From the President's Office
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19 January 2021

Mr Greg Donnelly
Chair
The NSW Legislative Council

Dear Mr Donnelly

Submission into the Health outcomes and access to health and hospital services in rural, regional and remote New South Wales

The AMA(NSW) thanks you for the opportunity to provide this submission into the Health outcomes and access to health and hospital services in rural, regional and remote NSW.

The AMA(NSW) supports the aims of this inquiry, to examine health outcomes, patient experiences, wait-times and quality of care for people who live in rural, regional and remote NSW.

Our submission has been prepared with the input of our members who have experience working in rural, regional and remote facilities. The input covers experiences from doctors in training to senior practitioners. We believe their feedback and observations is invaluable when it comes to improving health services in our regions.

The AMA(NSW) asks that the Legislative Council give due consideration to our submission and the recommendations contained therein, with the view to improving health and hospital services for the communities of rural, regional and remote NSW.

Yours Sincerely,

Dr. Danielle McMullen
President, AMA (NSW)

NSW Parliamentary Inquiry into health outcomes and access to the health and hospital services in Regional, Remote and Rural New South Wales

As a stakeholder, the AMA(NSW) makes this submission based on the input of our members and research into the current state of access to health care in regional, rural and remote areas.

We have obtained the views of individual members, our Councillors and the Medical Staff Councils of rural, regional and remote hospitals to enable the medical profession to put their position before the Legislative Council and identify their concerns with the view to initiating change, where necessary, for patients and the medical professionals working in these settings.

Almost forty per cent of NSW's population does not live in Sydney and a quarter, or 1.8 million, live outside of metropolitan areas[i].

Although NSW's regional and rural communities are highly varied in many respects, overall, they face similar issues of disadvantage relative to their urban counterparts in relation to their health and welfare.

SUMMARY OF RECCOMENDATIONS

1. **Doctors in Training (DiTs)**
   (a) Provision of allowances and incentives for DiTs to rotate to regional hospitals; and
   (b) Review the accreditation of Rural and Regional hospitals to allow for further College training programs across more specialties.

2. **Vising Medical Officers (VMOs)** –
   (a) Greater flexibility in relation to on-call commitments; and
   (b) Access to Professional Support Payment to VMOs in regional areas in accordance with the terms of the Determination and to give effect to the policy behind the payment – namely, to attract and retain VMOs in regional communities.

3. **Career Medical Officers (CMOs)** – An increase in CMO roles to attract those medical practitioners who are not seeking to practice as a specialist seeking to establish themselves and their families in a regional or rural location.

4. **Renumeration** –
   (a) An increase for locum rates;
   (b) Review of VMO Fee-for-Service rates and allowance to access additional payments, such as claiming sessional rates in circumstances where the CMBS prevents payment for service; and
   (c) With the Commonwealth Government, review of CMBS for General Practice item numbers for rural and regional GPs.

5. **Relocation Grants –** An extension of relocation grants to specialists, for those specialities in shortage, including but not limited to psychiatry, cardiology, neurology and oncology.

6. **Oncology** – Decentralisation of radiotherapy and chemotherapy services to reduce travel time for cancer patients, particularly in the Western NSW and North Coast NSW Local Health districts.

RESPONSE TO THE TERMS OF REFERENCE

(a) Health outcomes for people living in rural, regional and remote NSW

Almost forty per cent of NSW's population does not live in Sydney and a quarter, or 1.8 million, live outside of metropolitan areas[ii].

Although NSW's regional and rural communities are highly varied in many respects, they each face similar issues of disadvantage relative to their urban counterparts in relation to their health and welfare.

Regional and rural communities also have a proportionally higher Indigenous population, whose health risks and outcomes across all measures are significantly worse than non-indigenous Australians[iii].

The disparities between regional/rural communities and their urban counterparts include:

- Higher incidence of death from all causes, resulting in a lower overall life expectancy with the greatest gap in life expectancy experienced by the indigenous population;
- Higher incidence of low birth weight neonates and perinatal mortality;
- Increased incidence of death, injury and disability amongst the Indigenous population and young adults in regional communities due to higher rates of violence, accidents and suicide;
- Higher incidence of many chronic conditions that together with later diagnosis and limited treatment options impact survival rates of patients. Cancer is one such condition[iv], although it is hoped increasing Cancer Care Centres across NSW, outcomes will improve.

With respect to Cancer Services in particular, noting it is a focus point to this inquiry, we received feedback that the continued lack of access to a complete cancer service – including allied health, nursing and phycological care, often means sending patients to metropolitan centres for large portions of time to receive treatment. Because regional centres cannot provide a complete service - many patients undergo social upheaval - leaving families/friends at times when they are most needed. Some patients decline the travel - and instead opt for alternate strategies that can be delivered closer to home - accepting the inferior survival outcomes.

(c) access to health and hospital services in rural, regional and remote NSW including service availability, barriers to access and quality of services;

The AMA(NSW) has consulted with our members who are currently providing services in these areas and are in a position to provide contemporaneous accounts and evidence of the availability and barriers to access services in rural, regional and remote locations within services.

