Submission
No 44

THE IMPLEMENTATION OF PORTFOLIO COMMITTEE NO. 2 RECOMMENDATIONS RELATING TO CROSS-JURISDICTIONAL HEALTH REFORM AND GOVERNMENT CONSULTATION WITH REMOTE, RURAL AND REGIONAL COMMUNITIES

Organisation: AMA New South Wales

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The Australian Medical Association of New South Wales (AMA (NSW)) provides its submission to NSW Parliament regarding the Inquiry into the implementation of Portfolio Committee No. 2 recommendations relating to cross-jurisdictional health reform and government consultation with remote, rural and regional communities.

AMA (NSW) is a medico-political organisation that represents more than 8,000 doctors-in-training, career medical officers, staff specialists, visiting medical officers, specialists and general practitioners in private practice. AMA (NSW) is the registered industrial body representing Visting Medical Officers in NSW. AMA (NSW) is dedicated to providing members with representation on a variety of medical issues, professional services and commercial benefits.

Please contract Isabella Angeli, Policy Officer at AMA (NSW) if you have any further questions.

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Introduction

1. All individuals in New South Wales, regardless of geographic location or socio-economic status, deserve access to high-quality healthcare. Unfortunately, residents residing outside of major cities face significant challenges in accessing essential health services, including non-GP specialist care. Despite the Remote, Rural, and Regional Health Inquiry, there has been limited progress in enhancing health services in these regions. In fact, anecdotal evidence indicates a concerning decline in workforce availability, funding and overall service delivery.

2. The Australian Medical Association (NSW) has identified several critical factors affecting healthcare delivery in remote, rural, and regional areas:

Cross-jurisdictional cooperation between the New South Wales and Australian governments

3. Issues persist in cross-border regions regarding disparate remuneration rates for health practitioners and access to specialist referral pathways. For example, in remote locations like Broken Hill, specialist access often requires transfer to South Australia. Patients from Southern LHD frequently require treatment in the ACT, and patients in Albury and surrounds receive care through the Victorian Health system. This creates issues with outflows of funds to other jurisdictions as well as issues with training and Award entitlements. As NSW is currently the lowest remunerated State for medical workforce, all LHDs close to other state borders report critical issues with attracting and retaining staff.

4. A compelling and common case is that of Dr. Ian Spencer, a general practitioner in Wellington, NSW, who, as reported by ABC News, is contemplating retirement but may become the sole GP at Wellington's Swift Street Medical Centre. With two GPs leaving at the year's end and two trainee positions unfilled, this scenario reflects a broader crisis affecting rural and regional towns, where around 80 GP trainee positions remain vacant this year. Incentive schemes in neighbouring states, such as Victoria's recent allocation of 400 grants of $40,000 for junior doctors entering GP training, exacerbate the workforce shortage in NSW.

5. While other states have funded GP training incentives from the State Health budget, given the critical issues facing the NSW health budget, we believe the Commonwealth Government should take responsibility for paying a nationally consistent incentive payment of at least $40,000 to match current state arrangements. Such an incentive payment would recognise the role of the Commonwealth government in the funding of out of hospital care and would prevent the disparity between states of incentive payments.

6. The difference between Commonwealth and State funding also has significant implications regarding private patient care in public hospitals.

7. A rural GP VMO shared, *''We are paid for hospital work via the settlement package, but only for public patients. For private patients, we must bill ourselves to the private health companies; which increases our admin burden/cost. More annoyingly there are very few MBS item numbers we can claim. So, I am basically working for about $40 per patient per day, but taking all the responsibility; doesn't matter if they call me at 2am if they are admitted patients. We can't bill for ECG or after hours or weekends. If we don't have JMOs to carry that load like city-based doctors, we need to be adequately compensated.''*

8. The National Health Reform Agreement (NHRA), set to expire in 2025, outlines the shared responsibilities of the Commonwealth and State governments in providing public hospital services. This agreement shifted the funding model from block grants to retrospective activity-based funding (ABF), increasing the Commonwealth's contribution to public hospital services from approximately 38% to 45%. However, the ABF model has faced criticism for prioritising efficiency over quality improvement, leaving hospitals under-resourced to focus on enhancing

patient care, and disadvantages rural and regional facilities which provide essential care, but which do not at the activity levels of metropolitan areas.

