Special Commission of Inquiry into Healthcare Funding

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Name: Australian Salaried Medical Officers' Federation

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Australian Salaried Medical Officers' Federation (NSW)

Suite 46, Level 3
330 Wattle Street
ULTIMO NSW 200

www.asmofnsw.org.au
asmof@asmof.org.au
02 9212 6900

Submission to the Special Commission of Inquiry into Healthcare Funding

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Foreword

The Australian Salaried Medical Officers' Federation (New South Wales) – The Doctors Union ("ASMOF") welcomes the Special Commission of Inquiry into Healthcare Funding in NSW and thanks the Commission for the opportunity to contribute to the inquiry to ensure it effectively supports the delivery of high-quality, patient-centred care to the people of NSW.

Doctors are the foundation of any health system.

As the Doctors' Union, our vision is to protect, promote and advance the interests of salaried doctors in a fair and just society underpinned by a high-quality public health system.

We believe that the single most pressing issue facing the public health system in New South Wales is the shortage of employed doctors.

This shortage is compromising patient care and is leading to significant cost inefficiencies through the increased use of Visiting Medical Officers ("VMOs") and locum doctors. If left unaddressed this risks a significant structural workforce deficit in the medium term that will undermine the role of public hospitals as the backbone of medical training, research, and medical development in this state.

Doctors employed in the NSW public health system have the worst conditions of employment of any doctors employed in public health systems in Australia.

To fill current staffing vacancies and replenish the medical workforce in public hospitals, NSW needs to raise the employment conditions for medical officers such that they are the best in the country. The more time that passes without a complete overhaul of the employment conditions of doctors in the NSW public health system, the greater the rate at which the problems listed above will be compounded, as NSW becomes increasingly unable to compete to attract and retain doctors in a national and international market.

We have already witnessed significant work intensification for doctors remaining in the public system. This lessens the attractiveness of their roles, exacerbating the problem and adding to its urgency.

We hope that the Commission will take this opportunity to undertake a detailed analysis of the use of, and economic inefficiencies arising from, the current overreliance on VMOs and locum doctors as a substitute for employed medical officers; will use its powers to uncover the full extent of the current staffing vacancies in the medical workforce on what, in our opinion, is an inadequate and low base; and will recognise the vital role that raising employment conditions for doctors to outcompete other jurisdictions has in replenishing the permanent medical workforce.

We have a once-in-a-generation opportunity to address the flight of doctors from the NSW public health system and repair the foundations of NSW Health so that NSW residents can continue to be treated in a world-class health system.

In addressing the letters patent, I note that we have not confined our submission to the issue above and have addressed a vast array of issues raised with us by doctors in the NSW public health system.

We remain willing to assist the Commission in any way that we can to ensure that we continue to provide a world-class health system for the people of New South Wales.

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Introduction

The Australian Salaried Medical Officers' Federation (New South Wales) is the union for salaried doctors. ASMOF represents over 5,000 registered medical practitioners in NSW, including staff specialists, postgraduate fellows, clinical academics, career medical officers, interns, resident medical officers, and registrars. ASMOF advocates for high quality, publicly funded health services, and strives to protect and improve the wellbeing, rights and interests of salaried doctors.

This Inquiry is a fantastic opportunity for the NSW Government to transform the NSW Public Health system, to ensure doctors can work safely and effectively in the interest of safe patient care, now and into the future. It is pivotal that this Inquiry draws on the expertise and experience of health professionals working on the frontline of NSW Health. A key feature of our submission is primary evidence from an open survey of ASMOF members for the purpose of the Inquiry on healthcare funding and matters relating to the medical workforce in NSW ("Workforce Survey").

This submission and its recommendations are based on the voices of the more than 850 members who responded to our survey between September and early November 2023. Direct quotes from responding members are included throughout this submission. Secondary evidence from previous ASMOF submissions and existing national and international research is also included.