BARRIERS

The number of medical clinicians has increased in recent years on average across Australia. These numbers are likely to grow with increasing domestic and international graduates seeking employment and looking to regional and rural areas. However, modelling suggests that this growth will be in the GP rather than specialist workforce[v].

As at June 2012, there were 1153 (FTE) doctors employed by the rural LHDs and 2778 appointed as VMOs (headcount) representing an increase of 59.3% and 20.2% respectively, from 10 years earlier[vi]

However, as indicated by significant number of regional areas that are classified as Districts of Workforce Shortage and/or Areas of Need there continues to be considerable service shortages access the State. Distribution of the specialist workforce by speciality is not possible to accurately ascertain from published statistical measures, making assessment of the (in)adequacy of the workforce difficult to quantify. It is understood the NSW Health together with the Colleges is currently improving data collection and transparent in relation to the specialist workforce and unmet need, a task that is critical for targeting specialities and communities and as a benchmark to assess the success of existing future policies.

Australia-wide there continues to be a discrepancy between the number of clinicians in major cities (408 FTE per 100,000) compared to the remote areas with the lowest being 237 FTE per 100,000 in our outer regional areas. This discrepancy is even more marked when considering the specialist workforce. In major cities, over half of clinicians were specialists and specialists in training (234 FTE per 100,000). This proportion decreases with remoteness, with 104, 81 and 55.4 FTE specialist and specialists in training per 100,000 in inner regional, outer regional and remote/very remote areas respectively[vii].

The low number of specialists in regional areas is particularly concerning, as these areas are not only serving their own populations but also the rural and very remote.

By contrast the number of GPs (including GP proceduralists) per 100,000 population increases slightly into regional areas, reflecting their broader scope of practice and provision of services to smaller populations over larger distances. Ongoing support to comprehensive primary healthcare to these communities is essential.

Regional and remote areas are also heavily reliant of international medical graduates, and more transient workforce short term placements, visiting staff and FIFO workers which means patients are often not receiving continuity of care, or the value of their own family GP, unlike their metro counterparts.

> **Case Study – Port Macquarie – Bed Shortages**
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> *Case numbers through Port Macquarie Base Hospital theatres have risen steadily since 2013, from 6855 cases in FY2013-2014, to 7863 in FY2018-2019. This increase has been mainly in elective surgery, with emergency surgeries around 2900-3100 cases in a FY. In the last few years, multiple elective surgeries have been cancelled due to lack of beds available postop, in part due to increasing admissions through the Emergency Department. With the covid shutdown this year, this has meant our elective waiting times are now the highest in the state, and a 12 bed "surge" capacity ward has finally opened in November 2020 but this barely covers the expected Emergency Department admissions.*
>
> *The increasing wait times as outlined above has meant patient experience has suffered. At the Pre-Anaesthetic Clinic, all patients are forewarned that they may be cancelled on their scheduled surgery date due to lack of beds or emergency cases. From doing 3-4 orthopaedic joint replacements a day in the elective theatre, often this is now down to 1-2 due to lack of beds.* [viii]

Despite clinicians requesting another specialist join them, including urologists or gastroenterologists, its reported that the LHD remains reluctant to engage further specialists to assist in distribution of the

workload. This has meant on several days that there are two urology theatres, with the specialist expected to supervise across two theatres, despite possibly needing to engage fully in one theatre doing a more complex case such as a nephrectomy.

In the Hunter New England Local Health District access to trauma services was identified to be of major concern. Currently, John Hunter Hospital ('JHH') provides a trauma retrieval service, however, given the area and number of incidents within this LHD, the service is reportedly poor. An upgrade to any one of Tamworth, Port Macquarie or Coffs Harbour Hospitals might alleviate the pressure felt at JHH and improve access.

QUALITY

Recruitment and Retention

The rural and regional workforce face similar issues to rural GPs, particularly in recruitment, as most doctors need to move to go there. As the numbers of medical graduate's swell, doctors may increasingly look to be forced to find work outside of major centres. However, the feminisation of the medical workforce, dual career couples, older graduates and a desire for work-life balance may mean that a higher proportion of doctors will be less keen to go regional. It is therefore imperative that we explore initiatives to ensure that regional practice is an attractive option.

The majority of current initiatives focus on the important issue of provision of primary care services to rural and remote populations, with fewer initiatives targeted specifically towards either the regional workforce or specialists. Programs that have specifically targeted regional areas include expansion in GP training and Specialist Training Program placements (STPs), as well as the creation of academic centres the Rural Clinical School (RCS) and University Departments of Rural Health Program (UDRH).

- **Supporting the Rural and Regional Pipeline** – recruiting rural/regional students and creating opportunities for rural/regional immersion throughout medical training has provided a long term but effective strategy to maintain and increase the rural and regional medical workforce, especially the GP workforce. Some advances have also been made in developing the specialist pipeline, such as increasing STPs. However, further STPs and more generalist training options are needed to cater for the numbers of junior doctors wanting to train and practise regionally.

