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5th January 2024

Mr Richard Beasley SC
Commissioner
Special Commission of Inquiry into Healthcare Funding

Dear Commissioner Beasley,

Re: Special Commission of Inquiry into Healthcare Funding

We would firstly like to thank the commission for affording us the opportunity to provide a submission to the inquiry.

By way of background to the authors, Dr Kenneth J Herington is currently a resident medical officer within the emergency department at Royal North Shore Hospital and has an active clinical teaching position with the University of Sydney Medical School. In addition to working within the public health sector, Dr Herington has also undertaken locum doctor work with various private hospitals, and prior to his clinical career he worked in the clinical research management space within the private sector.

Dr Justin Bowra is a Fellow of the Australasian College for Emergency Medicine (FACEM) and is a senior emergency physician with more than 25 years' experience working in the hospital

system, both in Australia and overseas. He is the chair of the ACEM Emergency Telehealth Network, a Professor for the Ultrasound Leadership Academy, and the Clinical Lead in Emergency Ultrasound at Royal North Shore Hospital in Sydney. Dr Bowra is also the founder of the emergency telemedicine company, My Emergency Doctor.

Below we provide our experience, personal anecdotes, and subsequent recommendations to some of the points of interest to the commission outlined in the letters patent.

B. iv. *The impact of privatisation and outsourcing on the delivery of health services and health outcomes to the people of NSW*

We acknowledge the tremendous value that privatisation of certain services (such as pathology and the private hospital system) plays in providing high quality health care to the people of NSW while simultaneously taking the pressure off the stretched public health service. However, in our experience, in certain circumstances the privatisation and outsourcing of the delivery of health services has a deleterious effect on healthcare access among patients of lower socioeconomic status because it removes the impetus to provide an equitable service. Here are two examples:

1. At many public hospitals within NSW, there are public (i.e., free) orthopaedic outpatients clinics, but other specialties do not provide such free clinics. After discharge from ED or from inpatient wards, hospital doctors often refer patients for outpatient specialist followup, at the recommendation of that specialist team. However, if there is no public clinic available (for example for general surgery), typically those patients have to see the general surgeon in that surgeon's private rooms for outpatient follow-up. Although we do not believe that this occurs at our own hospital, we are aware that at other LHDs we have worked, the private surgeons charge a gap for this follow-up, which seems unfair to the patients. As a point of principle, we would suggest that patients who originally seek treatment in public Emergency Departments who then require outpatient follow-up should be able to access public follow-up clinics for that same medical/surgical discipline, and those who can afford private clinic follow-up are already able to access this if they choose.

2. Additionally, when doctors transfer a patient from a public to a private hospital for a procedure or operation that the public site cannot provide (e.g. because of overbooked theatre lists), although the private hospital and surgeon typically do not charge a gap fee, anecdotally the patients are sometimes charged other fees - for example anaesthetists' gap fees. This puts the patient in a difficult position because of the perceived power imbalance between the consultant doctor and the patient who needs the operation. In this setting, it can be difficult for the patient to feel empowered enough to challenge the fee.

Recommendations:

1. Public clinics should be made available for all surgical and medical disciplines for patients who require follow-up following an operation/procedure or medical admission in a public hospital.
2. Patients transferred from the public to the private system to facilitate an operation or procedure (that the public has contracted the private to provide) should not be charged gap fees.

***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 two-tier healthcare funding system whereby states fund hospital-based care while the Commonwealth funds Medicare can lead to gaming of the system by clinicians and health services alike, e.g. cost shifting. For example, anecdotally some hospital radiology departments encourage ED clinicians to arrange outpatient scans for patients because Medicare will bear the cost, although we should point out that we have not seen this in our LHD.

Recommendation: that the states and Commonwealth begin negotiating to end the complex two-tiered system of healthcare funding.