We have made 21 recommendations which are needed to address the key issues of recruitment, retainment, wage stagnation, workplace conditions and future sustainability – all of which are central issues to ensure the best possible patient care in NSW public hospitals, now and into the future.

Symptoms of a larger problem

Doctors are driven by a profound dedication to public health and ensuring the health and wellbeing of all in the community. Doctors are valued by the community for the expertise and care they provide.

However, a decade of policy neglect and a deliberate policy of suppression of workplace conditions by the previous NSW Government has eroded doctors' working conditions in the NSW public health system. These policy decisions have contributed to an ongoing and worsening exodus of doctors, either to other states, into private practice, or leaving the profession entirely. The healthcare system is overwhelmed, under-resourced, and neglected as a result; a healthcare system which increasingly focuses on corporatised metrics of efficiency rather than outcomes for the health and wellbeing of the community it serves.

Quote from Member:

"I guess the perspective on this differs depending on whether the aim is to cut costs or to actually provide health care and treat illness equitably across the population."

The following sections speak to the symptoms of the larger problems of policy failures and the continued creep towards the privatisation of public services. The current and future workforce capacity has been reduced and undermined. Chronic understaffing is a concerning, though commonplace, reality in NSW's public health system. There is an increasing reliance on expensive short-term solutions (such as temporary staffing arrangements) to fix the understaffing situation. Alternatively, in many cases, the shortage is not backfilled and Staff Specialists (SS) are left to carry the extra workload. Current working conditions are dire: characterised by burnout, chronic stress, substantial unpaid overtime, and a demoralised workplace culture.

Recommendations

Recommendation 1: Enhance Funding for the Public Health System

Advocate for increased funding for the NSW public health system through a multi-faceted approach, including indexing public health funding to inflation, augmenting the proportion of the state budget allocated to health, discontinuing "efficiency dividends" in the budget cycle, and seeking additional funding from the federal government. This increased funding will facilitate elevated staffing levels, improved working conditions, and enhanced resources for patient care.

Recommendation 2: Address Workforce Challenges

To alleviate chronic understaffing and associated challenges, the NSW government should employ a multifaceted strategy, encompassing improved recruitment and retention strategies for doctors, offering competitive salaries, and easing pathways for overseas-trained doctors. The focus should be on creating a resilient workforce and minimising burnout, stress, and unsafe working hours.

Recommendation 3: Workload Reduction Measures

Propose measures to alleviate workloads for doctors by diminishing administrative tasks, augmenting support staff, and implementing revised rostering arrangements to allow for adequate breaks and recovery periods. These initiatives will contribute to a more sustainable and positive workplace culture.

Recommendation 4: Invest in Doctor Training and Retention

Urge the government to invest in comprehensive training and retention programs for doctors, such as incorporating scholarships for medical students, financial incentives for rural placements that meet or exceed those available in other states, and streamlined processes for overseas-trained doctors. This will fortify the healthcare workforce and ensure a steady supply of skilled professionals.

Recommendation 5: Enhance Data Collection on Doctor Fatigue

Propose developing and implementing a robust system for collecting and reporting data on doctor fatigue and burnout. Utilise fatigue surveys or monitoring devices to track trends, identify intervention areas, and enhance overall workplace well-being.

Recommendation 6: Improve Rostering Practices

Advocate for enhanced rostering practices that prioritise doctors' rest and breaks, reduce consecutive work shifts, and consider individual workload variations. This will contribute to a healthier and more sustainable working environment.

Recommendation 7: Investigate Doctor Burnout and Patient Safety

Encourage further research investigating the relationship between doctor burnout and patient safety. This research should identify contributing factors to burnout and assess its impact on patient care, providing valuable insights for targeted interventions.

Recommendation 8: Improve Public Awareness of Doctor Wellbeing

Promote a public awareness campaign on the importance of doctor wellbeing through educational initiatives, media support, and collaboration with community groups. This will foster understanding and support for the challenges faced by doctors.

