Special Commission of Inquiry into Healthcare Funding

Statement of Philip Minns

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1. I have provided three statements to this Inquiry dated 9 April 2024 (**MOH.9999.0764.0001**), 7 June 2024 (**MOH.9999.1868.0001**) and 17 July 2024 (**MOH.0011.0024.0001**). This, my fourth statement, accurately sets out the evidence that I would be prepared, if necessary, to give to the Inquiry. The statement is true to the best of my knowledge and belief.

A. INTRODUCTION

2. I am the Deputy Secretary, People, Culture and Governance of NSW Health.

3. As outlined in my previous statements, in this role, I am responsible for the People, Culture and Governance Division, which comprises of branches specifically relevant to this Term of Reference including the Nursing and Midwifery Office, led by the Chief Nursing and Midwifery Officer, the Workforce Planning and Talent Development Branch and the Workplace Relations Branch, all led by Executive Directors.

B. SCOPE OF STATEMENT

4. This statement addresses the identification and consideration of potential responses and solutions to the circumstances, issues and challenges identified during the first stage of the Workforce hearings held 22 July to 9 August 2024. The focus of the response is workforce solutions.

C. DEVELOPING WITH ALL STAKEHOLDERS A DIFFERENT IDEA OF SUCCESS

5. During my first year working in the Ministry of Health (commencing 6th November 2017), I was struck by what I will call the focus of Health politics in NSW. The then Government was engaged in a record-breaking period of capital investment in new hospitals, hospital rebuilds/upgrades, and, to a lesser extent, improvements to other Health care delivery facilities. It is also the case that the investment presented a striking political strategy to win community support.

6. Capital investment must surely be a good thing? Essentially yes, but it is not without its problems if the capacity to match operating budgets with capital budgets becomes

constrained, or when the capacity to attract the necessary workforce to operate new facilities, especially in regional locations is highly challenged. The general approach by NSW Treasury is that the increased operating costs, as a result of the bringing new or upgraded facilities on line, are to be absorbed by the existing operating budget as there is a growth assumption for new builds included however that is not linked to operating costs of specific facilities nor the scale of program we are currently experiencing. NSW health politics, as well as communities, had become wedded to the notion of new buildings and facilities being the gold standard in health care delivery, with an assumed availability of the necessary workforce.

7. One of the drivers of the launch of the Future Health Strategy work in 2019 was to generate a different dialogue about what success might look like. In a somewhat crude distillation of the essence of the work – is the best future for health care in all parts of our state the presence of a shiny new building – but perhaps with a less than required workforce complement and therefore constrained care delivery – or is it a networked and integrated suite of care services that can deliver the necessary care in the most timely way, including by the use of digital technologies?

8. Flipping the thinking in the manner above was driven by a recognition that the flow of capital investment was not going to continue at the same scale of new developments due to fiscal constraints It was also driven by pressures starting to form with operating budgets and workforce supply – both of which have been exacerbated by the COVID-19 pandemic and its aftermath. However, the extent to which the idea of new buildings had become synonymous with the best care model was strongly embedded in politics and communities.

9. The aim, therefore, of the Future Health Strategy work was to attempt to demonstrate what sustainable health care delivery could look like across the next 20 years, and in doing so, highlight to all stakeholders that new models of care delivery were not just possible, but likely more timely and patient centred, as well as more affordable. They very often would involve investment in services and facilities but would not be focused solely on hospital environments. They would also be care services designed with a real recognition of workforce supply constraints, rather than premised upon a simple assumption that workforce would, in all cases, exist.

D. THINKING ABOUT HEALTH SYSTEM CAPABILITY PLANNING IN A DIFFERENT WAY

10. Despite all the effective work that has been advanced since the launch of the Future Health Strategy in May 2022, it is arguably the case that the NSW Health system has a missing middle function related to service planning and configuration. The sense of this gap is derived for me at least from a comparison of Health system planning with Defence capability planning. This extract below is from the Defence White Paper, 2009 at 1.3 "The Long Term Nature of Defence Planning":

> *"1.3 Defence planning is, by its very nature, a complex and long-term business. This is driven by the nature of military technology, the very long lead times involved in developing defence systems, which often take many years to acquire, the significant sums of public money involved, and not least, the complicated challenge of managing strategic risk in the face of future global and regional uncertainty."*

11. The parallels to Health planning are obvious:

    a. Health care complexity and long-term nature of health assets;

    b. Rapidly evolving health technology complexity and optionality together with long lead times for health workforce supply;

    c. Significant sums of public money; and

    d. Managing strategic and actual public health risks in an increasingly uncertain global and regional environment.

