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Submission to NSW Special Commission of Inquiry into Healthcare Funding

November 2023

About The Royal Australasian College of Physicians (RACP)

The RACP trains, educates and advocates on behalf of over 31,000 physicians and 9,000 trainee physicians, across Australia and New Zealand, including over 5,850 physicians and 2,350 trainee physicians in New South Wales. The RACP represents a broad range of medical specialties including general medicine, paediatrics and child health, cardiology, respiratory medicine, neurology, oncology, public health medicine, infectious diseases medicine, occupational and environmental medicine, palliative medicine, sexual health medicine, rehabilitation medicine, geriatric medicine, and addiction medicine. Beyond the drive for medical excellence, the RACP is committed to developing health and social policies which bring vital improvements to the wellbeing of patients.

We acknowledge and pay respect to the Traditional Custodians and Elders – past, present and emerging – of the lands and waters on which RACP members and staff live, learn and work. The RACP acknowledges Māori as tangata whenua and Te Tiriti o Waitangi partners in Aotearoa New Zealand.

Introduction

The RACP welcomes the opportunity to provide a submission to the Special Commission of Inquiry into Healthcare Funding in New South Wales. As the sole accredited provider of specialist physician and paediatrician training in Australia, with Fellows and trainees in every public hospital (and many non-hospital community settings) in New South Wales, we are uniquely placed to comment on the NSW health and public hospital system as a whole and suggest areas for improvement. We would welcome the opportunity to discuss these matters further with members of the RACP and the Special Commission.

A safe and well-resourced medical specialist workforce is essential to a functioning, effective and sustainable health system. The NSW health workforce faces many challenges that have been further exacerbated by the ongoing COVID-19 pandemic, such as increasing pressures and demands affecting health workers' mental health and wellbeing, and an uneven distribution of medical professionals across locations and specialties. Our submission outlines improvements to the NSW health system to better meet the population's health needs in a sustainable way.

The RACP has a clear commitment to advancing Aboriginal, Torres Strait Islander, and Māori health and education as core business of the College, implemented by a comprehensive Indigenous Strategic Framework. We are a founding member of the Close the Gap Campaign for equality in health status and life expectancy between Aboriginal and Torres Strait Islander peoples and non-Indigenous Australians by 2030. We work closely with valued partners including Indigenous peak health organisations to further the needs of First Nations peoples.

Responses to Terms of Reference

Our submission takes the form of brief responses to selected terms of reference and parts thereof.

> **A:** *The funding of health services provided in NSW and how the funding can most effectively support the safe delivery of high quality, timely, equitable and accessible patient-centred care and health services to the people of NSW, now and into the future***.**

The Australian health system relies on a range of interlinking Commonwealth and state funding streams aimed at delivering high quality care in an equitable and efficient way. Our views about Commonwealth funding streams are best outlined in our 2023-24 Commonwealth pre-Budget submission. Our submission to the Pricing Framework for Australian Public Hospital Services 2024-25 lays out opportunities and concerns about hospital funding. Our specific recommendations for the current NSW Government are set out in our 2023 NSW Election Statement (from which some parts of this submission are adapted).

> **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.*

Preventive care

NSW Health funding should reflect the National Preventive Health Strategy which commits 5% of health expenditure for prevention over 10 years till 2030.

In addition, direct investment in the broader, society-wide, social determinants of health is needed. Social determinants of health are the "…non-medical factors that influence health outcomes. They are the conditions in which people are born, grow, work, live, and age, and the wider set of forces and systems shaping the conditions of daily life"[1] such as level of education, income, housing, and environment. Social determinants of health influence the health and well-being of individuals, communities and populations, and play a significant role in shaping quality of life outcomes.

[1] Health Topic: Social Determinants of Health [Internet]. World Health Organization.; [cited 2023 Sep 27]. Available from: https://www.who.int/health-topics/social-determinants-of-health#tab=tab_2

The RACP's 2016 Health in All Policies Position Statement[2] is premised on a large body of evidence which demonstrates the link between health status and socioeconomic circumstances. It is driven by two central ideas for addressing the social determinants of health:

- Diseases and illness are directly related to social inequities. Social determinants of health influence health inequities, and the unfair and avoidable differences in the health status of populations.
- Addressing the social determinants of health will reduce the burden of avoidable disease, enhancing the lives of Australians. It can also promote economic growth and development through maximising the health and wellbeing of our people.

The social determinants of health are complex and operate at many levels to influence health. Most of these factors lie outside the immediate reach and traditional remit of the health system.

The NSW Government must work with physicians, sectors outside the health system and the private sector to encourage a more health-focused, joined-up approach to policy-making that addresses the social determinants of health to reduce the burden of avoidable diseases.

Integrated care and the role of physicians

Health policy reforms must address the need to improve the integration of healthcare delivery, retain and continually advance the quality and safety of services, and overcome inequities in health. Integrated service delivery structures are needed to better support accessible, more patient centred health services offered closer to home for diverse populations, compared to the hospital-centric and siloed services into which our services have evolved. Reorienting our way of delivering services is a sensible approach to addressing the challenges Australia shares along with many countries with an ageing population, increasing numbers of people with chronic and multiple conditions, and uneven service distribution.

Although excellent examples of integrated care can be seen in New South Wales (as in other parts of Australia), these often work despite the system, and are not widely translated into the broader system as standard best practice.

At the general level, the RACP has proposed[3] a set of key principles to underpin effective and sustained integrated care, including enabling strategies to drive reforms so that integrated care becomes the norm rather than the exception.