- **Multiple initiatives** – Not all doctors with a rural background will practise in regional/rural areas, and because of the smaller number of medical students with a rural background, the majority of regional/rural doctors have an urban background. This emphasises the fact that multiple bundled initiatives – professional , organisational, personal and financial – that target other key driving factors in a doctors choice of geographical location, such as regional training and support, streamlined recruitment processes, succession planning, reviewing family needs, and financial initiatives, are required to recruit and retain doctors in regional and rural settings.

- **Critical Mass** – Building and retaining 'critical mass' (multiple doctors with the same speciality in a popular location) is imperative for recruitment and retention. A critical mass ensures seamless high-quality services to the community and partly counteracts the professional, organisational, and social disadvantages or remoteness and urban centres.

- **Appropriate Infrastructure** – The specialist workforce is in many ways a more difficult beast than the GP workforce, requiring adequate infrastructure and hospital appointments. Adequacy of heath infrastructure, including availability of long-term certainty of theatres and lists, diagnostic services, access to specialist drugs, specialist nurses and staff, access to private hospitals as well as connections to metropolitan colleagues, are all key issues for recruitment of specialists and maximising their benefit to their community.

- **Engagement and Planning** – Doctors on the ground are often keen to be involved in succession planning and recruitment and more broadly in planning and service delivery decisions. Engagement of clinicians by hospital administration in workforce planning is critical to the success of recruitment and retention drives in regional and rural areas.

Case Study

The recent and widely publicised difficulty to recruit a VMO to Gulgong MPS is provides an example of the difficulties associated with recruiting experienced medical practitioners[ix]. Gulgong is one of many smaller facilities in the in the Western NSW LHD.

Whilst local GPs are available, the MPS provides for the most part, a telehealth service and patients are referred to Mudgee or Dubbo Hospitals.

Doctors in Training ('DiTs')

Recent feedback from members, particularly in regional and rural locations, have highlighted the struggles of retaining Doctor-In-Training workforce though out the clinical year, and the difficulties associated with attracting locum staff to fill vacant positions. This is particularly so in 2020 with travel restrictions limiting the available supply.

There is a perception amongst our DiT members, that regional and hospitals are disadvantaged by decisions made by the tertiary referral hospitals which appear to prioritise their own workforce needs over those of the regional hospitals, pulling staff back to meet their staffing shortfalls creating staffing shortfalls in regional areas. Not only does this create an immediate potential issue of unsafe rostering and working hours for staff left to cover the roster, but also creates or adds to the perception that regional opportunities are not valued in the same way as opportunities in metropolitan areas.

In a similar way, hospitals within a Local Health District can face staffing challenges when resources (including but not limited to training positions and funding for same) are not equitably shared or prioritised across hospitals but rather the allocated is made primarily to the major hospital or hospitals within a District.

For those DiTs who are based at a regional hospital, as opposed to a metropolitan hospital, are disadvantaged by a policy which provides allowances and incentives to those from metropolitan hospitals who rotate to regional hospitals but does not provide any allowances or incentives when they rotate to a metropolitan hospital. The Award and NSW Health Policies have not kept pace with the changing structure of training.

AMA(NSW) Hospital Health Check

In 2020, 1332 doctors-in-training completed the AMA(NSW) Hospital Health Check survey.

We believe the survey results for regional hospitals provide a valuable insight into the experiences of the medical workforce at these hospitals. In order to improve retention rates, and attract staff, it is imperative that those hospitals where poor results were identified address the matters of concern.

Because many doctors-in-training rotate through multiple hospitals and health services, all participants were asked to answer questions based on one hospital in which they had worked the most in the last 12 months.

The data gathered from the survey was used to provide hospitals with grades in five different domains and to calculate an overall rating for each facility. The five domains measured are:

1. Overtime & rostering
2. Access to leave
3. Wellbeing
4. Education & training
5. Morale & culture

Of the Regional Local Health Districts the Murrumbidgee LHD performed very well, with Wagga Wagga Base Hospital achieving an overall 'A' rating. The Mid-North Coast LHD, on the other hand, achieved only a 'C', with Manning Hospital having a 'D' rating.

We make available to this Inquiry, the survey results, and encourage close observation and attention to those LHDs that are shown to be lacking as to supporting the junior medical workforce so that attention and assistance can be given to those hospitals where their doctors have voiced real concerns about their experiences.

Standardised Contracts and Working Conditions for VMOs

The AMA(NSW) identified many members displeased with the "standard" contract which has been identified as failing to take into account difficulties such as a specialist possibly needing to be on call 24/7 because they are the only specialist in their field in their region. This makes it difficult to attract additional or in some cases, any, specialists. The AMA(NSW) believes LHDs need more flexibility to be able to address local issues as they arise.

Of our surveyed members, 25% held RDA contracts, which offer slightly higher rates than the rates payable for those providing services at regional hospitals. 56.68% of respondents to the survey held both public and private appointments, presumably to supplement their income, and which takes away from the public system. Only 29.41% worked exclusively in public hospitals.

One of the driving factors for a medical practitioner to work in a regional or rural location can be a better work-life balance and connection to immediate and extended family.