Recommendation 9: Conduct a Review of VMOs and Locums

Call for a comprehensive review of the use of VMOs and locums in the public health system, considering their impact on patient care, cost-effectiveness, and the well-being of permanent salaried Staff Specialists. This should investigate the use of VMOs and locums to fill permanent positions and could include reviewing NSW Health's recruitment and retention practices and identifying any barriers to hiring and retaining permanent salaried Staff Specialists. This could be undertaken by the NSW Auditor General.

Recommendation 10: Increase transparency around the use of VMOs/locums

Call for greater transparency around the use of VMOs/locums, including through publishing data on the number of VMOs/locums being used, the cost of VMOs/locums, and why VMOs/locums are being used. This information should be made available to the public so that they can hold NSW Health accountable for its use of VMOs/locums.

Recommendation 11: Establish clear guidelines for the use of VMOs and locums

Establish clear guidelines for the use of VMOs and locums. These guidelines should specify when VMOs and locums can be used and for what purposes. For example, VMOs should not be used to replace permanent salaried Staff Specialists. LHDs must be required to demonstrate difficulties in recruiting doctors for a specific location despite unsuccessful recruitment attempts.

Recommendation 12: Standardise the Locum Fee Structure

Advocate for establishing a standardised fee structure for locum doctors based on experience, qualifications, and location. This will eliminate bidding wars and promote fairness in locum engagements.

Recommendation 13: Engage in Direct Employment of Locum Doctors

Suggest that NSW Health ensure all locum doctors are directly employed rather than sourced through external agencies. This would grant more significant control over recruitment and retention and reduce costs associated with agency fees.

Recommendation 14: Review Breakage Fees

Call for a review of breakage fees in locum doctor contracts, considering banning or regulating them to ensure they do not discourage doctors from taking permanent positions in the public health system.

Recommendation 15: Undertake a Review of Third-Party Agencies

Propose a thorough review of the use of third-party agencies in recruiting locum doctors, evaluating cost-effectiveness and potential impacts on patient care. Consider whether direct recruitment by NSW Health would be more efficient.

Recommendation 16: Review and Reform all NSW medical practitioner Awards

Recommend a comprehensive review and reform of medical practitioner Awards to ensure fair and equitable wages that outcompete other states to mitigate the consequences of decade-long wage suppression.

Recommendation 17: Prioritise the Retention of Staff Specialists

Advocate for strategies to prioritise the retention of Staff Specialists, emphasising competitive salaries, professional development opportunities, improved work-life balance, and support for participation in non-clinical work.

Recommendation 18: Enhance Consultation Processes and Representation

Establish standardised consultation mechanisms between medical practitioners and executive management at the departmental and LHD levels, fostering two-way communication and ensuring meaningful clinical representation. This should include the creation of positions such as "Executive Clinical Director," held by qualified medical practitioners, tasked with providing independent clinical advice and facilitating regular forums for two-way communication between management and clinicians.

Recommendation 19: Improve Workplace Investigation Processes

Urge a comprehensive review and overhaul of workplace investigation processes within NSW Health. Ensure the inclusion of experienced medical professionals in investigation teams for fairness and informed decision-making and address the issue of abuse of process and vexatious complaints.

Recommendation 20: Develop a New System for Benchmarking Doctor Salaries

Collaborate with the Union to develop and implement a new system for benchmarking doctor salaries, ensuring fair and competitive compensation.

Recommendation 21: Commit to the Public Ownership of Health Services

Advocate for a commitment to increasing, maintaining, and enshrining public ownership of all public health services in NSW.

1. Current workforce capacity and workplace conditions

Letters Patent items: F(i), F(ii), F(vi), F(v), F(iv), G(ii).

The current NSW Health workforce is stretched far beyond capacity. Chronic understaffing significantly impacts doctor wellbeing, patient outcomes and effective hospital functioning. The findings in this section – understaffing, overwork, unpaid overtime and inaccessible entitlements – demonstrate that the current doctor Awards in NSW are not fit for purpose.