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.*

1. We believe that NSW Health would greatly benefit from addressing the issue of rational test ordering and decreasing low-value care. There are very significant cost savings for the NSW health system if we critically address the untrammelled ability of all doctors to order any test or procedure they desire, regardless of their seniority (for example, junior doctors ordering unnecessary CT scans / blood tests) and regardless of any actual or perceived conflict of interest (for example procedural specialists recommending a procedure that they will themselves perform, and thereby derive a financial benefit). There have been many previous attempts to rationalise and decrease low-value care, and in the past they have foundered, often because of opposition from vested interests. Practically it would be simple enough to introduce a set of state-wide 'traffic light' rules or a so called 'traffic light system' of test ordering, for example, no junior doctor can order a CT, and no procedural specialist can book a procedure unless it has been recommended by another, non-procedural specialist without affiliation to that doctor. In fact, such traffic light systems have already been developed and are ready to be implemented across all local health districts (see the following resource: https://aci.health.nsw.gov.au/networks/eci/administration/quality-and-safety/ed-qf-project/ed-qf-sensible-test-ordering & https://www.choosingwisely.org.au/). In many LHDs this will result in decreased test ordering, decreased costs, and improved patient flow.

We recommend an evidence-based, collaborative approach with stakeholder groups such as medical colleges to overcome a natural disinclination of clinicians to submit to restraints on their clinical freedom to order tests, but if such an approach fails then a unilateral approach (of mandating such rules) would be justifiable. Coincidentally, it has been demonstrated that applying such rules would greatly boost NSW Health's chances of achieving its net zero targets (see the following resource: https://greened.rcem.ac.uk/).

Recommendation: that NSW Health reintroduce a rational test ordering program, for example at a pilot site, to evaluate the impact of decreasing low-value care on cost savings and carbon footprint. This trial would be unlike previous trials in that it would contain mandatory elements agreed with the heads of department (for example certain tests can only be ordered

by senior doctors). Based on the outcomes, the aim would be to roll the program out across NSW Local Health Districts.

2. There are many other opportunities available to NSW Health to limit waste and improve financial management. One such strategy is to ensure Local Health Districts and individual hospitals have sufficient autonomy, flexibility, and oversight of their own budgets and cash flow, to manage unusual circumstances regarding patient care to reduce costs. For example, we are aware of a case in another LHD where a patient required an MRI scan for further characterisation of a new solid organ tumour. The patient was an inpatient of that hospital, however unfortunately the patient was too large to fit into the hospital's on site MRI machine. In these circumstances, the hospital had a pre-existing arrangement with a private radiology clinic who had a larger MRI machine to provide MRI imaging to public patient's of increased body habitus. However, in order for the LHD to pay for the private scan which the patient was entitled to as a public patient, the patient needed to maintain admitted inpatient status at the time the MRI scan was undertaken. The next available MRI scan in this private clinic, and in several other clinics within the local area, was not for several days. The patient was medically fit for discharge and did not need to stay in hospital to wait for this MRI scan which could be undertaken as an outpatient. A suitable strategy to both save money and provide the best possible care for this patient would have been for the hospital to provide the patient with a cheque or money order addressed to the radiology clinic for the cost of the scan, book the patient's scan for the following week, discharge the patient from the hospital, and have the patient undertake the scan in the community. Instead the patient remained for several days in the hospital for their scan, then was transported to the clinic via Patient Transport services, underwent their scan, and was discharged from the hospital immediately thereafter. Although this is simply a single case, it illustrates the enormous potential for savings if more flexible decision making was encouraged at a local level. The average daily cost of an admitted acute care bed in Australia is $2003 according to the National Hospital Cost Data Collection Cost Report for the Financial Year 2015-2016. The average cost of the required MRI scan as per the Department of Health and Aged Care website, is about $460.

Recommendation: That NSW Health provides LHDs and individual hospitals with more autonomy and flexibility over their cash flow management, and encourages rational, case-by-case decisions related to individual patient care, to reduce costs and free up health resources.

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:*

iii. *Evaluating financial and non-financial factors impacting on the retention and attraction of staff* ***& iv.*** *Existing employment standards*

There are many financial and non-financial factors which are currently having a large impact on the attraction and retention of medical staff within NSW Health and hence there are many opportunities for improvement to address these issues and prevent the drain of health professionals to other states. We further suggest that ensuring medical and health professional remuneration is commensurate with, or even slightly better than other Australian states and territories, is key to attracting and retaining staff. We make the following observations and suggestions.

1. Junior Medical Officer staff (i.e., medical interns, resident medical officers, and medical registrars) salaries in NSW are among the lowest in the country. The following table has been taken from the NSW Health Professional and Medical Salaries (State) Award 2023 and outlines the salary schedule of Medical Officers in NSW.

Medical Officers		
Intern		
Intern	Per annum	76,009
Resident		
1st Year	Per annum	89,095
2nd Year	Per annum	97,993
3rd Year	Per annum	110,986
4th Year	Per annum	120,489
Registrar		
1st Year	Per annum	110,986

2nd Year	Per annum	120,489
3rd Year	Per annum	130,027
4th Year	Per annum	139,187
Senior Registrar		
For the purposes of calculation of payments to officers pursuant to the provisions of this Award, one hour's pay shall be calculated in accordance with the following formula: Per annum Salary x 1/ 52.17857 x 38 and one day's pay shall be calculated by multiplying one hour's pay (as calculated in accordance with the above formula) by 7.6		
Senior Registrar	Per annum	156,494

Table 1: Schedule of Medical Officer Annual Salaries in NSW as per the NSW Health Professional and Medical Salaries (State) Award 2023

This next table below has been taken from the equivalent Queensland medical officer award document, the Medical Officers' (Queensland Health) Certified Agreement (No. 6) 2022, and it outlines the salary schedule of Medical Officers in QLD. Please note, L1 is equivalent to Intern in the NSW award, L2 is equivalent to Resident 1st Year in the NSW award, and so on.

Classification Level	Wage Rates payable from 01/07/22		Wage Rates payable from 01/07/23		Wage Rates payable from 01/07/24	
	Per Fortnight	Per Annum	Per Fortnight	Per Annum	Per Fortnight	Per Annum
	$	$	$	$	$	$
L1	3,225.50	84,151	3,354.50	87,517	3,455.10	90,141
L2	3,494.40	91,166	3,634.20	94,814	3,743.20	97,657
L3	3,763.10	98,177	3,913.60	102,103	4,031.00	105,166
L4	4,636.70	120,968	4,822.20	125,808	4,966.90	129,583
L5	4,771.00	124,472	4,961.80	129,450	5,110.70	133,335
L6	4,905.30	127,976	5,101.50	133,094	5,254.50	137,086
L7	5,107.10	133,241	5,311.40	138,571	5,470.70	142,727
L8	5,241.40	136,744	5,451.10	142,215	5,614.60	146,481
L9	5,376.00	140,256	5,591.00	145,865	5,758.70	150,240
L10	5,913.30	154,274	6,149.80	160,444	6,334.30	165,257
L11	6,115.10	159,539	6,359.70	165,920	6,550.50	170,898
L12	6,316.50	164,793	6,569.20	171,386	6,766.30	176,528
L13	6,516.20	170,003	6,776.80	176,802	6,980.10	182,106
L14	6,719.90	175,317	6,988.70	182,330	7,198.40	187,801
L15	6,922.70	180,608	7,199.60	187,832	7,415.60	193,468
L16	7,128.30	185,972	7,413.40	193,410	7,635.80	199,213
L17	7,332.10	191,289	7,625.40	198,941	7,854.20	204,910
L18	7,526.20	196,353	7,827.20	204,206	8,062.00	210,332
L19	7,727.80	201,613	8,036.90	209,677	8,278.00	215,967
L20	7,959.20	207,650	8,277.60	215,957	8,525.90	222,435
L21	8,130.90		8,456.10		8,709.80	

Table 2: Schedule of Medical Officer Annual Salaries in QLD as per the Medical Officers' (Queensland Health) Certified Agreement (No. 6) 2022

As can be seen by comparing the two tables, salaries for medical officers in NSW are substantially lower than in QLD, for roles that are equivalent in their required amount of education and duties, ranging from ~$5000 less to ~$15000 less per year depending on the increment.

Recommendation: we recommend matching the NSW medical officer salary scale to the Queensland salary scale, to help prevent the drain of health professionals from NSW to other states.

