overservicing and identify gaps or areas of improvement in financial management and proposed recommendations to enhance accountability and efficiency;

Many general practitioners do not feel valued or engaged with their local hospitals and this is leading to VMOs withdrawing their services earlier than planned, or not offering their services at all. When local VMOs aren't used in rural hospitals, generally more costly locums need to be arranged to provide services in the hospital, or patients may need to be transferred to another hospital. Patients miss out on continuity of care, and this can lead to unnecessary tests being arranged. The transfer of patients to another hospital is expensive and wasteful to not only the health service but to the patient. Strategies need to include making VMOs feel valued in the hospital and included in the consultation processes. The RDA NSW is aware of cases where local GP VMOs have not been consulted during the hospital redevelopment and services have been downgraded leading to the withdrawal of the VMOs services. NSW Health needs to accurately address where the costs to the health care system are being incurred and to address the financial impacts of regulation.
Lack of financial management training and understanding of budgets can lead to incorrect decisions being made.
Lack of understanding of funding available from different sources leads to missed opportunities, e.g. HETI provide funds for some advanced skills training positions that hospitals need to apply for. Lack of understanding from local health administrators on how to access additional funding to support the new positions and expand the services provided in the hospital can lead to loss of rural generalist seeking employment to utilise or increase their skills. For example: one base hospital failed to apply to HETI for a paediatric registrar due to a misunderstanding of how HETI funding is done. This resulted in reduced capacity in the hospital paediatrics department and unsustainable rostering.

E. Opportunities to improve NSW Health procurement process and practice, to enhance support for operational decision- making, service planning and delivery of quality and timely health care, including consideration of supply chain disruptions;

The NSW Health procurement process now appears to be too burdensome that the path of less resistance is taken, and easier options are pursued, e.g. arranging a short-term locum, at a higher daily rate is preferred compared to lengthy contract negotiations and processes to offer a VMO a quinquennium contract. These negotiations seem often to be unnecessarily complex and slow. Some improvement in the process or understanding of contract negotiations by LHD staff could help.

Supply chain disruptions- e.g. centralisation of sterilisation services with no back up provision, has the potential to close operating theatres in the peripheral hospitals. Recent floods provided examples of this and a lack of creativity in admin to arrange work-around arrangements.

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, including:

i. the distribution of health workers in NSW;
That there are shortages of health staff in rural areas is not news. Effective solutions to the attraction/retention equation need to be found. Promotion of and appropriate rewards generalist skills would help.
Employing a psychologist who is a specialist in children's behavioural disorders only meets the need of a small percentage of the rural communities, whereas a psychologist who is able to provide services to children and adults across a broad spectrum is needed in rural areas.

ii. an examination of existing skills shortages;
There is a skills shortage across the board in all areas.

iii. evaluating financial and non-financial factors impacting on the retention and attraction of staff;
Need to do more with fewer workers. Need to employ health care workers with a broad range of skills, i.e. generalists

iv. existing employment standards;

v. the role and scope of workforce accreditation and registration
The desired outcome needs to be addressed initially. We need to avoid the risk of overcomplicated accreditation and regulation systems unless there are proven patient benefits. We feel currently that accreditation systems are overly complex.

vi. the skill mix, distribution and scope of practice of the health workforce;
Adequate support for facilities and staff is critical to attraction and retention. People with a broad range of skills need to be recognised and remunerated appropriately

vii. the use of locums, Visiting Medical Officers, agency staff and other temporary staff arrangements;
We feel that there is an overuse of agency and temporary staff which is leading to increased costs. Use of locums and temporary staff is indicative of poor management of staff. To be clear, VMOs are not temporary staff.

viii. the relationship between NSW Health agencies and medical practitioners;
This needs to be more supportive and collaborative. At the moment it often seems adversarial.

ix. opportunities for an expanded scope of practice for paramedics, community and allied health workers, nurses and/or midwives;
This needs to be approached with a commitment to robust assessment of health outcomes and costs. It is not clear that expanding the scope of practice for allied health will lead to improved access to health care for patients. If anything, it feels like increasing fragmentation of care. It is also not clear that this approach will reduce costs. For rural communities, the questions of attraction and retention still need to be addressed.

x. the role of multi-disciplinary community health services in meeting current and future demand and reducing pressure on the hospital system;
This may be very useful, as long as a multi-disciplinary care team is not seen as a replacement for a hospital and and results in deskilling of local hospital services. There can be simply displacement of care and transfer of the pressures to other parts of the hospital system. The replacement of a hospital by a multi-disciplinary community health service does not change the needs of the community.

xi. opportunities and quality of care outcomes in maintaining direct employment arrangements with health workers;
It is not clear what this sentence means.

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

i. placements;
Mandatory

ii. the way training is offered and overseen (including for internationally trained specialists);
There is scope for improving training and addressing qualifications. This incorporation of internationally trained doctors into the system is outrageously complicated and expensive. See the report "Lost in the Labyrinth" from 2002

iii. how colleges support and respond to escalating community demand for services;
Please refer to Dr Susan Velovski's submission

iv. the engagement between medical colleges and local health districts and speciality health networks;
There seems to be little appetite for colleges to maintain rural services. There are considerable opportunities for general physicians and surgeons in particular, to train and practice in regional areas. This needs promotion at the medical student and junior doctor level as well as robust local support.

v. how barriers to workforce expansion can be addressed to increase the supply, accessibility and affordability of specialist clinical services in healthcare workers in NSW;

H. New models of care and technical and clinical innovations to improve health outcomes for the people of NSW, including but not limited to technical and clinical innovation, changes to scope of practice, workforce innovation, and funding innovation;

As technology and innovation streamline care and reduce the amount of time required, there should be a commensurate reduction in the cost of these.

Dr Charles Evill
President
Rural Doctors' Association NSW