Quote from Member:

> *"Our current working conditions are exhausting and putting ourselves and our patients at risk. We are not being remunerated to a level which reflects the work that we do and which contributes to our sense of burnout."*

1.1. Inadequate staffing levels and workforce fatigue

Adequate staffing is essential for the effective functioning of hospitals and for patient outcomes and safety. Data from the Australian Institute of Health and Welfare (AIHW) shows that between 2015 and 2020 New South Wales had among the lowest FTE rate for medical practitioners (415.6 FTE per 100,000 people in 2020).[1] This AIHW data also shows that between 2015 and 2020, New South Wales also had the lowest FTE rate in Australia for healthcare professions more broadly (which includes allied health, dental, medical and nurses and midwives). Growth in the medical workforce has generally lagged behind the demand for services in the past decade, and the supply of doctors in rural and remote areas in NSW remains of critical concern.[2] Workforce shortages are projected to increase even further by 2032 based on the current demand for services and workforce supply trends. Medical specialties with the largest projected gaps in workforce availability include psychiatrists, pathologists, specialist physicians and anaesthetists.[3]

Thus, understaffing has long been an issue in the NSW public health system and is exacerbated by the sub-standard conditions of employments doctors in NSW receive.

In our Workforce Survey, the overwhelming majority (94.7%) of respondents had *frequently* or *occasionally* encountered situations where staffing levels were inadequate for patient safety (*frequently:* 65.3%; *occasionally*: 29.4%). Concerningly, 0 respondents had *never* encountered situations where staffing levels were inadequate for patient safety.

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[1] Australian Institute of Health and Welfare 2022, fig. 1: Total FTE and FTE rates, by profession, state and territory, age, and sex, 2015-2020.

[2] Australian Medical Association (NSW) 2023, 14-15.

[3] Australian Medical Association (NSW) 2023, 16.

These results are similar to the AMA NSW's 2022 *Workforce Whitepaper Survey*, where three quarters of respondents reported perceptions that their work settings had an inadequate or highly inadequate number of medical staff.[4]

In our Workforce Survey, the overwhelming majority (96.2%) of members surveyed reported that inadequate staffing levels contributed to a higher workload and burnout for doctors. Many of the members responding to our Workforce Survey described conditions of chronic understaffing. Many described the current workforce as too small to meet demand (e.g. from the community, from NSW Health) and for the increased complexities and intensity of their clinical workload. Understaffing – especially of Staff Specialists, but also non-clinical support staff – was also seen by members to contribute to the increased size of individual workloads, especially for administrative tasks. These conditions, for many members, contribute to staff burnout and chronic stress, which have led to low morale and disenfranchisement among hospital staff. Having highly qualified medical professionals spending excessive time on administrative work is also an inefficient use of resources, particularly at a time when there is a shortage of doctors. Some members shared that they have taken, or been advised to take, extended sick leave due to burnout.

Quotes from Members:

> *"I have never seen such levels of apathy disengagement and burnout amongst colleagues across health [...]. Nothing has changed in decades and this has left us all worn out. Nobody thinks anything will change either and many have left or given up fighting."*
>
> *"[Existing employment conditions have] Severely impacted my work to the point I required stress leave and extensive medical treatment (still ongoing) to recover. I had to reduce the overtime worked and move to a private hospital to access a workload I could manage after becoming severely burned out. The intense staff shortages could not keep up with the exponential demand in hospitals. There is no solution in sight as we can't fill our basic positions as nobody wants to do this job or gets damaged and leaves or drops to part time to cope. It's bleak and demoralising."*

In the AMA NSW's *Workforce Whitepaper Survey* in 2022, the vast majority of respondents (81%) reported experiencing workplace stress. In a similar vein to ASMOF's Workforce Survey the key contributors to this stress reported by respondents to the AMA NSW survey were excessive workload and lack of resources.[5]

Additionally, free-text responses from members highlighted that, in some places, newly funded buildings or beds remain empty due to inadequate staffing. These statements point

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[4] Australian Medical Association (NSW) 2023, 17.