Many medical practitioners in two-doctor households, or two-income households will, from time to time, be required to juggle family and work. VMOs looking to strike a balance and perhaps have a leave of absence from on-call commitments while children are young are reliant on goodwill if they make such a request.

The industrial instruments giving effect to VMO arrangements, provide no formal acknowledgement of flexibility. To keep and retain workforce this is an area for urgent attention.

VMO Contracts – Professional Support Payments

The difficulty for VMOs to access the Professional Support Payment ('PSP') under the VMO Determinations is a source of ongoing frustration for members.

The PSP was introduced in 2007 in acknowledgement of the additional costs and challenges confronting regional VMOs wishing to participate in CME activities, or simply wishing to take leave but unable to do so because of the need to ensure cover for their patients.

While AMA NSW maintains that hospitals have a positive obligation to assist in finding and securing cover, for private rooms which are a necessary supplement to public hospital earnings, this can be a challenge for VMOs. In more recent years Local Health Districts have pushed back on approval of payments for anything other than CPD activities.

The definition of professional support under the Determinations is not exhaustive and clearly contemplates payments for expenses over and above travel, accommodation and CME activities:

> *For the purposes of this clause, professional support expenses include:*
>
> *(a) travel, accommodation, conference or course costs in respect of continuing medical education;*
>
> *(b) costs of locum cover while the visiting medical officer is on unpaid leave;*
>
> *(c) such other item/s in connection with the ongoing professional support of the visiting medical officer as a public health organisation may approve in any particular case*[x].

PSPs should be paid to VMOs in regional areas in accordance with the terms of the Determination and to give effect to the policy behind the payment – namely, to attract and retain VMOs in regional communities.

VMOs – fee-for-service

VMOs in regional and rural hospitals are often remunerated on a Fee-for-Service basis and the fees they charge are referenced to the Commonwealth Medicare Benefits Schedule (CMBS) as opposed to hourly rates paid to VMOs engaged on a sessional basis.

The Fee-for-Service Determination does not stipulate that VMOs are required to strictly meet the requirements of the CMBS. While fees are referenced to the CMBS, the model of care in public hospitals is not the same as that in the private system, and the insistence on VMOs meeting the strict requirements of the CMBS mean many are providing services but not being paid. For example, an arrangement whereby specialists who were conducting consultations with patients following procedures to avoid the need for patients to travel for a future appointment have gone unpaid because under the CMBS a consultation cannot be charged on the same day as a procedure.

In order to attract and keep specialists in the public hospital system in regional and rural areas, VMOs must be confident they will be fairly remunerated for services they provide.

Career Medical Officer Contracts

In recent years, there have been declining numbers of CMO positions offered. As CMO appointments provide the security of ongoing employment within the public system, one measure to address workforce issues in regional and rural areas may be to revisit CMO roles. Such roles may be attractive to medical practitioners seeking to establish themselves and their families in a regional or rural location and who, for a variety of reasons, are not seeking to practice as a specialist.

Locum Contract Rates

Several regional areas have difficulty attracting locums to fill vacancies on rosters. While there is likely no easy answer as to why this is so, the locum rates payable may have a bearing on these challenges.

Attracting locum services is critical for those areas where the medical workforce is so slim, without same, patients will be forced to travel further or the impact upon retrieval services will be even more burdensome than they already are.

Recruitment and Retention of regional procedural general practitioners

Our members have expressed concern about the retention of GP fellows in rural communities, without which, the identification of health concerns with the primary doctor (the GP) can prevent patients from accessing the correct specialist care.

To date, workforce shortfalls resulting from a patchwork of health systems and the dwindling availability of GPs with procedural skills have made rural communities increasingly dependent on locums and fly-in fly-out services.

As defined by the Australian College of Rural and Remote Medicine, rural generalist medicine is a broad scope of care that includes comprehensive primary care, in-patient and/or secondary care, emergency care, and specialised skills in at least one discipline (e.g., emergency medicine, Indigenous health, internal medicine, mental health, paediatrics, obstetrics, surgery or anaesthetics); and hospital and community-based public health practice.

The report said there were enough domestic medical students already in the system to fill GP workforce needs, noting a growing mismatch between medical graduates and available vocational training places that exceeded 500 in 2018 and may reach 1000 in 2030. The high cost of training and the continued reliance on immigration to fill workforce gaps mean that it is important … to ensure the potential benefits to the community of these doctors is fully realised. This may mean the development of pathways that help fill workforce gaps are considered.[xi]

> *Feedback received from a rural generalist/GP with 15-20 years' experience:*
>
> *"The situation now is worse than when I was a registrar. The rural generalist training scheme will benefit hospitals, but not general practice, where most people are cared for. What country people need most is more qualified GPs (fellows). I have seen many initiatives in my time, but none have worked. The federal government needs to pay more to fellowed GPs through Medicare, such an increased rebate on the Medicare levy, to recognise the increased complexity of the work and to reward the fact that we live in places no other doctors wish to i.e. a higher hourly rate). I am of this opinion despite the fact that I am a proceduralist (obstetrics and anaesthesia)".*