12. A review undertaken in 2011, commissioned by the then Director General NSW Health, adopted a fundamental principle of a commitment to devolution and localism. The new governance arrangements implemented as an outcome of the review resulted in clinical services planning occurring at the Local Health District (**LHD**) level. While this change in responsibility for planning resulted in greater local planning with staff, clinicians and community, it limited broader statewide oversight of service design and alignment.

13. Throughout the long period of capital investment since 2011, there has been a very limited application of a Defence style capability lens where whole of health system strategic objectives would operate to influence specific localised decisions while also drawing the linkages between strategy, service delivery planning and capability, redesigned models of care, sustainable financial resources and workforce availability –

both immediately and after deployment of pipeline building strategies. The statement of Mr Richard Griffiths prepared to address workforce solutions, makes this point under the heading “identifying current in demand service areas”.

14. This missing middle function existed prior to the 2011 governance changes to the NSW public health system. Recreating this missing middle function cannot be done in a way that removes the involvement of clinicians, staff and communities in local planning for individual service plans. Rather, what needs to happen is that this local engagement occurs in a coherent overarching context provided by a system level design of networked service delivery.

15. The aim of this different approach to health system capability planning would be to ensure that we are indeed making investment and planning decisions based on the direction of the Future Health Strategy, and in workforce terms, we are assessing workforce challenges, constraints and reform opportunities at the earliest point in health system capability planning.

16. How this new approach is implemented will determine its success in generating a broader and more rounded form of total system capability planning with local engagement and consultation. The approach will need the support of all stakeholders – not just within NSW Health, but also the colleges and universities – to acknowledge that the way this issue is currently being managed is not sustainable in workforce or financial terms.

E. THE MOST CRITICAL AND ENDURING WORKFORCE CHALLENGES

17. The various statements of Ms Melissa Collins and Mr Griffiths are comprehensive in their canvassing of the enduring workforce challenges faced by NSW Health, the complex barriers that impact their resolution, the non-aligned perspectives of key stakeholders, and the array of innovative initiatives that are either in place or being developed by their teams.

18. All the initiatives that are deployed or being planned make a positive contribution to the workforce situation, but they cannot, in part or combination, address the five most critical challenges that confront the system:

    a. The generational drift away from general practice;

    b. The lack of appeal of non-metropolitan employment;

    c. Sub-specialisation in medical disciplines;

d. Wage disparities with other jurisdictions; and

e. Cultural issues that impede reform.

19. The solutions to these five critical challenges are not entirely in the control or influence of NSW Health and in many cases NSW Government.

F. REVERSING THE GENERATIONAL DRIFT AWAY FROM GENERAL PRACTICE AS A CAREER CHOICE

20. The data is conclusive: (see the National Medical Workforce Strategy 2021-2031, page 62 (**MOH.0010.0056.0001**)) the number of medical interns choosing a career in General Practice is in chronic decline. In 2015, 1529 doctors entered general practice training in Australia this fell to 1292 in 2020 and while there has been some recovery since 2020 the numbers are still below 2015 numbers, with 1415 entering training in 2022. The universal health care system in Australia is premised on an adequate supply of General Practitioners (**GPs**). For more than a decade, all states have relied on International Medical Graduates to get sufficient supply of GPs to rural and remote communities. The Commonwealth Supply and Demand Study: General Practitioners in Australia Report (**MOH.0010.0680.0001**) notes that GPs who obtained their initial medical qualification overseas has grown at a faster rate (2.2%) compared to Australia/New Zealand trained graduates (0.7%), over the years 2018 to 2023 and GPs who obtained their initial medical qualification overseas made up 43% of the workforce in 2023, but accounted for 54% of the total GP FTE in the same period. This supply – significantly disrupted during COVID-19 – is not meeting the required demand and challenges are now emerging in GP recruitment in outer metropolitan areas.

21. The Commonwealth Government launched a "Fixing Medicare" package in 2023 with increased bulk billing incentives. There have been modest improvements in rates of bulk billing in some regional locations but as yet, no evidence of any improvement in applications to specialise in General Practice.

22. There are fundamental demographic and intergenerational changes making the commitment to GP life an unappealing option in comparison to other medical disciplines. Changing this position or finding a way to cope with it requires a national response involving all jurisdictions, medical colleges, other clinical communities and universities.