[5] Australian Medical Association (NSW) 2023, 17.

to funding gaps and inefficiencies in recent health policy. More funding is required to recruit and retain the medical workforce.

Quotes from Members:

> *"Our hospital has a new building which remains a third empty 3 years after it was built because there is no budget for additional staff to support the additional beds and [the] accompanying increase in services."*

> *"Our hospital has almost 150 unfunded bed spaces whilst our ED has chronic bed block. There are no medical registrars in the hospital, so the workload falls to ED staff for admitted medical patients. The hospital and Network management do not seem to have made any efforts to address this situation."*

1.2. Unpaid overtime, unsafe after hours work and improper breaks

Australia-wide AIHW workforce data indicates that medical practitioners overall worked more than their FTE of 40 hours per week, and that medical practitioners, specialists, specialists-in-training, and hospital non-specialists worked the longest hours.[6] This data is corroborated by a sizeable number of the members who responded to our Workforce Survey. Many members described working excessive hours far beyond what is adequately compensated for in their Award and having to complete work outside of hours in order to manage the workload and ensure timely patient outcomes. Out of this group of members, some described working unsustainable hours on a frequent basis, including without substantive rest breaks or working excessively long shifts.

Quotes from Members:

> *"Excessive unpaid overtime. Routinely work 60 hour weeks, can't recall last time I had a weekend when I wasn't working. These are not call backs, this is routine work. Requests for additional staff are not met. We feel obliged to not delay patient results so are forced to work long hours."*

> *"More legislation regarding rostering. Surgical registrars commonly end up working 12 to 40 days in a row without a day off."*

> *"Erosion of working conditions. Expected to work more weekends, more evenings and work beyond 10 hours rostered shifts on a regular basis."*

[6] Australian Institute of Health and Welfare 2022, fig. 3: Ratio of FTE total to number of practitioners among medical practitioners, by job area, 2015-2020.

"Low morale, working up to 10 - 21 days on end, coming to work every single day. Who works like this? I don't even get renumerated to come in to hospital 3 weekends in a row."

"The unpaid 30 minutes lunch break is rarely practical to take, often with a pager, still on call. Many jobs have entailed 10+ hours of unpaid overtime per week as a JMO and the numerous presentations and research is frequently unpaid. My children and husband have suffered due to the expectations and workload of the NSW public hospital system."

"Our workload has increased more than 3 times over the past 3-5 years. There has been no increase in staff. We have no registrars so on call in our hospital is first on call and as we do as many CTs in hours as after hours on call is really overtime. [...] When I was doing the 24 hours on call I fell asleep in my car on the way to work, ran into the back of a parked truck and wrote the car off."

"Our out of hours work has exploded. We now run 6 theatres every night and every weekend. The 'reasonable on call' used to be from home, and occasionally come to hospital. We now spend entire nights and weekends unpaid - it's why people are leaving in droves."

ASMOF has long been concerned with these issues. In 2019, ASMOF filed proceedings in the NSW Supreme Court to prosecute the NSW Government for breaching the Award and for failing to pay overtime and meal allowances to junior doctors.

Additionally, in a separate ASMOF survey on remote, rural and regional (workforce issues, workplace culture and funding) (September 2023), around one quarter (24%) of respondents reported they worked between 51-60 hours per week in the month of September, while over one fifth (21.7%) reported they worked between 41-50 hours per week in the month of September. These workloads are of significant concern for worker wellbeing and safety.

The most recent AMA "Safe Hours Audit" from 2016 found that over half (53%) of doctors in public hospitals – including around three quarters of Intensive Care doctors (75%) and Surgeons (73%) - were working shifts that placed them "at significant and higher risk of fatigue".[7] Doctors in the higher risk category were also more likely to work longer shifts (18 hours), work three or more consecutive days on call, and to skip meal breaks on three or more days.