In 2019, Federal AMA released a position paper[xii] regarding the retention of general practitioners in rural communities across Australia. The Federal position aligns with the RDAA Rural Workforce Rescue Package.[xiii] The AMA(NSW) agrees with the recommendations made by the Federal AMA for sustaining a GP workforce in rural Australia and believes the same apply to the rural NSW workforce. In short the focus of the initiatives are to:

1. encourage students from rural areas to enroll in medical school and provide medical students with opportunities for positive and continuing exposure to regional/rural medical training;
2. provide a dedicated and quality training pathway with the right skill mix to ensure doctors are adequately trained to work in rural areas;
3. provide a rewarding and sustainable work environment with adequate facilities, professional support and education, personal comfort, and flexible work arrangements, including locum relief;
4. provide family support that includes spousal opportunities/employment, educational opportunities for children's education, subsidy for housing/relocation and/or tax relief; and
5. provide financial incentives including rural loadings to ensure competitive remuneration.

Recruitment and retention of regional specialists

In 2020, Federal AMA released its Position Statement with respect to the state of Rural Training Pathways for Specialists in Australia[xiv]. The concerns raised in that statement are reflective of the issues facing the specialist workforce in NSW. Below we surmise the issues identified by our DiT members, who raised some of the same, and additional barriers to rural training as those expressed by Federal AMA. These include, but are not limited to:

1. The need for Colleges to accredit rural facilities and establish rural training programs;
2. Consider alternative models of supervision and assessment;
3. Adequate funding for relocation and support for doctors' partners in finding suitable employment;
4. Sufficient remuneration so that additional private work may not always be a necessity to cover the costs of living;
5. Clear pathways for promotion and ongoing employment.

Doctors in Training – the feedback

Only 10.3% of our DiT members surveyed remained in roles because of professional opportunities, such as further training, research and academics. The AMA(NSW) believe more opportunity for career advancement would assist in recruit and retain more qualified medical workforce and increase the specialist workforce over time.

It was pleasing to see of our DiT members who responded to the survey, 82.14% had undertaken training in a rural setting rotation, and 58.33% reported they would pursue a career in a rural, remote or regional setting. However, it appears those who do not wish to pursue such work have made that decision because of the limitations associated with specialisation, and the likelihood of onerous on-call responsibility without sufficient support.

We note the majority trainees' surveys undertook rotation the Royal Australasian College of Rural and Remote Medicine (ACRRM) (33.3%) and a further 66.67% with the Royal Australian College of Geneal Practitioners.

Only seven of our junior doctor members who responded to the survey were training with specialist colleges in rural, remote and regional areas.

Many of our DiT members report that poor experience with hospital administration and management has reduced due to poor experiences with administration.

Recruitment and Retention of Nursing Staff

Our members identified issues with retaining experienced nursing staff. The issue relates strongly to the way NSW Health contracts nursing staff.

Some LHDs reported that many nurses and operating assistants have been given casual, or part time hours contracts, some despite years of service, preventing them from taking steps to remain the community by starting families and purchasing homes (we note reports of nursing staff being unable to access home loans due to the nature of their contracts).

For example, in feedback obtained from members, we are advised that during a recent recruitment four anaesthetic nurses to Port Macquarie who were put through a 3-6 month training program (to meet ANZCA standards), but towards the end of their training no further hours were promised. Only 1 of those 4 nurses has remained, the others were forced to accept other jobs for economic reasons.

Offering casual or low permanent hours also makes it difficult to recruit from any metropolitan area, as moving to a regional area requires a significant commitment and there are fewer opportunities to pick up work at other nearby facilities.

(g) an examination of the staffing challenges and allocations that exist in rural, regional and remote NSW hospitals and the current strategies and initiatives that NSW Health is undertaking to address them;

It was consistently expressed by our members that there is a lack of surgical and non-surgical specialists as well as nursing staff.

Specialists, particularly neurosurgeons, oncologists and psychiatrists appeared to be identified as most lacking.

From the Murrumbidgee LHD one surveyed member commented:

> *Visiting psychogeriatrics outpatient service - again raging population and no service set up in in Wagga. Psychiatry public clinics- we have a big problem with young adults' psychiatric needs. Only once they are in crisis can they access psychiatry and then it is in Wagga, taking them far away from any family/social support.*

We also note a lack of rheumatologists, were identified, reportedly there are 4 specialists in this field between Newcastle and Queensland.

These specialities, amongst others need to be addressed. Some options expressed for solving this may include rural / regional bonding for some advanced training positions or enhanced Medicare funding for areas of need to attract specialists to rural areas.

Rural Incentive Programs

Current Strategies and Initiatives

Current incentive strategies to address staffing challenges focus on the recruitment, and upskilling of Rural General Practitioners and Rural Generalists.

The Workforce Incentive Program (WIP), previously the General Practice Rural Incentives Program (GPRIP), provides financial incentive to those in the AGPT or ACRRM training pathways to practice in regional, rural, and remote communities (MMM3 or above). The WIP encourages practitioners to remain in these areas with increases to the maximum annual incentive every additional year in place. The WIP stipulates that should the practitioner be inactive for 24 quarters (6 years) or more they will lose their accrued year status and start the program as a new participant.

Anecdotally practitioners who relocate to a metropolitan area for their own health or family, such as starting a family with access to sufficient care, face a barrier when returning rurally if they have lost the accrued years and begin WIP again but now with higher financial burden such as a young family.

Relocation grants of up to $5,000 AUD are available to eligible GPs, nurses and allied health practitioners moving to rural (MMM3 and above) NSW communities. The Rural Procedural Grants Program (RPGP) exists to provide financial assistance to procedural GPs in rural and remote areas to update and maintain their skills in Emergency Medicine, Surgery, Anaesthetics and/or Obstetrics.

Currently these programs do not address the notable shortage in specialists and surgeons.

We recognise many factors contribute to the lack of surgical and other specialists, in rural, regional and remote NSW. Factors such as lack of accredited training in these areas, insufficient local hospital and clinic infrastructure, and lack of directed incentive programs for specialists, and subsequent overcommitment of those who do work in these areas, all contribute to the lack of specialists in rural and remote areas. Targeting specialists with incentives such as WIP, relocation, and training grants may entice more to consider working rurally while infrastructural barriers must also be addressed.

(i) the access and availability of oncology treatment in rural, regional and remote NSW;

We surveyed our members in order to obtain qualitative data in relation to the staffing challenges in oncology. Those Medical Staff Councils ('MSCs') who responded raised concern with respect to oncology services.

We understand some regions have access to private cancer care centres, however this comes with significant out of pocket expenses, and is prohibitive. In some cases, is appears fly-in fly-out oncologists service the private hospitals, but do not hold public appointments due to inadequate rates of remuneration. Attracting an oncology workforce, the public system in in the regions calls for better contracting terms with respect to, but not only, renumeration.

Amongst surveyed members, it was noted that apart from having an initial consult at a Base hospital, there were positive observations with regard to subsequent telehealth consultations for cancer patients living in remote settings:

> "Oncology services are well-provisioned in regional centres of more than about 10,000 population. Radiotherapy is a little less readily available. More remotely-living patients often

have to travel more than an hour to receive treatment, but are now well-served with telehealth consultations".

However, was repeatedly reported that access to clinical trials is very limited for cancer patients in regional areas. For example, the Mid North Coast Cancer Institute has many trials operating for common cancers but rare cancer trials are dealt with in metropolitan centres. Patients remain reluctant to attend. At the very least, access to telehealth studies need to progress to allow regional patients to access these important drug trials.

Medical Staff Council and Member feedback regarding Oncology Services

Access to oncology services associated with Gynaecology and Obstetrics is limited in regional areas In Port Macquarie and Kempsey:

> "*Cancer care needs to be accessed in Newcastle, although local chemotherapy and radiotherapy is available though. …. Long wait lists for seeing a gynaecologist and for surgery in rural areas due to unequal distribution of specialists compared with metropolitan areas. Growing aging population will worsen this"*[xv].

Although local chemotherapy and radiotherapy is available, this same region reported delays in the commencement of chemotherapy and radiotherapy as their local cancer centre MNCCI is over capacity with waiting lists of 3 – 4 weeks for most treatments.

While Base hospital services were generally exported to be adequate, the regional local hospitals had very little offering.

At Tamworth, one member described the service as follows, also noting issues with and interference by with administration and management:

> *"Appalling. Medical oncologists working remotely from home since Pandemic. No infrastructure or procedural respect for Rad onc. No understanding of staffing requirements Minor operations manager at Tamworth closed rad onc service because technical staff felt stressed and ops manager worried about HR fall out No patient respect from hospital operations staff"*

In Taree and Foster, a community of over 100K people, with an aging population services are not local, and travel to Port Macquarie or Newcastle is the only service available. However, it was reported that John Hunter Hospital's telehealth consultation service is reliable and useful in the absence of access to an oncologist, when it is appropriate for patients to be treated at the local hospital.

Similarly, in the Macleay Valley members reported patients travelling up to 150-180km to access chemotherapy at the Base Hospital.

In Western NSW, chemotherapy and radiology services are accessed from Orange Base Hospital, this means members of the public in this region are travelling many 100s of kilometres,

> Members generally called for a decentralisation of radiotherapy services from the larger and tertiary hospitals to improve local access and reduce travel time for patients.
>
> *"Visiting medical oncologist. All radiotherapy services are 2-4 hours away. Region is part of $64 million commitment for regional radiation oncology services in last Federal election, but*

nothing has eventuated. Most gynaecological oncology is referred to Sydney - 4 hours away. No local colon cancer service and minimal breast cancer service".

Haematologic Disorders and Blood Cancers

A Haematologist AMA(NSW) member, in Port Macquarie provided feedback. This doctor provides services to Hasting, Macleay and Mid-North Coast NSW LHD, ('MNDLHD') regarding the providing of services in relation to haematologic disorders and blood cancer patients.

The inferior outcomes of those with haematologic disorders is established and reported in the recent 'State of the Nation, Blood Cancers in Australia[xvi]'.

This paper highlights the metro-regional divide in outcomes. Whilst much of the data utilised in this report is low quality, there is not better-quality data to use (again a manifestation of funding divide). It points out that if variable outcomes in survival were eradicated, 9300 lives would be saved by 2035.

Our member reports that access to medications is becoming an issue. The PBS lags behind scientific advances. Whilst medications a caught in the process of TGA/PBS submissions, more financially well-resourced units are able to fund treatments for patients, or occasionally patients self-fund medication. The rural/regional/remote community is less likely to be able to self-fund, and certainly regional hospital budgets do not have the capacity.

Concern about access to novel diagnostics was raised - again the MBS schedule for laboratory/imaging testing lags scientific advances. To obtain detailed genetic assessments for diagnostic/prognostic assessments - many of my patients confront the issues of $400-600 for a genetic test on their diagnostic sample, where in the larger centres the unit/laboratory absorbs this cost. Again, our smaller/less well funded units cannot absorb the cost, and because our local labs do not offer the service - the cost is ultimately borne by the patient.

Access and retention of support services required for cancer patients was identified, including access to specialised nursing – a funding discrepancy sees lack of specialised CNC support and access to specialised Allied Health – for example, in the MNCLHD there is no psycho-oncologist, no Occupational Therapy, and no physiotherapy presence within the oncology unit.

Regional patients also have a Lack of access to clinical trials. Our member reports efforts to establish a haematology clinical trial portfolio:

"The challenge is that relatively speaking our small units will recruit less patients than our metro-counterparts. For Pharm- companies funding the trials - this creates relatively lower yield for their investment of registering a trial site. Thus, studies are generally offered to metro sites first.
Furthermore - NSW is notorious for is disjointed/laborious/red-tape laden process for passing through ethics committees/governance. Victorian/Qld based colleagues frequently comment to the same effect. I have more highly skilled, and pre-eminent opinion leaders/researchers at the Peter MacCallum in Melbourne that have suggested considerable changes, some of which will require high level advocacy within the Ministry of Health, in order to streamline the ability for a trial to register sites in more flexible/adaptive ways - such that patients presenting with less common diseases in the regions will be able to be effectively recruited to be on comparable therapies to if they were diagnosed in the metro-postcodes (of course without compromising ethics/safety)."

(j) the access and availability of palliative care and palliative care services in rural, regional and remote NSW;

The overwhelming response to our surveyed members was that palliative care services were described as inadequate.

The most common observation was that local GPs are managing palliative care both in the community and in the local hospitals. There is occasionally a palliative care nurse available. Consultations are otherwise provided by telehealth via specialists in Sydney. Whilst the AMA(NSW) recognise the benefit of telehealth, in the absence of a medical practitioner, palliative care in person is the ideal option for patients at such a sensitive time.

Observations from our surveyed members in regional areas confirmed the lack of palliative care specialists on the ground. It was also noted that of those communities that do have a local palliative care specialist available, they did not have admitting rights to the local hospital and were unable to care for patients within the hospital setting. The following member comments support this lack of service:

> *"No formal palliative care service. Local GPs helps coordinate most outpatient palliative care services. Palliative care advise from Wagga 2 hours away via CNS, but nil face to face for inpatients."*

> *"Abysmal access. There is a sole fly in fly out doctor infrequently, and two community nurses, for tens of thousands of people in the community. It is completely inadequate".*

> *"Pall care doesn't have right for admission unfortunately. The service is available only for consult. sometimes patient has to be admitted under medical team as that's the only way to be linked to pall care services initially. There is community pall care but initial referral must happen and it is frustrating when this occurs over the weekend or after hours as there is no pall care".*

> *"Very limited, especially at a medical level. One palliative care MO for a town of over 40000 people and a broader catchment of approximately 100000 people".*

> *"This is always challenging. Although hospital general physicians should be able to look after the majority of these patients' needs, this younger than about 50 years lack the judgement to know when to stop active treatment, as a rule. The same applies to some more experienced physicians, unfortunately. There are not many Palliative Care Specialists in regional areas. As a result of both these issues, many patients receive sub-optimal care at the end of life."*

Despite the above issues, a senior medical practitioner from the Hunter New England LHD, reported that John Hunter Hospital provides a reliable telehealth services, and has a palliative care nurse available to take calls from regional services 24 hours a day.

(l) any other related matters.

Head Trauma Services

A specific concern arose as to the access to trauma services for head injuries. This concern arose through a study initiated by Dr Rowena Mobs, who has reviewed the services with specific focus upon the head trauma following farming and other rural accidents – sporting and motor vehicle.

With recent media attention concerning repeated head injury and long-term neurological effects in sports, while the public are alert to the impact such as dementia, migraine and psychological injury.

Dr Mobs has proposed a campaign to encourage those affected by head injury – be it on the sporting field, or on the farm, or though road incidents, to access appropriate clinical review via their GP and/or a neurosurgeon.

The *National Repetitive Head Trauma Network* (NRHTN) provides rural, remote, and regional centres access to specialist clinics (Repetitive Head Injury Assessment clinics or RHIA clinics) in which diagnosis and management of single or repetitive mTBI may be made. A public educational component for medical staff, parents, sporting administrators, and schools is proposed under this structure.

