Witness Statement

Name: Dr Kathryn Austin

Occupation: Obstetrician and Maternal Fetal Medicine Specialist

1. This statement sets out the evidence that I am prepared to give to the Special Commission of Inquiry into Healthcare Funding as a witness.
2. This statement is true to the best of my knowledge and belief.

A. My role

3. I am an obstetrician and sub-specialise in Maternal Fetal Medicine ('**MFM**'). I have sub-specialised in maternal fetal medicine (also considered 'high risk obstetrics') since 2019.
4. I am currently the President of the Australian Medical Association ('**AMA NSW**'). I have most recently been an AMA NSW Council member since 2018 and an AMA NSW Non-Executive Board Director since 2020.
5. I am currently employed as a 0.5 full-time equivalent ('**FTE**') staff specialist at Royal North Shore Hospital ('**RNSH**') in the specialist obstetric clinic for medical complications of pregnancy. MFM specialists are obstetricians with extra training, qualifications, and experience in the management of high-risk pregnancies. There are only a limited number of MFM Specialists in NSW.
6. I also have an appointment as a Visiting Medical Practitioner ("VMP") at North Shore Private Hospital. I consult from rooms at the North Shore Health Hub in St Leonards. My staff specialist contract and VMP appointment are able run concurrently because my VMP appointment is at a private hospital which falls outside NSW Health .
7. My role includes teaching fellows in MFM in the Royal Australian and New Zealand College of Obstetricians and Gynaecologists (**RANZCOG**) Certification in Maternal Fetal Medicine

(CMFM) Training Program. I assist the fellows with training co-ordination, examination preparation, documentation preparation and attend to administrative tasks.

B. Staff Specialist Renumeration

Generally

8. I believe MFM is best done in the public sector because the care is delivered holistically by a multidisciplinary team. Unfortunately, this field of medicine is not well remunerated in the public sector.
9. As discussed in more detail below, there are very few 1.0FTE roles for staff specialists in MFM in the public sector. My 0.5 FTE in the public sector accounts for 50% of my working week, but only 10% of my weekly income.
10. Staff specialists are paid in part based on the private "billings" that the practitioner generates from treating private patients in the public hospital. Billings are collected on the clinician's behalf by the employing public hospital. Upon commencement of employment, a staff specialist elects to participate in a level arrangement under the Rights of Private Practice ('**ROPP**') arrangement as set out in the Staff Specialist Determination 2015. A staff specialist may, if he/she so chooses, elect prior to 30 June each year to change his/her level arrangement to commence on 1 July of the following financial year.
11. I am a level 1 staff specialist. A level 1 staff specialist assigns their private billings to the hospital and receives an allowance of 20% of their salary to compensate them for the assignment of their private billings. Staff Specialists who elect a higher level, have their private billings paid into a trust fund and they draw funds from the trust fund.
12. The rates of pay for staff specialists differ significantly across the states. It is my understanding based on discussions with colleagues that NSW is one of the lowest paying states for staff specialists in Australia based on my personal communication with doctors n

other States. This negatively impacts the junior workforce as Junior Medical Officers or early career specialists may go out of State for a registrar position, with the consequence that they may ultimately permanently leave NSW's health workforce. I have observed this occurrent across a broad range of junior consultant positions especially those in the early stages of establishing their careers.

13. Despite my view that staff specialists in my field are not remunerated well enough in the public sector, particularly in NSW, I think that there are some real benefits to being a staff specialist. For example, staff specialists who make a level 1 ROPP election (but not higher levels) have guaranteed access to an allowance for training, education and study leave ('**TESL**') allowance (albeit there is often an administrative burden that falls on the staff specialist in arranging training and education events and then seeking reimbursement). That allowance is approximately $38,000 per year. Those electing Levels 2, 3, 4, and 5 draw from the trust fund for TESL.

14. In my experience, the guaranteed TESL allowance for level 1 staff specialists, and the provision of TMF cover for private patients without the need to participate in trust fund arrangements means some practitioners elect to remain as level 1 staff specialists rather then elect a different level. I am not overly familiar with how TESL funding works for staff specialists electing level 2, 3 , 4 or 5, but based on my discussions with colleagues all staff specialists in New South Wales regardless of level would benefit from a system similar to that in Western Australia where an a allowance for education and training funding is paid (pro-rated as appropriate) to the medical practitioner to be used at their discretion as opposed to the reimbursement process staff specialists in New South Wales are required to navigate.

On-Call Remuneration

15. As a staff specialist, I provide on-call coverage, which falls into two categories: overseeing maternal transfers; and birth unit cover. On-call work is additional to the other duties of the staff specialist role.
16. On-call work in relation to maternal transfers involves providing education and advice for all maternal transfers that occur within the Northern Sydney Local Health District. Currently, staff specialists are rostered for this on-call on a 1 in 6 basis (i.e. each staff member works for 1/6th of the overall overtime roster). This may involve being on-call for 7 days in row, 24/7.
17. On-call work is remunerated under the staff specialist award by the payment of a Special Allowance which forms a component of the salary. The Special Allowance is 17.4% of salary under the Staff Specialist State Award. There is no additional payment on top of for on-call. In my view, the allowance is very small in the context of the work undertaken by obstetricians, given the inconvenience of being on-call.
18. The on-call allowance is the same across different specialties despite the difference in the on-call commitment in terms of time. For example, a dermatologist will be far less likely to be called to attend an emergency when rostered on-call compared with an obstetrician who is far more likely to be called when on-call, yet the Award provides the same allowance for all. This disincentivises those who are more likely to be called in as they are significantly inconvenienced but are paid no more than the person who is rarely called in.
19. The second category of on-call work is on-call birth unit cover. The roster for the birth unit is pro-rata-ed based on a person's appointment.
20. In my experience, due to staffing shortages (discussed in more detail below) and the nature of the work, the on-call birth unit cover obstetrician is often required to be physically

present in the hospital for the entire shift, working as the senior consultant. This can be for periods of up to 24 hours.