Fundamental to effective integrated models of care is a cross-disciplinary, cross-organisational approach; especially for patients who need care for multiple, chronic and often complex health issues. In Australia that will require strong cross-jurisdictional collaboration and cooperation and, most likely, new ways of funding and responsibilities. Regional planning, reporting, commissioning and organising are likely to come to the fore, providing challenges but also opportunities to drive a more patient-centred and connected health system. There can be no single model or approach to integrated care that will meet the needs of all patients. The RACP is particularly cognisant of this due to the wide and varied range of medical disciplines that the RACP represents. We need to be future-focused and move to service delivery environments where physicians and other clinicians are more collaborative (multidisciplinary team-based care) and supported to practice more in ambulatory and community settings. As an educational organisation, the RACP ensures our trainee physicians are well-prepared for clinical practice in these contexts and supports physicians' continuing professional development in skills and knowledge associated with integrated care.

Experience to date shows that while integrated care has significant support, it is not easy to deliver within the context of a complex healthcare system. The potential benefits of integrated care have made it an important policy priority for the RACP. There is potential for integrated and patient centred care to:

- Improve the timely provision of appropriate care
- Reduce unnecessary or inefficient appointments or referrals made for patients

[2] Health in All Policies Position Statement [Internet]. The Royal Australasian College of Physicians; 2016 [cited 2023 Sep 27]. Available from: https://www.racp.edu.au/docs/default-source/advocacy-library/health-in-all-policies-position-statement.pdf. The statements in this section are referenced in this position statement.

[3] Integrated Care Discussion Paper: Physicians supporting better patient outcomes [Internet]. The Royal Australasian College of Physicians; 2018 [cited 2023 Sep 27]. Available from: https://www.racp.edu.au/docs/default-source/advocacy-library/integrated-care-physicians-supporting-better-patient-outcomes-discussion-paper.pdf

- Improve the patient experience
- Increase patient attendance and lead to fewer patients lost to lack of follow-up
- Reduce the incidence or potential impact of conflicting clinical advice or management (for example, medication interactions)
- Lead to higher levels of professional job satisfaction
- Assist in reducing unnecessary hospitalisations
- Reduce waste of other professional services (unnecessary use of services) within the health system.

The health of Aboriginal and Torres Strait Islander people

The number of people in NSW identifying as Aboriginal or Torres Strait Islander has risen to 278,000 (as of the 2021 Census of Population and Housing), representing 3.4% of the New South Wales population. This is up from 2.9% in 2016, and 2.5% in 2011.[4] This places the onus on the Government and on health services to properly quantify and plan for the availability of appropriate culturally safe services.

Census data also tells us that in 2021, 51.8% of Aboriginal and Torres Strait Islander people in New South Wales were aged under 25 years. This means that while of course there is a need for good access to specialist care for chronic disease care/treatment across all disciplines, there is also a large need for essentially paediatric, adolescent, and young adult medical services, and for public health physician involvement in disease prevention. For detail on the RACP's policy recommendations, please see our Indigenous Child Health Position Statement.

Aboriginal and Torres Strait Islander health leadership and genuine community engagement is crucial to achieving improved health outcomes. The Aboriginal Community Controlled Health sector is of vital importance in delivering effective, culturally safe care to Australia's First Peoples. The RACP is committed to respecting Aboriginal and Torres Strait Islander self-determination and agrees that service development and provision should be led by Aboriginal and Torres Strait Islander health organisations wherever possible.

The RACP is committed to playing its part within our direct sphere of influence, via the implementation of the Indigenous Strategic Framework 2018-2028. This has five detailed commitments, each with strategies, outcome and progress indicators, and timeframes:

- Priority 1: Contribute to addressing Indigenous health equity differences
- Priority 2: Grow and support the Indigenous physician workforce
- Priority 3: Equip and educate the broader physician workforce to improve Indigenous health
- Priority 4: Foster a culturally safe and competent College
- Priority 5: Meet the new regulatory standards and requirements of the Australian Medical Council (AMC) and Medical Council of New Zealand (MCNZ).

The RACP's Aboriginal and Torres Strait Islander Health Committee has developed the Medical Specialist Access Framework, a strengths-based guide for health sector stakeholders to promote and support equitable access to specialist care for Australia's Indigenous peoples. We know there is inequitable access to medical specialists for Indigenous Australians throughout Australia, despite higher burden of disease (especially chronic disease) and greater need for specialist services.

The Framework includes case studies of innovative and successful models of Aboriginal and Torres Strait Islander people accessing specialist care, including two case studies of NSW services. The Framework aims to connect stakeholders involved in delivering specialist medical care including patients, carers, communities, funders, facilitators, service providers and individual medical specialists and other health practitioners.

We strongly urge the NSW Commission of Inquiry to consult directly with Aboriginal and Torres Strait Islander people and peak bodies, and:

[4] New South Wales: Aboriginal and Torres Strait Islander population summary | Australian Bureau of Statistics [Internet]. Australian Bureau of Statistics; 2022 [cited 2023 Sep 27]. Available from: https://www.abs.gov.au/articles/new-south-wales-aboriginal-and-torres-strait-islander-population-summary#:~:text=In%20New%20South%20Wales%20278%2C000

- Prioritise and support the leadership and engagement of Aboriginal and Torres Strait Islander leaders and communities.
- Support Aboriginal and Torres Strait Islander community led early childhood services.
- Prioritise Aboriginal and Torres Strait Islander community engagement and leadership for public health programs.
- Prioritise equitable access to specialist care for Aboriginal and Torres Strait Islander people in NSW. This requires systems and mechanisms to drive regional collaboration in identifying and planning specialist healthcare service provision for Aboriginal and Torres Strait Islander people.
- Properly quantify the need for specialist services and plan to ensure this is appropriately met.
- Encourage the use of the RACP's Medical Specialist Access Framework in NSW, including for developing innovative and effective models of care that meet the health needs of Aboriginal and Torres Strait Islander people and communities.

Climate change and health

Medical professionals in NSW are seeing the impacts of climate change on health firsthand. Bushfires, extreme heat, and flooding have severely impacted NSW's healthcare system, and appropriate health system readiness for the future is essential. We have seen health services evacuated due to extreme flooding, children coughing through smoke haze and the mental health of entire communities put under severe pressure. We need action to protect the health of patients and communities and to improve the resilience of the healthcare system.

In addition, the healthcare sector has to play its part in reducing the climate emissions feeding the problem (noting the health sector currently contributes around 7% of Australia's carbon emissions[5]). The RACP has called on the NSW Government to achieve net zero healthcare emissions by 2040.

The RACP is proud to play a leading role in responding to the climate challenge, developing a research report, Climate Change and Australia's Healthcare Systems - A Review of Literature, Policy and Practice, produced for the RACP by the Monash Sustainable Development Institute, Climate and Health Alliance, Monash University's School of Public Health and Preventive Medicine and the University of Melbourne's School of Population and Global Health. The report has been guided by an advisory committee with representatives from 10 medical colleges contributing knowledge, and expertise from a diverse range of specialties.

In our 2023 NSW Election Statement the RACP has also called for a boost to the NSW Climate Health and Net Zero Unit to coordinate and guide the development and implementation of locally led resilience strategies, manage innovation and research funds, and work in partnership with the Office of Energy and Climate Change in NSW Treasury.

Expanding the Unit has the potential for it to scale up its work on healthcare system emissions reduction while also building capacity and resources to support the NSW health system to become climate resilient.

The COVID-19 pandemic has shown us that rapid system change is possible in the face of serious threats. Our recovery presents an opportunity to accelerate the delivery of climate resilient and environmentally sustainable healthcare. By supporting our healthcare system to reduce its emissions and to become more adaptable, we can save money in energy costs and deal with extreme weather events. Most importantly, we can act to safeguard the health of our communities and that of future generations.

The RACP's specific Climate Change and Health recommendations for NSW are:

- Commit to achieving net zero healthcare emissions by 2040.
- Grow the NSW Health Climate Risk and Net Zero Unit to coordinate and guide the development and implementation of locally led resilience strategies, manage funds, and work in partnership with the Office of Energy and Climate Change in NSW Treasury.
- Establish a Climate Friendly Health System Innovation Fund to provide grants to local health services for implementing emissions reduction, climate impacts and sustainability initiatives. This could be established as a category of the NSW Environmental Trust or as part of NSW Health's planned Net Zero Innovation Program.

[5] Malik A, Lenzen M, McAlister S, McGain F. The carbon footprint of Australian health care. The Lancet Planetary Health [Internet]. 2018 Jan [cited 2023 Nov 3];2(1):e27–35. Available from: https://www.thelancet.com/journals/lanplh/article/PIIS2542-5196(17)30180-8/fulltext

- Establish a Climate Ready Health System Research Fund to identify resilience strategies suited to our health system. This could be established via the NSW Health's Net Zero Innovation Program and work in partnership with the Office of Energy & Climate Change in the NSW Treasury.
- Develop and implement locally led resilience and adaptation plans for the healthcare sector.
- Audit, monitor and report on healthcare system emissions, and set more ambitious objectives going forward.
- Substantially contribute to developing and implementing the National Health and Climate Strategy.
- Urgently transition to zero emissions including a rapid transition to 100% clean renewable energy across all economic sectors with support for affected communities to improve health and address the underlying causes of climate change.

Investment in the early years

There is substantial evidence that investment in the early years of children's health, development and wellbeing is the most cost-effective means of tackling long-term health conditions and health inequity. Investing in the early years offers the possibility of shifting the trajectory of a person's health over the course of their life and disrupting intergenerational cycles of disadvantage. The antenatal period is included because of the unequivocal evidence for the influence of fetal wellbeing on the life course.

Significant populations of children and young people in Australia and New Zealand are at risk of poorer developmental outcomes due to entrenched and often intergenerational disadvantage. For children, the effects of disadvantage can result in less satisfactory early development before and after birth. It can lead to fewer opportunities for education and later employment, less opportunity to learn about healthy nutrition and lifestyles, and unhealthy behaviours such as smoking and heavy alcohol use. The RACP believes that a comprehensive, coordinated and long-term strategic approach to identifying and addressing disadvantage and vulnerability in children and infants should be considered by all tiers of government to ensure that every child receives the best possible start in life.

For detailed evidence and 47 detailed policy recommendations we refer you to the RACP's position statement on Early Childhood: The Importance in the Early Years,[6] and to the RACP's submission to the Productivity Commission on Early Childhood Education and Care.[7]

We also refer you to our recommendations to state governments contained in our position statement on the Health Care of Children in Care and Protection Services.[8]

Aged care and Disability Care

The availability of, and access to, quality residential aged care facilities (RACFs) and disability services affects the operation of NSW hospital services. RACFs are stretched and operate in an environment that has seen state government funding reductions to other providers of related services.[9] There is constant pressure to discharge patients from acute care facilities back to residential care. Residential care funding for higher care patients is insufficient and the level of resourcing is too narrow given the span of responsibility across residential aged care.

Some RACP members are concerned that some patients may remain in hospital for lack of appropriate accommodation or suitable disability or behavioural services – in some cases, for many months. Discharges can be delayed for non-clinical reasons; in other cases, discharge occurs to facilities that are suboptimal and not designed to meet the patient's needs. For example, it can take too long to provide post-hospital discharge care and accommodation for people who have intellectual disabilities with significant behavioural issues.