Taken together, all of this evidence should be seen as red flags for fatigue across the medical workforce. Doctors deserve to be remunerated in a way that reflects the hours worked and their expertise and in line with those of other states which compensate doctors for the time

[7] Australian Medical Association 2016, 6.

they work. Doctors also deserve to maintain a healthy work/life balance, which is crucial for their mental wellbeing and overall effectiveness and which would indirectly impact on patient care and safety.

1.3. Inaccessible entitlements: TESL and annual leave

ASMOF has long advocated for our members to be able to access their 'Training, Education and Study Leave' (TESL). Our members consistently report having difficulties accessing their TESL funding or leave for this entitlement.

In our Workforce Survey, many respondents similarly described challenges in accessing their entitlements, including not only TESL funding or leave, but also annual leave. Again, many members attributed these issues to chronic understaffing, although some responding members indicated that impediments or blocks on leave access may be an active decision by some levels of management.

Quotes from Members:

> *"There are always staff shortages with no relief for day teams when doctors are placed on afterhours shifts or leave. Annual leave requests are often ignored or declined."*
>
> *"Poor access to leave is a recurring theme throughout my medical career."*
>
> *"Due to the constant shortage, we're asked to cover multiple shifts and don't get leave when requested. It's especially bad in the western LHD where a lot of my friends work. The administration is atrocious and beyond unprofessional. On a personal note, WSLHD didn't give me off on my wedding day despite requesting it months in advance."*
>
> *"Access to leave (of all sorts) is poor - most of us have hundreds of hours of leave we can't take because of inadequate staffing."*
>
> *"It's increasingly difficult to take leave including annual leave and TESL due to the stretched nature of the workforce. The idea of taking long service leave (after 25 years of service!) seems like a mirage."*
>
> *"TESL is a great incentive to work as a Staff Specialist but due to COVID and other factors I have some $70 000 in my TESL funds and I will not be allowed to use all of this."*

TESL, and the equitable accessibility thereof, is a core component of a robust public health system.

The entitlement exists to enable Staff Specialists to pursue professional learning and development opportunities, to ensure NSW Health can retain the brightest and best Staff

Specialists so they can better serve the public health system and deliver the best possible care to the people of NSW.

It is a mandatory requirement under the Policy Directive (PD), Training, Education and Study Leave (TESL) for Staff Specialists that "all Staff Specialists employed in the NSW Health System have appropriate and equitable access to TESL that is relevant to both the Staff Specialist and the PHO", and that the Public Health Organisations (PHO) have responsibility to establish entitlements to TESL."[8] However, the entitlement and responsibility of PHOs to provide access and funding is often breached, as LHDs often ignore the PD, or a local LHD guidance or interpretation takes precedence.

Notwithstanding the issues in metro regions of the state, several members in a separate survey of RRR workforce issues noted the difficulty in accessing TESL. One member said:

> *"Increased difficulty getting approval & reimbursement for TESL despite minimal use of TESL over the 4 years of COVID."*

In 2021, ASMOF surveyed 1,473 members on TESL as it related to a log of claims put to NSW Health. In this survey, more than four in ten (45.2%) respondents cited having problems with accessing either their TESL funding or leave. Anecdotally these issues have only gotten worse since then.

In our Workforce Survey, many respondents wrote at length about their issues accessing TESL and other leave entitlements, which suggests significant work is needed to address this issue.

Part of the response to this needs to be the addressing of structural barriers, particular those that disproportionately include women. For example, 38.9% of respondents to the 2021 ASMOF survey on TESL said that their caring responsibilities (i.e., children, partners or dependents with a disability, medical condition, mental illness or otherwise needing care due to old age) prevented them from accessing TESL due to the costs associated with the care not being covered by TESL.