C. Use of VMOs

21. Within my department at RNSH, there are both staff specialists and VMOs.
22. The VMOs are deployed in a similar way to staff specialists, in that they undertake similar clinical work such as attending antenatal clinics, however, staff specialists may do more policy-based work such as writing clinical guidelines for the hospital because they have guaranteed non-clinical hours under the Award and VMOs do not under the Determinations.
23. In my department VMOs are generally paid a sessional rate, plus an hourly callback rate for any after-hours work. The remuneration of VMOs is much higher than that of staff specialists on an hourly basis.
24. Within the current model of care, VMOs are essential to my department and obstetrics generally, because obstetrics is a 24/7 service. There is a need to have enough doctors, with the requisite skill sets, available to work across the required shifts (or prepared to be called in) and on an on-call roster. The current number of obstetric staff specialists in the NSW public health system is insufficient to meet this demand, therefore, VMOs are necessary to meet the shortfall.
25. I believe that a reason for the significant reliance on VMOs in my department, to the extent they are used, is due to funding arrangements. Allegedly there is never enough funding for the required staff specialist positions, and VMOs will take the hours that are made available as they can work across multiple sites. Some VMOs will eventually seek out a Staff Specialist position if a position becomes available. The difficulty to know whether funding will be available makes it difficult to forward plan for a department.

26. Whilst I do not think that all obstetricians would choose to be employed in 1 FTE full-time staff specialist role, due to the lower remuneration in these roles in compared to VMO work, I do believe that there is a lack of staff specialist roles available, including fractional roles (less than 1 FTE roles). It is an increasingly fractionated workforce generally with people electing to work across a variety of areas e.g public and private practice or due to carer requirements meaning they elect for part time work.

27. I have observed that the lack of staff specialist roles within the public health system has been an issue for a number of years. For example, I started my career as a locum staff specialist on rolling contracts at the Women's Hospital in Randwick. Despite many vacancies at RNSH, only one staff specialist position was advertised due to funding constraints. I therefore had to commence at RNSH as a VMO before becoming a staff specialist when a position became available.

28. In my view, an increasing proportion of the workforce would be attracted to fractional staff specialist roles because those roles allow flexibility, for example to do other work in private practice, or to spend more time with family. Many hospitals with a 1 FTE position available would be willing to divide it up for people these days, recognising private practice commitments, life commitments and so forth, which mean many do not want to work full time in the public system.

D. Staff Shortages

29. Beyond the lack of staff specialist roles, discussed above, I have also observed that my department is short of senior staff more generally. I do not believe that is due to a lack of interest on the part of practitioners to join RNSH but rather the result of insufficient funding to facilitate appointments.

30. This contrasts with regional areas, which have large amounts funded FTE positions, but have difficulty attracting staff to work there.

31. Across the State generally the lack of roles places pressure on existing staff to meet the growing demand for obstetric care. Further, the seeming inability to access funding for additional roles prevents succession planning.

E. Capacity of Neonatal Units

32. In terms of the growing demand for obstetrics, it is becoming a more frequent problem that neonatal units across the state are 'black', meaning they do not have the capacity to support the newborns in their nursing environment. In these cases, the newborn will be transferred to another facility that does have capacity.

33. The facilities that are code black around the state may change from day to day. For example, there are times where RNSH is at capacity, and other times when other tertiary hospitals such as the Sydney Children's Hospital, Randwick and the Children's Hospital at Westmead are at capacity.

34. Most of the capacity issues relates to concerns about having the appropriate number of staff available, but it also can be that there are not enough cots for the babies.

35. Part of the reason for this problem becoming more frequent is population growth in areas such as Westmead, Nepean and Liverpool. Another aspect is the increasing amount of successful complex births. This means babies are being delivered earlier with the effect that babies are then in the care of tertiary units for longer periods of time.

F. Administrative Challenges

36. In addition to the funding issues outlined above, in my view there are some structural and administrative challenges which place a burden on clinicians.

37. First, I have observed there to be a disconnect between heads of departments and upper management. For example, the head of my department is proactive in planning the services we want to deliver. However, bureaucratic barriers, such as the need for multiple levels of approval to make relatively insignificant changes, makes service planning for the future more difficult. As a consequence there is an inability to succession plan or consider an expansion of services due to the uncertainty of whether funding will be secured.
38. Further, my head of my department does not have any administrative support. Instead, secretarial support is shared across different positions and departments, such that the value derived from the secretarial support is limited. Anecdotally, I understand this to be true across most divisions in the public hospital system.
39. In my view, a greater degree of transparency and understanding of the interrelationship between clinical work and funding would assist to align stakeholders within the system. For example, it would be more efficient if doctors were better trained on the coding requirements for ABF and billing and how they interact with service components. In my experience, my peers and I are not well versed in how what is documented record is translated by a clinical coder and applied to determine funding.

Name: Dr Kathryn Austin

Date: 24/7/24.

Signature: