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President Dr Nicholas Spooner | **Secretary** Dr Tony Sara

24 January 2025

The Hon. Dr Joe McGirr, MP
Committee Chair
The Select Committee on Remote, Rural and Regional Health
Parliament of New South Wales
Macquarie Street
Sydney NSW 2000

Delivered by email: *remoteruralregionalhealth@parliament.nsw.gov.au*

Dear Dr McGirr,

ASMOF NSW Response to Questions on Notice – Dr. Chris Selvaraj, SET5 (Accredited) General Surgical Trainee, NSW

The Doctors Union NSW extends its thanks to the Committee for providing the opportunity to further elaborate on remote, rural, and regional (RRR) health issues, as discussed during the December 12, 2024, parliamentary hearing.

Please find below Dr. Chris Selvaraj's response to the question on notice.

> *"**The CHAIR ...** Your report—I hope I've got this right—made the point that recruitment and retention wasn't any better and it referenced a couple of situations with psychiatry, and I think obstetrics on the Central Coast where there had been some pretty significant downgrading of services, threats to services or difficulty with recruiting. You referenced both the extensive amount of money spent on locums to keep services going and the issues around culture as being a factor in terms of recruitment and retention. I wonder if any one of you might expand on those issues."*

Response by Dr. Chris Selvaraj, SET5 (Accredited) General Surgical Trainee, NSW

Please note that the following statements represent my opinions and experiences and not those of the Doctors Union, NSW.

- ***Locum expenditure***

Throughout ASMOF's negotiations with the Ministry of Health (MoH) and NSW State Government regarding Award reform, NSW Treasury data has repeatedly been sought regarding locum expenditure. During the hearings for the Special Commission of Inquiry into Healthcare Funding

(SCOI) on 22 July 2024, the Ministry of Health (MoH) presented a dataset ((Exhibit H, Tab H MOH 005.024 .0010.0377.0001) with metrics such as "Total FTE" that obfuscate and manipulate honest interpretation of medical workforce issues in NSW, rather than simple metrics such as headcount, vacancies/locum positions filled, or actual cost of locums in each LHD.

Despite MoH claims that these simple metrics are not possible to obtain, Government Public Information Access (GIPA) requests filled by the MoH do present headcount data for the medical workforce and visiting medical officers (VMOs) - from over five years ago. ASMOF is yet to view headcount information for any years since onset of the pandemic in 2020, or any information about registered practitioners within NSW Health since the AHPRA pandemic sub-register was closed. Instead, MoH presented total Full-Time Equivalent (FTE) data in its 2024 report to the SCOI may include double counting VMO positions across multiple hospitals (not an issue in 2018) and overtime hours (this is explicitly stated in the nursing dataset, but the methodology for calculating total FTE is omitted in the medical workforce section).

Regarding the issue of obfuscated data, and the question on notice, I have been informed of a locum company's dataset for NSW, which rounds data to whole numbers. The data, which cannot be independently verified by myself or ASMOF, demonstrates the following:

Between 2020 and 2023, there was an increase in locum positions filled each year for:

- Psychiatry registrars (+51% to 129 in 2023)
- Psychiatry consultants (+41% to 324)
- Obstetrics and gynaecology (OnG) registrars (+59% to 167) and
- OnG Consultants (+57% to 232).

Between 2019 and 2024**,** there was an increase in the average hourly rate for:

- Psychiatry registrars (+13% to $137 in 2024),
- Psychiatry consultants (+33% to $280),
- OnG Registrars (+15% to $185), and
- OnG Consultants (+51% to $313).

- ***The impact on culture, recruitment and retention***

As it relates to the impact of the use of locums on workplace culture, recruitment, and retention – I will briefly explore governance issues between metropolitan and regional areas. Following that, I will briefly comment on the importance of investing in Doctors in Training (DiTs) to prevent workforce shortages in specific regional communities.