G. ADDRESSING THE LACK OF APPEAL IN NON-METROPOLITAN EMPLOYMENT

23. This issue resonates across many occupational groups in addition to health roles. The evidence presented to the Inquiry has broken down the myriad reasons why attraction and retention to rural and remote areas is a persistent challenge for virtually all forms of Government employment. NSW Health has devised programs and initiatives to address this challenge which have had some impact. Examples of these programs and initiatives are set out in the statements prepared to address workforce solutions by Ms Collins and Mr Griffiths. NSW Health will continue to devise programs and incentives and seek Government funding for new initiatives both within Health and other parts of NSW Government. The fundamental issue remains one for the Australian community to confront.

H. REVERSING OR AT LEAST HOLDING THE CURRENT TREND ON SUB-SPECIALISATION IN MEDICAL DISCIPLINES

24. As a result of the growth of medical knowledge in recent years across the various specialties of medicine, the medical colleges of Australia/New Zealand are promoting the trend of increasing sub-specialisation of medical training and practice. I Other contributing factors include the design of the MBS rebate scheme, which provides higher remuneration for item numbers for non-GP specialist procedures, the locational relationship between large tertiary teaching hospitals and universities, and the limited exposure of many students to generalist practitioners.

25. Until recently, neither the Commonwealth Government nor the State Governments have been exerting strategic influence on this development. If the issue of how medical specialists are trained and then practise their craft is not addressed in the new approach to health system capability planning in NSW (discussed at 15 above), misalignment between medical workforce supply and demand will persist. In addition, efforts to generate integrated models of care utilising multi-disciplinary teams operating to their possible scopes of practice will be frustrated.

26. Considering how to achieve a stronger focus on generalism in medical speciality is a matter for Australian Health Ministers and the Medical Board of Australia. The Australian Health Ministers could issue a Ministerial Policy Direction to direct this change in direction. For example, this was done in 2023 when the Australian Health Ministers required the Australian Health Practitioner Regulation Agency and the Medical Board of Australia to direct the Australian Medical Council to work with medical colleges and jurisdictions regarding accreditation of training sites.

I. NAVIGATING BUILT UP WAGE DISPARITIES BETWEEN NSW AND OTHER JURISDICTIONS

27. Ms Collins, in her statement prepared to address workforce solutions, has elegantly described the complexities associated with interjurisdictional pay comparisons. To recap the salient points:

    a. The effect of the former Government's wages cap and the absence of a corresponding cap in neighbouring jurisdictions has produced significant – although not universal – disparities;

    b. In consequence, the expectations of industrial associations are inordinately high and well above historical levels when entering a bargaining round;

    c. Stakeholder and media commentary constantly reference interstate staff migration which is unsupported by evidence provided to the Commission – in part because there is a multitude of reasons that impact where graduating clinicians choose to practice;

    d. Even if the fiscal context of the NSW Government did not operate as a constraint, the promotion of leap-frogging relativity-based claims between state jurisdictions would not be a useful development for the public health systems of Australia – nor for that matter the sustainability of the private hospital system which is currently the subject of a Commonwealth Government review;

    e. The level of the gap between the NSW Health and relevant unions suggests that the active assistance of the NSW Industrial Relations Commission is likely to be required for any progress or settlement to be achieved;

    f. If matters proceed to arbitration, the Industrial Relations Commission will be required under the Objectives of the IR Act (section 146 of the *Industrial Relations Act 1996* No 17 (NSW)) to determine salary increases, the terms of "no extra claims" clauses and the term of the award in part by reference to expert evidence on the state of the New South Wales economy and the Government's fiscal position and outlook;

    g. The likely prospect for addressing wage disparities will be a matter for the Industrial Relations Commission based on the evidence, but in any case, a decision can be expected to involve a multiyear consideration of the matters and their resolution.

J. ADDRESSING CULTURAL ISSUES IN NSW HEALTH THAT ARE BARRIERS TO REFORM AND FUTURE FOCUSED MULTI DISCPLINARY CARE

28. My previous statement dated 7 June 2024 (MOH.9999.1868.0001) has discussed issues associated with the various cultures within the NSW Health system. Working on how to influence those cultures – to ensure that as often as possible, the direction is towards safe, harmonious and productive workplaces – is the constant task of leadership at all levels of the organisation.

29. Pockets of medical workforce culture operate to frustrate consultation, dialogue, discourse about reform, the operability of multi-disciplinary care – and ultimately workplace safety and patient care.

30. There are international peer reviewed research papers that suggest about 5% - 6% of the medical workforce can be characterised as being a disruptive workplace presence (see, for example, The Nature and Causes of Disrespectful Behaviour by Physicians, published in *Academic Medicine* (**MOH.0010.0679.0001**)). There is no reason to see NSW Health as an outlier that this research would not apply to also. Indeed, several case studies that I have needed to address across nearly seven years are clearly consistent with the research.