2. Similar to Junior Medical Officers, Staff Specialist Salaries in NSW are also among the lowest in the country. The following table has been taken from the NSW Staff Specialists (State) Award 2022 and outlines the salary schedule of Staff Specialists in NSW.

PART B - MONETARY RATES

In the period 1 July 2023 to the commencement of the first full pay period on or after 1 July 2023, the applicable rates of pay are those that applied immediately prior to the first full pay period on or after 1 July 2023.

SCHEDULE 1 - STAFF SPECIALISTS SALARY RATES

Staff Specialist	**Frequency**	**Rates from first pay period on or after 01-Jul-2023 $**
Staff Specialists		
1	Annual	186,241
2	Annual	197,132
3	Annual	208,017
4	Annual	218,934
5	Annual	229,825
Senior	Annual	251,618
Postgraduate Fellow		
Postgraduate Fellow	Annual	216,339

Table 3: Schedule of Staff Specialists Salaries in NSW as per the NSW Staff Specialist (State) Award 2022

This next table below has been taken from the equivalent Queensland medical officer award document, the Medical Officers' (Queensland Health) Certified Agreement (No. 6) 2022, and it outlines the salary schedule of Staff Specialists in QLD. Please note, L18 is equivalent to Staff Specialist 1 in the NSW award.

Classification Level	Wage Rates payable from 01/07/22		Wage Rates payable from 01/07/23		Wage Rates payable from 01/07/24	
	Per Fortnight	Per Annum	Per Fortnight	Per Annum	Per Fortnight	Per Annum
	$	$	$	$	$	$
L18	7,526.20	196,353	7,827.20	204,206	8,062.00	210,332
L19	7,727.80	201,613	8,036.90	209,677	8,278.00	215,967
L20	7,959.20	207,650	8,277.60	215,957	8,525.90	222,435
L21	8,130.90		8,456.10		8,709.80	

		212,129		220,614		227,232
L22	8,332.60	217,392	8,665.90	226,087	8,925.90	232,870
L23	8,534.40	222,656	8,875.80	231,563	9,142.10	238,511
L24	8,742.00	228,073	9,091.70	237,196	9,364.50	244,313
L25	9,000.20	234,809	9,360.20	244,201	9,641.00	251,527
L26	9,273.20	241,931	9,644.10	251,608	9,933.40	259,155
L27	9,542.30	248,952	9,924.00	258,910	10,221.70	266,677
L28	9,945.10	259,461	10,342.90	269,839	10,653.20	277,934
L29	10,483.10	273,497	10,902.40	284,436	11,229.50	292,970

Table 4: Schedule of Staff Specialists Salaries in QLD as per the Medical Officer' (Queensland Health) Certified Agreement (No. 6) 2022

Recommendation: we recommend matching the NSW Staff Specialist salary scale to the Queensland salary scale, to help prevent the drain of specialist medical professionals from NSW to other states.

3. Currently there is no mandated 10-hour rest/fatigue break between shifts in the Public Hospital Medical Officers (State) Award 2023, whereas in the equivalent QLD aware there is. This can lead to burnout of NSW medical officers. Additionally, if a medical officer is required to return to work before a 10-hour break has elapsed due to being on call, the first 2 hours are paid at 1.5x, and the subsequent hours are paid at 2x the hourly rate, whereas in the QLD award, all hours worked before a 10 hour break has elapsed are paid at 2x the hourly rate.

Recommendation: we recommend updating the NSW award to mandate a 10-hour rest period between shifts and to pay overtime commensurate with the QLD award.

4. We are aware that in other hospitals and LHDs, junior medical officers (interns, residents, and registrars) are rostered to work 14-hour long shifts on Saturdays and Sundays to cover the hospital wards. At Royal North Shore, weekend after hours ward daytime shifts are split into two separate 7 hour shifts, which is far more sensible, ensures high quality patient care, and avoids staff burnout.

Recommendation: we recommend mandating in the NSW award that weekend hospital ward day shifts should be no longer than 7 hours to avoid medical officer burnout and optimise patient care.