I have worked in the Central Coast Local Health District (CCLHD), which is often regarded as one of the best environments for junior doctors. I am not aware of any cultural issues affecting Wyong Hospital. However, small hospitals within an LHD are ultimately governed by administrative staff at larger hospitals in the district, such as Gosford Hospital for Wyong.

Geography plays a role here; hospitals within the CCLHD risk losing services to the better-resourced and metropolitan Northern Sydney LHD hospitals in close proximity, and so clinical governance will often focus on preventing loss of services to the nearby metropolitan hospitals – though in some cases, the opposite occurs. The governance culture in any regional area tends to variably follow this pattern, dependent on its proximity to metropolitan tertiary hospitals and referral pathways. Thus, any commitment to ensuring the reliability of local services in regional communities is challenged by the dominance of the nearest metropolitan tertiary referral centre.

In my opinion, issues with recruitment and retention are more likely to result from suboptimal administrative management within the LHD leading to a dependence on either a metropolitan-based or temporary (locum) workforce. The role of training colleges and speciality societies may further complicate this.

I have already spoken highly of my experiences working in Wagga Wagga (MLHD), but conversely my experiences at Shoalhaven Hospital (ISLHD) showed me how a lack of oversight of governance processes and administrative culture within LHDs can result in vastly different experiences for doctors across NSW. Shoalhaven's administration displayed hostile and persecutory behaviours towards junior and senior doctors seeking to improve the system or identify inefficiencies/errors.

The shortcomings at Shoalhaven are not only due to the staff's lack of knowledge regarding proper clinical governance but also a hospital culture characterised by a lack of interest in attracting, accommodating, and retaining DiTs who are seconded there. Additionally, there is a metro-centric bias towards visiting senior doctors from tertiary centres rather than local doctors, and a dependence on locums to fill staff shortages.

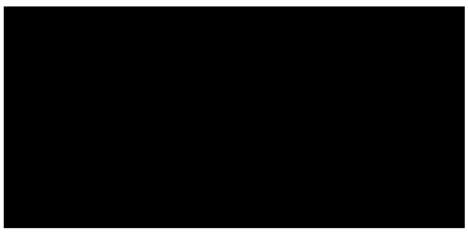
This culture is reinforced by an apparent lack of investment by administrative staff in the community; many are quick to report that they are not from the area. This culture is also likely consistent with patterns of executive direction focusing on the subjugation of smaller regional hospitals and utilisation of their resources by larger counterparts within the LHD (i.e. the Wollongong Hospital in ISLHD, and the clinicians/management there).

My overall impression is that a lack of centralised oversight of workforce management and clinical governance within any LHD can easily lead to mismanagement by administration and clinicians. To address this, middle management and administrative processes should be further centralised, shifting responsibility away from the largest hospitals in each LHD towards a parent organisation, such as the Ministry of Health, with clear lines of accountability. This strategy could help enforce policy directives, optimise culture and workforce management to benefit staff invested in the local community, properly consider geography and population distribution to improve healthcare efficiency and funding, and achieve significant cost savings.

Housing availability, cost of living, community support, and lifestyle are all relevant factors in optimising the investment in the medical workforce in regional communities. In some ways, the

regional communities adjacent to metropolitan LHDs could be seen as "watershed" areas at high risk of a temporary and unstable medical workforce as they resist the transition from valued regional experiences to commercial outposts of the metropolitan districts. Much like the recruitment and retention strategy of investing in medical students through rural clinical schools, these "watershed" areas would benefit from further investment in DiTs, with incentives relevant to their stage of life, at a pivotal point in their medical career. Financial subsidies for housing/accommodation and cost of living, as well as establishing lifestyle and community supports for young families will encourage DiTs to establish long term connections to regional communities and remain there as consultants; their positions in the hospital and community well protected by centralised oversight and governance that extends beyond the district.

Warm regards,



Dr Christopher Selvaraj
ASMOF Federal DiT Delegate, NSW Branch Councillor