31. While the international literature talks about addressing the existence of these patterns of behaviour, it is clear that NSW Health in comparison to large health systems in the United States, the UK and Europe often does not have the scale of alternative workforce supply that exists in those systems. So, while the literature clearly demonstrates the need for conclusive action, the capacity to take that action in NSW Health is often constrained by potential impacts for service and care delivery – especially regionally/remotely – and particularly so when the taking of necessary action will result in a community and media dialogue about the curtailment of a service.

32. I am aware of several people who have alleged that they have been the victim of or have observed poor medical clinician peer behaviour. The consequence of this behaviour has ranged from people exiting workplaces due to a lack of psychological safety as well as other very unfortunate outcomes.

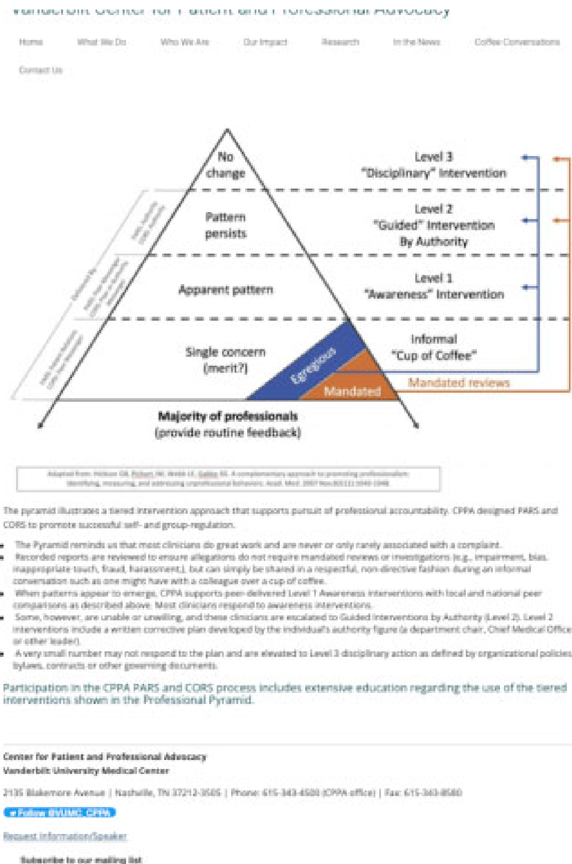
33. Invariably the reason why little headway can be made in addressing these circumstances is the fear that witnesses and complainants have that their career will be adversely impacted if they speak up. If an individual does seek to speak up, they often find that their colleagues remain too intimidated to provide supporting testimony. The prevalence of these experiences is highest among junior doctors and likely higher for female doctors,

both junior and more senior. The overwhelming emotion of these people when I have spoken with them is that they feel helpless in the face of unrelenting pressure from someone who they believe – and they suggest likely believes themself – is untouchable.

34. This attitude is reflected in the way management, who attempt to address these circumstances, often find themselves the subject of counter complaints of bullying.

35. There are international programs and practices designed to address this disruptive cultural behaviour. The best in my view, seek to invoke the voice of the 94% of medical clinicians who do not bring a disruptive presence to the workplace. I have visited the Vanderbilt University Medical Center and researched the Professionalism Pyramid developed by the Vanderbilt Center for Patient and Professional Advocacy.

> *"The Professionalism Pyramid was developed by the Vanderbilt Center for Patient and Professional Advocacy (CPPA), a US-based academic centre working in the area of healthcare leadership and professional accountability. The pyramid is a tool for guiding employer responses to unprofessional conduct, through a structure of escalated communication as patterns of unacceptable behaviour develop."*[1]



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[1] https://www.respectatwork.gov.au/resource-hub/professional-pyramid-vanderbilt-center-patient-and-professional-advocacy

36. Implementing something like the Vanderbilt Professionalism Pyramid – or an alternative framework – across NSW Health, would require the support of the Australian Salaried Medical Officers' Federation, Australian Medical Association, Medical Staff Councils, and the Colleges. An ideal implementation would also extend the use of any adopted framework to medical schools so that the principles of respect in the medical and clinical workplace are reinforced in every context that is experienced by a student through to a Senior Staff Specialist, Visiting Medical Officer and Head of Department.

37. I view this as a foundational strategy to build the capability of our workforce to have challenging conversations in a respectful way. If this foundation can be consistently implemented across NSW Health, we can then review and implement the most useful architecture, for example through the use of clinical councils and medical staff councils, for effective consultation and engagement with our clinical workforce.

Phil Minns

8/10/2024

Witness: Paul De Carlo

8/10/2024