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[6] The Royal Australasian College of Physicians. Position Statement: Early Childhood: The Importance of the Early Years [Internet]. 2019 [cited 2023 Oct 19]. Available from: https://www.racp.edu.au/docs/default-source/advocacy-library/early-childhood-importance-of-early-years-position-statement.pdf?sfvrsn=e54191a_4

[7] The Royal Australasian College of Physicians. RACP Submission to the Productivity Commission: Early Childhood Education and Care [Internet]. 2023 May [cited 2023 Oct 19]. Available from: https://www.racp.edu.au/docs/default-source/advocacy-library/racp-submission-to-the-productivity-commission-early-childhood-education-and-care.pdf?sfvrsn=b4fdd21a_4%C2%A0

[8] The Royal Australasian College of Physicians. Health Care of Children in Care and Protection Services [Internet]. 2023 Jun [cited 2023 Oct 19]. Available from: https://www.racp.edu.au/docs/default-source/advocacy-library/health-care-of-children-in-care-and-protection-services-australia-position-statement.pdf?sfvrsn=6325d21a_4

[9] RACP (2019) Submission to the Royal Commission into Aged Care Quality and Safety

To respond to aged care needs in NSW and health system pressures:

- It is imperative older people have better access to specialist care and multidisciplinary teams readily available wherever they reside, given the current and projected demands on the health care system, on residential care facilities (which are not health care facilities), and the increasing proportion of people with complex chronic co-morbidities in our population.
- NSW and other state and territory governments should work with the Commonwealth to formulate more healthcare pathways or care programs that are appropriate for managing older patients with multi-morbidity and/or frailty and which take account of competing risks and potential for harmful interactions between treatments for different conditions or groups of conditions.
- Multidisciplinary assessment services for older people should remain state based, and appropriately funded.
- The NSW Government should address Recommendation 58 of the Royal Commission into Aged Care Quality and Safety: Access to specialists and other health practitioners through Multidisciplinary Outreach Services. The key features of the model as outlined in Recommendation 58 include:
    - provision of services in a person's place of residence wherever possible
    - multidisciplinary teams, including nurse practitioners, allied health practitioners and pharmacists
    - access to a core group of relevant specialists, including geriatricians, psychogeriatricians and palliative care specialists
    - embedded escalation to other specialists (including endocrinologists, cardiologists, infectious disease specialists and wound specialists), who are already salaried within the hospital and assigned to the model for part of their work.

Drug reform

Substance use disorders are a health issue with complex biological, psychological and social underpinnings. In its more severe forms, it is a chronic relapsing, remitting disorder characterised by drug seeking and use that is compulsive, difficult to control and persists despite harmful consequences.[10] The underlying cause of substance use disorders can be linked to environmental factors and early adverse life experiences such as trauma, abuse, an unstable childhood or home environment, family substance use and attitudes, and peer and commercial influence, and also to biological factors including genetics, gender, and having concurrent mental health disorders.[11]

Social determinants that impact on a person's substance use and dependence include their socio-economic status, housing status and security, and education. Due to complex factors including intergenerational dispossession and the impact of the social determinants of health, Aboriginal and Torres Strait Islander people are at increased risk. Substance use disorder is a complex issue, not simply a personal choice. It can lead to changes to the brain that challenge a person's self-control and interferes with their ability to resist intense urges to take drugs. Governments at all levels need to move away from the dominant paradigm of criminality as the means to deal with individuals who use drugs including alcohol. We must first and foremost look at this problem through a health and social lens, rather than a criminal one. As the organisation representing public health and addiction medicine specialists, we encourage the NSW Government to commit to a health-based approach to drug policy in NSW.

The Inquiry should recommend a health-based approach to drug policy to improve outcomes for individuals and communities more broadly, with funding commensurate with the need. This means prioritising evidence-based harm reduction, prevention and treatment measures, including providing sustained, long-term funding to increase the capacity of drug and alcohol services to meet the demand for treatment, combined with real and persistent efforts to reduce disadvantage and inequities within society.

We have welcomed funding flowing from responses to the NSW Special Commission of Inquiry into the Drug "Ice," noting this funding was focussed on methamphetamine, not alcohol and other drugs, and noting that the recommendations of the Ice inquiry have not yet been implemented in full. In addition, many NSW services have only had minimal to moderate funding enhancements. The NSW population needs accessible drug and alcohol services, and a process to assess evolving need and adjust funding over time.

[10] National Institute on Drug Abuse. Understanding Drug Use and Addiction Drug Facts [Internet]. 2018 [cited 2023 Nov 2]. Available from: https://nida.nih.gov/publications/drugfacts/understanding-drug-use-addiction

[11] National Institute on Drug Abuse. Drug Misuse and Addiction [Internet]. 2020 [cited 2023 Nov 2]. Available from: https://nida.nih.gov/publications/drugs-brains-behavior-science-addiction/drug-misuse-addiction

Telehealth

The RACP supports expanding and integrating telehealth specialist services especially into NSW-funded hospital, community, and outreach-based services.

We invite the Inquiry to review our submission to the Australian National Audit Office's Audit of Expansion of Telehealth Services, including feedback from RACP Fellows indicating the benefits of telehealth for patient outcomes. Broadly understood, widespread telehealth (over and above the Commonwealth-funded MBS items) improves:

- regional access to care
- access to specialist care for Aboriginal and Torres Strait Islander people
- equitable access to care (e.g. for patients with a disability who cannot travel easily)
- climate footprint, in that telehealth has a much lower carbon footprint compared to the often extensive travel patients in regional areas undergo to see a specialist.

D (parts only): *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.*

We suggest the Commission examines the benefits of widespread promotion and uptake of recommendations from Evolve, a flagship initiative led by physicians and the RACP to drive high-value, high-quality care in Australia and New Zealand. Evolve is a founding member of Choosing Wisely in Australia and New Zealand, with all Evolve 'Top-Five' recommendations part of the Choosing Wisely campaign.

Evolve aims to reduce low-value care by supporting physicians to be leaders in changing clinical behaviour for better patient care, make better decisions, and make better use of resources.

Please also see response to Term of Reference H (below).

F (parts only): *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:*

i. the distribution of health workers in NSW;

ii. an examination of existing skills shortages;

iii. evaluating financial and non-financial factors impacting on the retention and attraction of staff;

iv. existing employment standards;

v. […]

vi. the skill mix, distribution and scope of practice of the health workforce;

vii. […]

x. the role of multi-disciplinary community health services in meeting current and future demand and reducing pressure on the hospital system;

We refer you to the first two priorities in the RACP's NSW 2023 Election Statement's, and recommendations (reproduced here):

1. Supporting the specialist workforce to meet growing healthcare needs:
   - Increase career pathways for Career Medical Officers and Junior Medical Officers (JMOs) across the NSW health system by providing doctors with rural and regional experience, attractive training and career opportunities. These might include recognition of rural/regional training by medical colleges as equivalent to significant research, flexible contract lengths for the JMOs and the incentivisation of rural/regional training for Basic Physician Training and Advanced Physician Training.

- In partnership with the Commonwealth and specialist medical colleges, support the development of rural specialist training hubs to attract and retain specialist trainees across rural sites and facilitate the transition to ongoing rural specialist practice.
- Track, map, and research the effects of increased rural medical scholarships on long-term specialist workforce distribution (noting the NSW Government recently more than doubled its rural medical scholarship commitment to attract and retain qualified medical staff in these areas and provide care to patients in place).
- Support a dedicated national training program for the public health workforce to address the workforce shortages exacerbated by the pandemic.
- Provide funding to increase the number of Aboriginal and Torres Strait Islander health professionals, including the integration of specialist care into Aboriginal Community Controlled Health Services.
- Adequately fund additional video technology and telehealth packages for the NSW health system to improve timely connectivity between patients and specialists, including across the metropolitan, rural and regional divide.
- Fund appropriate inpatient rehabilitation beds and staffing levels.
- Commit to working across sectors to remove barriers to discharge, including accessible rehabilitation, disability services and supported accommodation.
- Commit to developing and implementing of a culture of high-value care across NSW, including supporting the RACP's flagship Evolve initiative, led by physicians and the RACP to drive high-value, high-quality care.

2. Fostering a culture of wellbeing for physicians and trainee physicians:
   - Commit to providing a positive workplace culture and working conditions for trainees and physicians and provide workforce models that support high-quality specialty training, including research support.
   - Work collaboratively with the RACP and other stakeholders to eliminate bullying and harassment.
   - Boost the state's healthcare workforce by strengthening the capacity to train medical specialists and resourcing the overall system to serve the population's needs fairly and equitably.
   - Support strategies for flexible training, work hours, parental leave and other support mechanisms for specialists and doctors in training within the NSW health system and support our advocacy for national training and employment flexibility, where appropriate.
   - Develop a system of locum support to maintain service delivery in areas with specialist cover provided by very few practitioners. This should cover routine planned staff leave plus leave for specialty continuing professional development to encourage a highly trained and safe specialist workforce.
   - Become a signatory to our Health Benefits of Good Work principles, an initiative from the RACP's Australasian Faculty of Occupational and Environmental Medicine to further champion health, wellbeing, and supportive workplace culture in the health sector.
   - Join the RACP in committing to gender equity in medicine and health leadership, including endorsing the UN Women's Empowerment Principles.
   - Urgently implement and appropriately fund mental health initiatives and practical supports for healthcare workers, offering a range of mental health initiatives and practical supports for them and their families. These should be based on the National Mental Health and Wellbeing Pandemic Response Plan and the lessons of its implementation.

Many of these recommendations are reflected in the RACP's updated Flexible Training Policy. We note that many important recent reforms, and many potential reforms that have been proposed, are in areas where responsibility is shared by the RACP and by employers of doctors in specialist training (noting our roles are nevertheless separate and distinct). We seek collaboration and are committed to improvement in conjunction with NSW Health.

Occupational and environmental health in healthcare settings

We also encourage the Commission to review and consider the RACP's Faculty of Occupational and Environmental Medicine's two flagship initiatives, which are both relevant to this term of reference:

- Health Benefits of Good Work
- It Pays to Care.

It is important to recognise and support the health and community services sector. SafeWork Australia designates the health care and social assistance as one of the industries identified as a national priority for

prevention activities.[12] The health care and social services industry is one of the industries with the highest number of serious claims.[13] Health care and social services workers are further regarded by SafeWork Australia as a key risk group due to the nature of their work.[14]

Moreover, the strain on the health care sector related to the COVID-19 pandemic has revealed major gaps in current WHS frameworks and capability. The COVID-19 pandemic has exposed and sometimes exacerbated underlying challenges facing the health workforce, the safety of healthcare, and the overall health system.[15]

We refer you to the RACP's submission[16] to the Consultation Paper on the Pricing Framework for Australian Public Hospital Services 2021–22, where we highlighted how COVID-19 has exposed preventable vulnerabilities and gaps in the implementation of work, health and safety provisions for health care workers, notably in public hospitals.

Specialist Training Program

Currently there are 90 FTE STP positions funded in NSW, of which approximately 36 are positioned in rural/remote regions of NSW.

Ongoing engagement with Local Health Districts that cover rural and remote facilities is required to ensure trainee rotations occur to rural placements, with relevant rotational blocks also put in place so that positions meet Commonwealth requirements. This will allow for quality training of Physicians, provide greater services to rural and remote regions, resulting in better health outcomes in communities while strengthening the NSW Health workforce. Also, ongoing support is required, otherwise rural positions will be lost due to vacancies should they fail to meet the STP Operational Framework requirements.

Prioritise regional, rural and remote medical workforce

Populations living outside metropolitan areas have poorer health outcomes. 28% of the Australian population live in rural and remote areas. They have higher rates of hospitalisations, deaths, injury and have poorer access to, and use of, primary health care services, than people living in *metropolitan areas*.

Currently only 11.4% of all our Australian members (Fellows and Trainees) are living and working in outer regional, remote and very regions (Modified Monash Model 2-7). In NSW, the College has only 27 Members recorded in outer regional areas and none in remote areas.

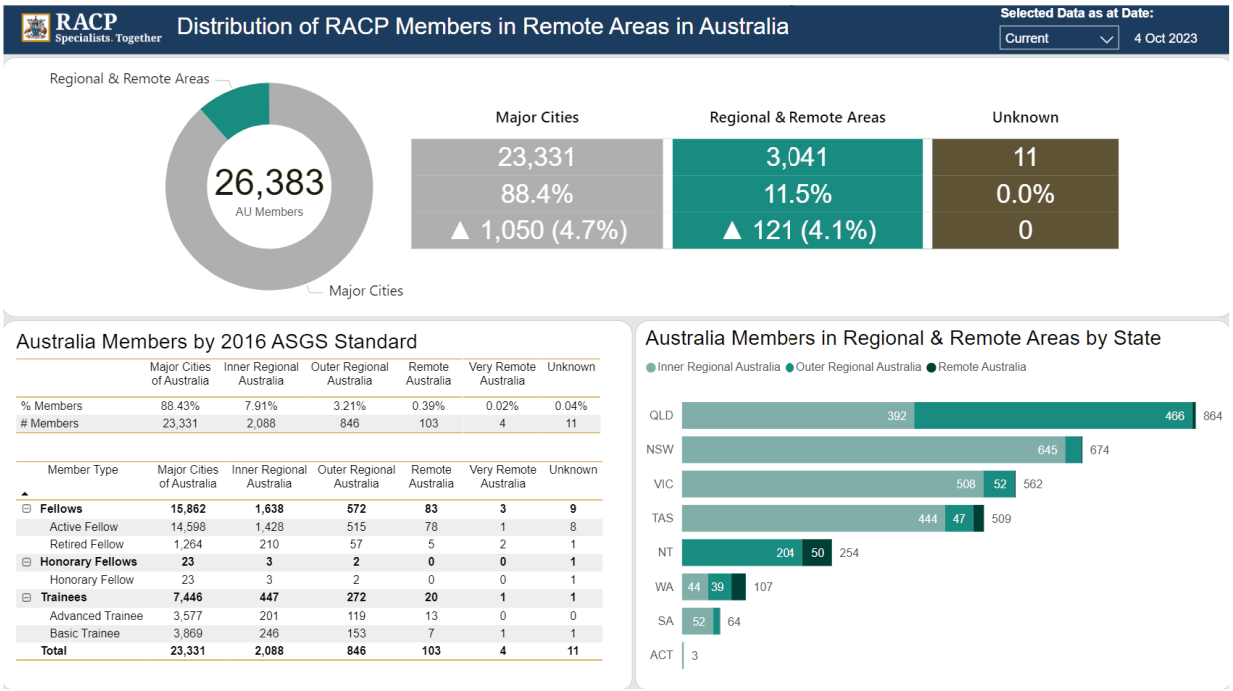
[12] Australian Work Health and Safety Strategy 2012–2022 [Internet]. 2020 [cited 2023 Oct 20]. Available from: https://www.safeworkaustralia.gov.au/system/files/documents/1902/australian-work-health-safety-strategy-2012-2022v2.pdf

[13] Health care and social assistance | Safe Work Australia [Internet]. www.safeworkaustralia.gov.au. [cited 2023 Oct 23]. Available from: https://www.safeworkaustralia.gov.au/safety-topic/industry-and-business/health-care-and-social-assistance

[14] Health care and social assistance | Safe Work Australia [Internet]. www.safeworkaustralia.gov.au. [cited 2023 Oct 23]. Available from: https://www.safeworkaustralia.gov.au/safety-topic/industry-and-business/health-care-and-social-assistance

[15] WHO. Patient Safety Charter: Health worker safety: a priority for patient safety [Internet]. 2020 [cited 2023 Oct 23]. Available from: https://www.who.int/docs/default-source/world-patient-safety-day/health-worker-safety-charter-wpsd-17-september-2020-3-1.pdf?sfvrsn=2cb6752d_2

[16] The Royal Australasian College of Physicians. RACP submission to the Pricing Framework for Australian Public Hospital Services 2024-25 [Internet]. 2023 [cited 2023 Oct 23]. Available from: https://www.racp.edu.au/docs/default-source/advocacy-library/racp-submission-ihacpa-pricing-framework-24-25.pdf?sfvrsn=1635d51a_4



Distribution of RACP members in remote areas in Australia

The RACP is currently implementing its Regional Rural and Remote Physician Strategy which has 26 recommendations that are grouped within the following focus areas:

1. Prioritise regional, rural, and remote (RRR) healthcare at the RACP.
2. Build capacity and capability to provide physician training in RRR areas.
3. Improve the attraction and retention of RRR physicians.
4. Collaborate to improve RRR healthcare provision.
5. Respect, promote and acknowledge Indigenous peoples.

The RACP seeks opportunities to collaborate with NSW Health to better understand workforce shortages, policy drivers to develop and retain the RRR workforce, and to discuss governance structures to support a sustainable workforce that delivers high quality, timely, equitable and accessible patient-centred care to the RRR population in NSW.

Consideration may include:

- Funding RRR network training pathways for specialist trainees that are not dependent on or subsidiary to metropolitan workforce needs.
- Ensuring all network training models are single employer models which safeguard security of employment and entitlement that include multi-year length of training employment contracts.
- Funding for supervision of training in RRR areas
- Funding pathways for training in the community for all specialties (especially General Medicine and General Paediatrics and non-clinical/hospital-based specialties includes those of Addiction, Sexual Health, Palliative Care, Population Health, Occupational and Environmental and Rehabilitation medicine.
- Ensuring consistent processes/systems for selection of trainees which prioritise those who are more likely to work outside large metropolitan areas people and have significant prior clinical or non-clinical experience in these settings ('grew up or worked in the bush')
- Explore options to build and expand high quality and attractive RRR training positions that support high quality supervision, reasonable workloads, travel for education and training, links with, and rotations to, metropolitan health services and ICT infrastructure for telemedicine including education.
- Prioritising dual training pathways including a generalist and sub-specialty field.