9. To address these challenges, the AMA proposes a four-point plan for hospital reform, advocating for targeted reforms to address the public hospital crisis:
 a) Improve performance: Reintroduce funding for performance improvement to enhance quality of care, separate from ABF funding.

 b) Expand capacity: Increase funding for additional beds and staff through a partnership with the Commonwealth to alleviate community demands and improve treatment times.

 c) Address demand: Invest in out-of-hospital care to treat patients in community settings, prioritising initiatives that reduce avoidable admissions and readmissions.

 d) Increase funding and remove funding cap: Raise the Commonwealth's funding contribution to 50% for activity-based funding and eliminate the 6.5% growth cap, representing a potential investment of $20.5 billion over four years.

Limitations surrounding initiatives, services or training programs

10. Career progression opportunities in regional areas are often limited, deterring doctors from practicing there. The reliance on locums complicates the supervision of DITs, as some locums lack the desire or qualifications to provide adequate oversight. This shortage of supervisors impacts hospitals' ability to offer accredited training positions. Regional hospitals typically have fewer senior registrar roles, requiring DITs to rely more on consultants for support, which can increase their workload and necessitate direct supervision.

11. As previously highlighted to this Committee, AMA (NSW) has received reports of severe shortages in intern positions this year, with one regional hospital only two out of 14 allocated spots, and another reporting a shortfall of 20 interns for 2024, partly due to higher pay in neighbouring Queensland.

12. To attract and retain DITs in regional areas, it's essential to provide supportive environments, including safe accommodation, adequate supervision, and financial incentives. AMA (NSW) advocates for colleges to establish regionally based training positions, noting that successful implementation depends on the availability of necessary support in regional hospitals.

Workforce

13. AMA (NSW) recognises the expansion of the GP single-employer model in 2023 as contributing towards improving access to quality health services in rural and regional communities across NSW. It is hoped that the single employer model will assist in addressing the rural GP workforce crisis, with a determination of its success observing practitioners returning to work in private regional practice.

14. Regional areas face significant obstacles in maintaining organisational stability and growth due to a shortage of doctors living and working in regional and rural areas. This shortage places undue strain on the existing workforce, leading to unsustainable rosters and contributing to burnout, which further deters doctors from relocating to and working in these regions. The lack of specialists and number of vacant junior medical officer positions is evident, with hospitals struggling to fill available roles. The reliance on locums for short-term coverage is growing, but this approach raises concerns about continuity of patient care and can create disparities in working conditions between locums and local doctors. Long-term solutions must focus on retaining resident doctors in regional communities to ensure quality care for patients.

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Budget

15. This year Premier Minns presented his second health budget, which fell short of addressing the urgent needs of the State's healthcare system, with only a 2.97% increase compared to 2023. This increase does not keep pace with health inflation, resulting in an effective budget cut. The budget particularly fails the needs of rural and regional communities, by providing limited support for already stretched local health districts (LHD) budgets in these areas, and no effective incentives to retain doctors within these communities. Moreover, the ABF model exacerbates these constraints by allocating funds based solely on service volume, failing to account for the unique challenges faced in delivering outside of major cities.

16. The issue is further compounded by hospital exit block, where patients cannot be discharged due to inadequate community or home-based care options, further burdening hospital resources and on-the ground medical staff. As a result of budgetary pressures, AMA (NSW) has been advised that administration officers are being pulled from services, leading to clinic cancellations and increased burdens on physicians, while reports indicate that even LHDs with sufficient doctor numbers are cutting services, including postponing emergency surgeries, resulting in patients with fractures experiencing delays in care of several days or weeks.

Conclusion

17. Access to high-quality healthcare for all residents of New South Wales, particularly in regional, rural, and remote areas, is an urgent priority. Addressing the challenges of workforce shortages, insufficient funding, and ineffective incentive structures is crucial to ensuring equitable healthcare delivery. AMA (NSW) strongly advocates for targeted reforms, including enhanced financial support, improved performance metrics, and increased training opportunities. By prioritising these initiatives, we can build a sustainable healthcare system that meets the diverse needs of all communities and retains healthcare professionals in underserved areas.

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