1.4. Impacts on patient safety and outcomes

We acknowledge the connection between working conditions and patient outcomes. We have concerns about the potential impacts the current working conditions may be having on patient outcomes and safety. Around 5 in 6 members responding to our Workforce Survey felt that inadequate staffing levels have resulted in a reduced quality of care (86.3%) and increased wait times (83.1%). Additionally, more than three quarters (76.2%) of members surveyed felt that inadequate staffing levels have compromised patient outcomes.

Quotes from Members:

[8] NSW Ministry of Health 2019.

"I feel complicit in harming patients because of the inadequacy of the service we provide - despite me staying back late every day to try and improve this."

"I'm not paid for the hours I do and have no spare time so if it's not urgent it doesn't get done and I'm constantly trying to discharge patients from my care. My clinic is unsafe because there is so much urgent demand and not enough time but they are aware of the problem and nothing happens. More staffing [is needed] to keep up with increasing population and increased complexity."

"Without more medical staff our unit continues to crumble and suffer and patients get much poorer outcomes. Nobody is listening or helping and we have been told so many times to 'do more with less' and 'work smarter' by CEO and bureaucracy at a LHD and MOH [Ministry of Health] level that is entirely out of touch with reality. Our hospital delivers world class care despite a broken underfunded system by relying on the goodwill and flagging energy of our medical workforce that is being pushed to the brink. I have friends with mental health breakdown and burnout and even suicide in this system and nothing changes. Nobody is listening and patients are suffering."

International evidence has demonstrated a strong association between medical practitioner burnout and worsening patient safety.[9] A systematic meta-analysis of international evidence also found health professionals' burnout is associated with unfavourable outcomes and patient dissatisfaction. High workload and long hours were found to be contributing factors for burnout, and "for health professionals with high burnout rates, high hourly loads had a strong negative impact on patient safety".[10] Organisational factors (such as resource constraints, inadequate staffing, disruptions in workflow and care coordination, and inadequate processes and procedures) and human factors (including fatigue, and burnout) have been named by the World Health Organisation as interrelated factors that can lead to patient harm.[11] Finally, a 2014 international critical-incident interview study found that one of the main risks to patient and staff safety is psychological overload, leading to stress-related impairment. This stress was seen to increase the chance of clinical mistakes and "near misses".[12]

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[9] Garcia et al. 2019, Eklöf et al. 2014.

[10] Garcia et al. 2019, 10.

[11] World Health Organisation (WHO) 2023.

[12] Eklöf et al. 2014.

The stretched capacity of the medical workforce may be related to a decreasing satisfaction with hospital experiences among the community. Recent Australian Bureau of Statistics (ABS) data on patient experiences indicates that people who needed to and saw hospital ED doctors and specialists in 2021-22 generally reported less positive experiences compared to 2020-21. In particular, people reported feeling less satisfied with the amount of time hospital ED doctors and specialists spent with them in 2021-22 compared with 2020-21.[13]

[13] Australian Bureau of Statistics 2022.

2. The impacts of temporary and contracted staffing arrangements

Letters Patent items: F(vii), F(xi).

In our Workforce Survey many members commonly felt that VMOs and Locums have a role in the staffing model and a healthy hospital system. VMOs and Locums can provide flexibility in staffing, allowing hospitals to cover gaps in rostering, handle increased patient loads, or manage unexpected events such as staff absences. VMOs are also particularly beneficial for short-term or project-specific needs or in specific medical specialities.

However, the use of locums and VMOs can have a significant effect on healthcare funding due to higher costs and budget uncertainties. There is evidence that NSW Health spent $1 billion on VMOs in the 2021-2022 financial year – a 54% increase in spending compared to 2011-2012.[14] Examining the impact of temporary and contract staff on healthcare expenses, quality, workforce, and patient access is crucial for effective financial planning and resource allocation.

2.1. Expensive stopgap measures for recruitment and retainment issues

Visiting Medical Officers (VMOs)

Visiting Medical Officers (VMOs) are medical practitioners who are contracted by NSW Health as statutory contractors, not employees, to provide specialist services to hospitals and other healthcare providers. VMOs are self-employed and typically have their own private practices. VMOs have a place in the hospital system, yet balancing the use of VMOs with a core team of permanent salaried Staff Specialists is essential for maintaining a stable and sustainable healthcare workforce.