We advocate for workforce planning founded on the goal of comprehensive healthcare worker wellbeing. Our physician workforce is increasingly demographically diverse with unique work life integration needs. A

sustainable workforce plan will support better work life integration through ethical rostering practices and the provision of flexible work arrangements. The RACP actively promotes flexible training.[17]

Although increasing digitisation of the workplace stands to generate efficiencies, clinicians must be involved at all levels of governance and implementation to ensure systems are fit for purpose and don't compromise patient or clinician harms. The RACP has also begun exploring the role of AI in medical training.

Term of Reference G: *Current education and training programs for specialist clinicians and their sustainability to meet future needs, including:*

i. placements;

ii. the way training is offered and overseen (including for internationally trained specialists);

iii. how colleges support and respond to escalating community demand for services;

iv. the engagement between medical colleges and local health districts and speciality health networks;

v. how barriers to workforce expansion can be addressed to increase the supply, accessibility and affordability of specialist clinical services in healthcare workers in NSW;

Overall training capacity and the RACP approach

The RACP trains as many physicians to the requisite standard as the training system can sustain, noting:

- We have a fundamental commitment to high standards of specialist medicine and specialist medical education, borne from a sense of professional responsibility and a duty to maximise patient health outcomes.
- The RACP is concerned about the health system's capacity to effectively support the training of its members. The RACP has previously considered formulas to determine capacity to train, caps on training numbers, and selection into training processes. These approaches were not progressed as they do not address the complexity of this issue. The RACP is choosing to use accreditation as the tool for monitoring a hospital's capacity to train. This allows better consideration of both the qualitative and quantitative aspects at a setting which determines their capacity to deliver a training program to cohorts of trainees.
- We monitor the training system through the College's accreditation standards and enables local settings to assess and plan for their capacity to train as outlined in the RACP Capacity to Train Guidance.
- We have endorsed the National Medical Workforce Strategy and stand ready to support implementation of the initiatives described within it.
- We do not cap numbers of trainees in particular specialties, beyond ensuring there is sufficient capacity to train.

The College looks forward to working with NSW Health, HETI, healthcare sites, and specialty societies on ensuring training occurs in a variety of settings in metropolitan, regional and rural locations, noting that extended experience in rural and regional practice is more likely to lead to future retention in those locations.

Overseas Trained Physicians

NSW currently is a high user of both the Overseas Trained Physician (OTP) competent pathway and the International Medical Graduate (IMG) Short Term Training Pathway (STTP), both in paediatrics and in adult medicine. We observe that STTP is mostly being used for workforce augmentation rather than true training, and we understand that IMGs are being told it is equivalent training to Australian training by employers. This is not the case. Short-term training in a medical specialty is not accredited by the RACP and doesn't lead to Fellowship of the College or specialist recognition in Australia.

[17] RACP Flexible Training Policy. 2023 Jan 1 [cited 2023 Oct 16]; Available from: https://www.racp.edu.au/docs/default-source/trainees/education-policies/flexible-training-policy-2023.pdf?sfvrsn=4afad11a_5

We are moving to competency-based training (away from time-based training) which will likely affect these pathways being interpreted or understood as equivalent training. We have placed some maximum numbers where supervisor capacity is a limiting factor. We are now seeking detail about training curriculums to support these positions as the registration type requires that the practitioner be in a training position. The RACP is asked to approve the position but has no oversight or feedback if things are going well or not well and these IMGs are potentially in a vulnerable position with no external oversight. Some of these STTP positions are in sites we have withdrawn accreditation due to trainee welfare concerns.

There is currently no appropriate registration category that is just for nonspecialists to fill workforce need at registrar level, for short term training – that is a barrier for workforce expansion at junior level as the Short Term Training Pathway is appropriate for IMGs who intend to complete a short period of training in Australia (of up to 24 months) and return to their country of practice once their Australian training ends. Medical practitioners in this group are potentially in a vulnerable position as we don't accredit or oversee (nor does any other college) the places they are working.

We now have similar start and finish dates for junior staff nationwide; previously this had presented challenges every January/February.

More broadly in relation to IMGs and workforce we have changed our process to assess OTPs in a limited scope of practice to respond to emerging workforce needs, in small specialties like paediatric audiological medicine as well as obesity or stroke medicine. Other colleges should be encouraged to do the same, and regulators can act to promote this.

Healthcare provided by other states and the ACT

We recognise that a large part of NSW subspecialty healthcare is delivered by medical practitioners in other states and the ACT. This needs to be included in planning. A considerable (but not precisely known) fraction of the NSW population north of Grafton flows to Queensland for some specialist services; southeastern NSW residents south of Wollongong go to the ACT, and southwestern NSW residents go to Victoria and South Australia. This is a particular issue for paediatric health care and when borders were closed for COVID response reasons.

Term of Reference 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.*

New models of care

Our response to Term of Reference C (above) considered the benefits of integrated care overall. The RACP has also developed a proposal for how integrated care can be delivered for a specific set of patients: the RACP Model of Chronic Care Management[18] for people with co-morbidities at an 'intermediate' level of care makes multidisciplinary team care more accessible and patient-centred.

Chronic conditions often require care through the primary, secondary and tertiary sectors. Without appropriate expert complex care, delayed, uncoordinated treatment of people with multi-morbidities can lead to preventable unplanned, reactive hospital admissions due to exacerbations of one or more of their conditions. One of the key elements for this patient group is specialist physician expertise.

Physician specialties cover a broad spectrum of clinical practice and these are commonly involved in multidisciplinary teams. Physicians have special training and expertise in the longitudinal care of patients with multiple and complex conditions. They play a critical role where there are complex health issues, psychosocial problems, and difficulties associated with effectively planning care in cases involving conflicting health priorities. In addition to organ and condition related specialties, there are generalist disciplines, such as paediatricians, geriatricians, general medicine physicians, palliative medicine and rehabilitation medicine physicians, that are critical to primary health care or ambulatory care.