5. Currently in many NSW hospitals, weekday evening ward cover is provided by medical officers who have worked their usual hours of work during the day, that is, each day an individual rostered doctor will work their usual hospital day job from 8-4:30, and then continue until 9pm covering entire wards until the night shift teams begin their shift. This also leads to burnout.

Recommendation: we recommend mandating in the NSW award that specific relief doctors should be rostered for an entire week to provide weekday evening after hours hospital ward cover, so that day teams can leave work on time, and avoid burnout among medical officers.

6. Currently, NSW Health employees have the option to enter into a salary packaging agreement with their LHD employer. In NSW, the tax savings are shared in a 50:50 split with their LHD, whereas in QLD 100% of the tax savings are passed onto the employee.

Recommendation: we believe that changing the NSW Health salary packaging model to match that of the QLD Health model would greatly improve medical officer morale and help ensure that NSW Health remains an attractive employer to prospective medical officers, and improve medical officer retention rates.

We strongly believe that implementing above recommendations would be a win-win for NSW Health and medical officers. Morale among the NSW Health Medical workforce would be lifted substantially, and staff numbers and retention would improve.

vi. *The skill mix, distribution, and scope of practice of the health workforce:*

1. We would recommend a greatly enhanced scope of practice for rural nurses and for paramedics, supported remotely by medical specialists. Telemedicine services have saved NSW Health and other health services millions of dollars in avoidable interhospital transfers and unnecessary tests by supporting nurses and junior doctors in rural emergency departments and hospital wards (declaration of interest: Dr Bowra's company 'My Emergency Dr' is one such service). It's simply not possible, nor financially viable, to have enough specialists to staff every ED and hospital in NSW, therefore a combination of highly trained nurses (but still more cost effective than specialist doctors), supported by a 24/7 roster of remote specialist doctors who can assess the patient remotely via telemedicine will greatly improve health equity for rural and remote communities.

Recommendation: enhanced scope of practice for regional, rural, and remote nurses and improved access to remote specialist doctors via a telehealth system.

2. We also recommend that NSW health enhances the scope of practice of paramedics, and supports them to make sound clinical decisions for patients at the time of their assessment in the community, to reduce unnecessary transfers to ED. This could be achieved with more on the job paramedicine training and with the support of a remote telemedicine specialist doctor who could be accessed by paramedics out in the field. In our experience, currently the model of paramedicine care often places the responsibility of definitive treatment on doctors in the

hospital emergency department by bringing patients to the ED who could ordinarily have waited to see their GP in the community. Sometimes low acuity patients are brought to the ED, triaged by a nurse as low acuity and subsequently sent to the waiting room or in some circumstances, given an emergency bed. For example, we are aware of a case at another LHD where a patient from a group home was brought to the ED for non-urgent blood tests. A nurse at the group home reviewed a patient's blood results from several days prior which showed a non-urgent abnormal result. The patient was medically stable, but they were still brought to the emergency department at 3am and given an acute emergency bed. The patient's blood tests during their emergency presentation were completely normal. The patient was subsequently discharged home without any intervention. In these circumstances, the patient did not need to be brought to the emergency department, rather, they could have been reviewed by their GP in the community during business hours. Paramedics with support from a telemedicine emergency specialist could have advised the patient and the staff at the group home that the patient can wait to be seen during business hours by their GP.

Recommendation: enhanced scope of practice and training for paramedics to defer non-urgent care.

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:*

We propose the following new models of emergency care and emergency clinical innovations.

1. We would support the adoption of 'physician assistants' (PAs) with a brief period of training (perhaps one year at most) to support the clinical workflow of emergency departments. A PA can support a busy emergency specialist doctor by charting their medications, writing their notes, and performing simple procedures under their direct supervision. This model has been in use for decades in other countries where emergency doctors are in short supply, e.g. the USA, and has now been adopted by other states. There is extensive literature on the benefits of PAs to patient care, patient flow and to healthcare costs, in Australia and overseas (see the following resources: https://clinicalexcellence.qld.gov.au/improvement-exchange/physician-assistants-emergency-department & https://www.ncbi.nlm.nih.gov/pmc/articles/PMC10288079/). It seems counterintuitive that a senior emergency physician (a very expensive resource for NSW Health)

should spend half their time providing low-value care such as charting routine medications and cannulating patients, while queues of patients waiting to see them get longer.