This initiative raises the concern about access to neurosurgeons, in regional areas. While telehealth can assist with review, neurosurgeons on ground remain an issue. As the associated services, such as rehabilitation and psychological.

Annexed hereto is a supplementary submission, concerning this matter, which was prepared by Dr Mobs, and which the AMA(NSW) supports.

Neurosurgery

An AMA(NSW) member and neurosurgeon based in Sydney who undertakes a clinic in a regional centre every two weeks provided feedback. Our member is in a group practice and five neurosurgeons run clinics in the centre. They maintain a full-time office and staff there.

This member has expressed concern that public patients in the regional centre are served well. They see patients who live in areas where the closest public hospital is approx. 400 km away and when they refer patients to the public outpatient clinic, they often wait a year or more for an appointment.

Continuity of care remains an issue, it was noted that rarely correspondence is received from the outpatient's clinics and they never see the patient again, despite indicating a willingness to remain involved in their care (e.g. post-operative checks).

In fact, this is this would not be financially attractive but many neurosurgeons, want to see better access to care for patients and are willing to provide public services in regional and rural areas.

The AMA(NSW) understands the Royal Australasian College of Surgeons does not have a rotation in regional areas, and are of the view, trainees and patents could benefit from such a rotation, which might encourage neurosurgeons to remain in these areas where there is a clear need for their services.

The Port Macquarie and Kempsey Hospital's Medical Staff Council reported that there is no neurologist in the region. The MSC reported that it is not uncommon for a gastroenterologist to provide neurological services in an emergency situation.

Stroke

It was reported by AMA (NSW) Council that there is a documented lack of stroke services in regional areas. Only 10% of patients have access to neurovascular treatment, with 1500 patients dying or ending up in nursing homes as a result of stroke.

Access and use of the tele-stroke which has demonstrated success at Coffs Harbour ED and the AMA(NSW) sees the benefit in providing this service across further areas.

Cardiology and Specialist recruitment

Dr John England, AMA(NSW) member and cardiologist and general physician provided a detailed account[xvii] of his 40 years' experience working as a CMO in the Western NSW Local Health district, at Orange Base, Bathurst and Mudgee. Dr England now works at Lithgow and Katoomba hospitals and provides comment upon services within the Blue Mountains and Nepean LHD also.

Over the years, Dr England has observed extreme difficulty in attract cardiologists (and specialist generally) to regional, rural and remote NSW. Dr England comments that his colleagues prefer to live in metropolitan or coastal areas. In his own current practice in Katoomba, he has failed to recruit a cardiologist despite 10 years of advertising for a suitable candidate.

Dr England also raises the issue of maintaining collegiate relationships with other like specialists. As an isolated physician in Mudgee, Dr England would liaise with fly-in-fly out practitioners and occasionally, visiting specialists from larger base hospitals. The absence of a permanent medical workforce impacts upon collegiate support and continuing education for those isolated specialists in regional, rural and remote NSW.

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[i](https://www.parliament.nsw.gov.au/researchpapers/Documents/Trends%20in%20NSW%20population%20growth.pdf)

[ii](https://www.parliament.nsw.gov.au/researchpapers/Documents/Trends%20in%20NSW%20population%20growth.pdf)

[iii] Steering Committee for the Review of Govt Service Provision, Productivity Commission, National Agreement Performance Information 2011-2012: National Indigenous Performance Agreement 2012

[iv] Coorey, et al, 'Australia is continuing to make progress against cancer, but regional and remote disadvantage remains' MJA; 199(9): 605-608, 2013

[v] Deloitte Access Economics for the DOHA, Review of the Rural Medical Workforce Distribution Programs and Policies, August 2011 (projected to 2020)

[vi] Health System Planning and Investment, NSW MOH, NSW Rural Health Plan: Issues Paper, July 2013

[vii] Australian Institute of Health and Welfare, Medical Workforce 2011: National health workforce series no. 3 Cat.no. HWL 49, 2013

[viii] Anaesthetics Dept. PMBH

[ix] https://www.mudgeeguardian.com.au/story/6949857/without-a-doctor-for-months-gulgong-residents-are-fed-up-with-reduced-medical-services/

[x] https://www.health.nsw.gov.au/careers/conditions/Awards/feeforservicedetermination.pdf

[xi] https://medicalrepublic.com.au/breaking-rural-doctor-drought/7165

[xii] Geographic Allocation of Medicare Provider Numbers - 2002. Revised 2019 | AMA

[xiii] Building a sustainable future for rural practice: the Rural Rescue Package | AMA

[xiv] Rural_training_pathways_for_specialists_2020.pdf

[xv] Dr Fiona Leslie FRANCOG, MBBS, BCs, Chair of the MSC, Port Macquarie and Kempsey Hospitals, 26.11.2020

[xvi] https://www.leukaemia.org.au/how-we-can-help/advocacy-and-policy/state-of-the-nation/

[xvii] Letter from Dr England to AMA(NSW) dated 18 December 2020