[18] Model of Chronic Care Management: Complex care, consultant physicians and better patient outcomes (Streamlined complex care in the community) [Internet]. The Royal Australasian College of Physicians; 2019 [cited 2023 Sep 27]. Available from: https://www.racp.edu.au/docs/default-source/advocacy-library/c-final-mccm-document.pdf?sfvrsn=f873e21a_14

Specifically, consultant physicians are an integral part of the healthcare of patients with chronic multi-morbidities. The type of healthcare includes complex condition diagnosis, treatment, management, stabilization, priority determination, along with acute care. Physicians are responsible for providing a considerable proportion of health services through the MBS and through hospitals, public and private.

Right now, public access to specialist care tends to be equated with the hospital setting. Too often, patient outcomes are limited because the consultant physician role in chronic disease management has been overlooked (including at the service planning and service design level). Especially for patients with chronic co-morbidities, the vital role played by physicians has been curtailed due to the lack of incentivised opportunities for them to collaborate with GPs in an ambulatory care setting.

The RACP is committed to providing excellence in contemporary physician education to train the physicians of the future, and those physicians need to work in a system that best deploys their skills and experience to meet patient needs now and into the future. Properly integrated physician care (facilitated by new models of care, virtual teams, use of telehealth, and other communications technology) emphasises multidisciplinary care, moving this care out of hospitals and into the community, and in ways that address co-morbidity. We note that this can also improve equitable access across rural and regional parts of NSW as well as in metropolitan areas.

Our submission to the Pricing Framework for Australian Public Hospital Services 2024-25 sets out some potential mechanics of the RACP Model of Chronic Care Management which we provide for the Special Commission's consideration as an example of the kind of innovation that NSW needs to foster and fund:

> *The target population of the RACP model are those with cardiovascular related multi-morbidities at elevated risk of hospitalisation and therefore requiring both a general practitioner and consultant physician to prevent exacerbation of their conditions. It excludes patients who make frequent presentations to the hospital and who are so 'high risk' that no significant improvements can be made in reducing their level of future hospitalisations. Patients meeting risk assessed criteria would have their care delivered and managed by a core multidisciplinary team of clinicians, including those based in hospital settings.*
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> *The RACP envisage that this model would be funded by pooling funding from Commonwealth and State governments into funds at the local hospital network area which would be jointly managed by their associated local hospital district/network (LHD/LHN) and primary health network (PHN), as well as Aboriginal Community Controlled Health Organisations (ACCHOs).*
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> *One possible source of funds could be a modest share of current Activity Based Funding of public hospitals contributed by both tiers of government. Other sources that could be considered include current MBS payments for Chronic Disease Management items and practice nurse incentive payments to fund the specialist nurses that may be required in the model.*

Urgent Care Clinics

The RACP has welcomed the establishment of Urgent Care Clinics in NSW and Victoria. Overseas experience shows Urgent Care Clinics can help relieve pressure on hospitals and support patients within community settings. To do so, the clinics must have access to a range of health professionals, including specialist physicians and paediatricians, for assessment and triage.[19] [20]

While Urgent Care Clinics are intended to address minor illnesses and injuries, in practice, paediatric and adult patients often present with complex presentations requiring advanced coordination, especially in rural and

[19] Access to specialist physicians must be included in establishment of urgent care clinics in NSW and VIC [Internet]. The Royal Australasian College of Physicians; 2022 [cited 2023 Sep 27]. Available from: https://www.racp.edu.au/news-and-events/media-releases/access-to-specialist-physicians-must-be-included-in-establishment-of-urgent-care-clinics-in-nsw-and-vic

[20] No choice but to face the crisis – RACP says Federal Budget must invest in healthcare system [Internet]. The Royal Australasian College of Physicians; 2022 [cited 2023 Sep 27]. Available from: https://www.racp.edu.au/news-and-events/media-releases/no-choice-but-to-face-the-crisis-racp-says-federal-budget-must-invest-in-healthcare-system

remote areas of the country where these clinics see virtually all categories of presentations.[21] Physicians support and enhance care management pathways that do not require hospitalisation. By including physicians in the planning and funding of these clinics, the NSW Government can best ensure the clinics improve access and relieve pressure on hospitals, becoming truly interconnected with the broader healthcare system and tailoring services to local area needs.[22]

We have some concerns about potential duplication (and public confusion) of *NSW Urgent Care Services*, of which we understand 25 have been announced, and *Medicare Urgent Care Clinics* which we understand to be coming to 14 locations in NSW (to be managed by Primary Health Networks, and funded by the Commonwealth) plus a state-wide Virtual GP Urgent Care Service (also funded by the Commonwealth).

For Urgent Care Clinics to be useful for patients and successful at reducing hospital admissions, we recommend that NSW should:

- Provide long-term sustainable funding for NSW Urgent Care Clinics to sufficiently resource effective co-piloted multidisciplinary team-based care models.
- Involve RACP members in planning clinical assessment, treatment and triage protocols within NSW Urgent Care Clinics. Physicians are specially trained to care for and treat patients with complex illnesses or presentations in collaboration with GPs and allied health professionals.
- Fund independent studies with priority populations exploring the number and location of Urgent Care Clinics needed NSW rural, regional, remote and metropolitan areas to have a marked impact on hospital admissions.

[21] Victorian Department of Health and Human Services. Urgent care centres: Models of care toolkit [Internet]. 2017 Aug [cited 2023 Sep 27]. Available from: https://www.health.vic.gov.au/sites/default/files/migrated/files/collections/policies-and-guidelines/u/ucc-models-care-toolkit.pdf

[22] Prime Minister of Australia. Media Statement - Meeting of National Cabinet [Internet]. www.pm.gov.au. 2022 [cited 2023 Sep 27]. Available from: https://www.pm.gov.au/media/national-cabinet-2022-12-09