2. The role of emergency medicine in society has transformed in recent decades and the traditional Emergency Department, within a fixed hospital structure, will not be fit for all purposes going forwards. Recognising that the *patient* is central to our work, not the clinician and not the emergency department, we consider that it is time to rethink the acute patient journey altogether, rather than focus on bricks and mortar EDs as the default site (and therefore bottleneck) for emergency care. We recommend that NSW Health collaborate with other organisations and stakeholders (e.g. ACEM, RACGP, ACRRM, and NSW Ambulance) to streamline the patient journey, minimise roadblocks, such as the ED waiting room, and incorporate non-ED models of care such as urgent care centres, telemedicine, scheduled ED visits, and community emergency medicine with patients using wearables. These areas of emergency medicine are fast growing and would become (sub)specialist areas in the future and should be at the forefront of most emergency care delivery while acting as a buffer and triage to the hospital.

3. We propose that we end the current 'ED front door' model altogether. Although this may sound far-fetched, this is an idea that builds on the UK NHS 111 model, whereby *"If you need to go to A&E, NHS 111 can book an arrival time so they know you are coming. An arrival time is not an appointment but helps to avoid overcrowding"* (see the following resource https://www.nhs.uk/nhs-services/urgent-and-emergency-care-services/when-to-go-to-ae/). In our opinion, the time for a 24/7 open door policy whereby the patient decides when to present to hospital, and even which ED to attend, is no longer fit for purpose. We propose that NSW Health works with stakeholders to design a system where no-one can simply come to ED whenever they desire and expect to be seen. Rather they need to either call 000 and a paramedic may undertake secondary triage as per NHS 111, and similar to many Australian state ambulance services, or call another number (for example HealthDirect) for a nurse to undertake secondary triage. Tele-FACEMs would support the nurses' and paramedics' triage decisions in real time, just as toxicologists back the Poisons Information Line nurses. Outcomes may include going straight to ED, booking an urgent ambulance, or an appointment the next day at a lower acuity centre, or being referred back to the GP. Those who simply attend the ED without having gone through this process, would be triaged as usual for safety's sake, but then may be advised that they will not be seen today, and instead will be provided with an

appointment for the next day (or even at another facility) depending on circumstances. This should not be seen as a *'closed door'* policy but rather a *'concierged door'* policy.

4. NSW Health could consider 24h FACEM cover without the pain of FACEM night shifts. There is an unspoken paradox in ED practice whereby FACEM-led care is lauded (rightly) as the standard of care, yet FACEMs do not work nights in most centres. In other countries, this is 'solved' by emergency specialists covering nights onsite, but in Aus/NZ, telemedicine could be used to create a 24h FACEM ED roster in which no individual FACEM actually works nights: at midnight the onsite FACEMs hand over to remote FACEMs based overseas and working in local daylight hours. (This model already exists in several Australian virtual ED services as well as My Emergency Dr; note disclosed conflict of interest as outlined above). This way, the ED is staffed with FACEMs 24/7 to assist the juniors in assessing and managing patients and do board/patient rounds, the patients get improved care, and the onsite FACEMs do not burn out. There would still need to be an on call roster for anything that requires hands-on FACEM expertise e.g. critical care procedures, but the onsite FACEMs would rarely be called and the onsite juniors would not be reluctant to call a senior for advice, and the patients would get reliable consultant-led care 24/7. Put it this way: if FACEM-led care is so important for patients and the system at 2pm, why not at 2am? Speaking as someone who has personally led resuscitations, board rounds in ED, and short stay units, all via real-time telemedicine, it is reasonably simple to improve patient care and patient flow when a tele-FACEM remotely supports junior clinicians. The ED 24/7 model would also benefit from extended-hours Patient Transport services to ensure efficiency of flow with admission and discharge of patients.

Thank you for the opportunity to make this submission. We would be happy to be contacted by the commission to provide further input if the commission so desires.

Sincerely,

Kenneth Herington

Dr Kenneth J Herington
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Justin Bowra

Dr Justin M A Bowra
FACEM CCPU