Mr Richard Beasley SC

Commissioner

The Special Commission of Inquiry into Healthcare Funding

I am a General Surgeon at Griffith Base Hospital in MLHD. Griffith is classified an MMM3 town, and the hospital provides Level 4 services according to the NSW Health plan. The MLHD is the second largest LHD in the state, covering around 125 000sq km.

Griffith hospital was initially staffed by resident specialists but for reasons including changes in service plans those specialists moved to other rural or regional practices. Today, most services in the hospital are reliant on locum - fly in, fly out - specialists. Some locum specialists come on a regular basis (one week a month) but many others come only one or twice a year.

Several factors require the Hospital to provide a 24/7 surgical service. These include and are not restricted to:

1. Remoteness of the location – although surrounded by several major interstate highways. It is two hours by road to our nearest referral hospital in Wagga Wagga.

2. Size of the catchment population (approximately 100 000). Around 2500 surgical procedures and 600 deliveries are performed each year in Griffith.

3. The nature of the regional businesses – farming, manufacturing, and transport - particularly long-distance heavy haulage.

I believe my role at Griffith Base enables me to address the Inquiry's Terms of Reference F and G.

<u>Staff Recruitment and Retention</u>

There is currently funding for 4 fulltime General surgeons, the minimum number required to provide surgical services (excluding obstetrics). However, despite many years of attempts it has not been possible to recruit that complement so the service relies heavily on locum surgeons.

Clearly the remoteness of the location cannot be changed but applicants for positions in Griffith have already decided this is not the limiting factor. Post-interview discussions with otherwise suitable candidates for employment have shed light on several issues.

Medical staff in NSW continue to be the lowest paid in the country and are offered the weakest remuneration package. Wages and benefits are significantly greater in Queensland and Western Australia and Victoria offers schooling incentives that are not available in NSW.

Housing in rural NSW is a particular problem. It is extremely difficult to attract fulltime specialists, but part-time doctors can provide an excellent service. The problem is the need

to maintain two dwellings – one in Griffith and the other in the second place of work. A typical rent in Sydney ($700 pw) plus a typical rent in Griffith ($500pw) would consume almost the entire salary of a specialist working part-time but paying for two fulltime rents.

However, there is a simple solution. For the cost of a locum specialist for 1 week (over $28000) NSW Health could provide a permanent staff member rent in a rural town for a year at the typical market rate of $500 pw.

Previous inquiries have identified issues with specialist locums - in particular the extortionate and restrictive business tactics employed by locum agencies. However, locums are not only used for specialist services. Junior Medical Officers are rotated through Griffith and other rural centres from hub tertiary hospitals in Sydney. However, when the Sydney hospital is short-staffed they will not send a JMO to a rural location. Our workforce is much smaller than the tertiary centre and it is not possible to staff rosters with less than a full complement. Subsequently, locum JMOs are hired, often for an entire term of 3 or 6 months, at rates higher than any other permanent member of the hospital staff. In addition to the high salary, locums are provided with accommodation and transport – neither of these are available to permanent staff.

From the 2012 NSW Health Rural Surgical Futures document:

"Recruitment of new staff including surgeons, anaesthetists, nurses and allied health professionals was an issue for almost every service. There is also significant disparity between award conditions for nurses, doctors and allied health staff in NSW compared to other states. Significantly higher remuneration and better employment conditions are available elsewhere and is leading to loss of staff, particularly across the Queensland and Victorian borders."

Sadly, little has changed in the subsequent decade.

Education and Training

I have previously held the position Chair of Training Board in General Surgery (NSW and ACT) for the Royal Australasian College of Surgeon (RACS) and have a long and involved commitment to the education of medical students and doctors. The diversity of rural practice makes it an ideal training location. There has been a concerted effort by universities to promote and strengthen rural education by placing students in rural practices. Hopefully this will encourage some to stay to work in the rural setting. Similarly, the RACS rotates its trainees through regional and rural hospitals.

However, many students and trainees comment that they feel unable to commit to a rural practice due to a fear of professional isolation.

This could be addressed by a two-part approach.

Firstly, increasing access to education and travel grants would help rural specialists attend appropriate educational events. The current funding of TESL for Staff Specialists is cumbersome and many colleagues have expressed difficulty accessing this part of their remuneration package. Medical Administration sign-off is required but not always forthcoming. Other states simply provide the funds for the practitioner to use as needed.

Secondly, despite attendance at educational meetings there is still a need to develop new skills under supervision. It would be helpful for rural specialists to be able to attend a tertiary centre on a regular (perhaps fortnightly) basis or for a more extended period (possibly a month) to observe then practice a new technique. This would require backfilling the rural position (using a doctor from the tertiary centre) and credentialling of the specialist at the tertiary centre. This should not be difficult given the national registration of practitioners. It would also be almost cost neutral as specialist wages are not location-dependent.

These practices would help reduce the sense of professional isolation plus strengthen referral networks and relationships for the care of the patients who need to be transferred to tertiary centres.

I had hoped to attend the Inquiry in person as there appears to be limited clinician input. However, due to the short notice and working commitments I was unable to attend the afternoon session in Wagga Wagga on March 14. I would be happy to be contacted if any elaboration or clarification is required –

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Griffith Base Hospital

17 March 2024