ASMOF is concerned about the increased use of VMOs in the public hospital system, over or instead of salaried Staff Specialists, without due explanation. Around 4 in 10 (39.9%) members surveyed said that their Department or Hospital's use of VMOs has increased in the last five years. Additionally, around 4 in 10 (41.9%) members surveyed also reported that their Department or Hospital had engaged a locum or VMO in circumstances when a salaried doctor position would have better addressed staffing and healthcare service needs. Reasons provided by respondents included issues with recruitment and "administrative decisions."

Quotes from Members:

> *"Hospital insisted on engaging [the] person as VMO for admin reasons."*

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[14] McGowan 2023.

"Lack of funding. Hospital is broke so locum positions [are] used to fill gaps and paid from No2 account."

"This has occurred recently when funding was given for ED Consultants to only be hired as VMOs, and with no access to non-clinical time (in contradiction to ACEM recommendations)."

"Hospital wants to save money. So they either outsource externally or internally to avoid recruiting permanent Staff Specialists. This has resulted in increased workload and less staffing. This causes burn out."

"All permanent recruitment has been frozen so any gaps in service are covered by locums/VMOs or expecting Staff Specialists to do more."

Our Workforce Survey highlighted concerns about the lack of transparency around the recruitment of contract or temporary staff. For example, over 4 in 10 (42.5%) members surveyed said their Department or Hospital had attempted to recruit salaried doctors (SS, CMOs or JMOs) and had their request denied. Responding members from non-metropolitan areas were more likely to say their Department or Hospital's requests to recruit salaried doctors was denied (47%), compared with responding members based in Sydney (37%).

Quotes from Members:

"My department has submitted business cases recurrently over the last 20 years without enhancement to the FTE number of general paediatricians. This is demoralising to have our persistent requests for help denied when we see so much need in the community for our services."

"We have been advocating constantly for the last 5 years, and on multiple occasions denied. The goalposts keep shifting, and admin are just coming up with excuses that make you think something will happen, but kicking the can down the road e.g. 'just wait until the next financial year' said for 5 years in a row."

"Last round of recruiting no one applied as level 1 Staff Specialist is not seen as competitive and administration have denied requests to advertise at higher level."

"The inability to appoint to SS [Staff Specialist] roles has led to the appointment of 2 year VMO roles with a view to re-testing the market at the end of this period. There is an unspoken inequality in income that is not always reflected in differences in roles/privilege."

There must be explicit guidelines that limit when VMOs can and cannot used. LHDs must be able to demonstrate that VMO positions were specifically filled to address challenges in

recruiting salaried doctors for a particular location after numerous unsuccessful recruitment attempts.

The Ministry of Health should be responsible for strategically evaluating the utilisation of VMOs compared to salaried doctors and ensuring that LHDs are using them effectively and within established guidelines. This assessment should encompass an analysis of the medical staff composition, determining whether VMOs, as opposed to formal salaried arrangements, better align with the staffing and healthcare service requirements. VMOs should not be employed when formalised salaried arrangements are better suited to fulfilling staffing and healthcare service needs. This would help to ensure that VMOs are only used when they are necessary, and that they are used in a way that is cost-effective and efficient.

Additionally, processes must be instituted to ensure VMO contracts and payments are transparent and accountable to NSW Health and the taxpayer. The processes for recruiting and retaining VMO contracts should be standardised across NSW Health to assess cost efficiency (e.g. with respect to quality of service and performance monitoring).

Locum Medical Officers (locums)

Locum Medical Officers (locums) are medical practitioners who are employed on a temporary basis to cover for permanent staff who are absent due to illness, vacation, or other reasons. Worringly, they are increasingly being used to fill vacancies in the medical workforce on an ongoing basis at great cost.

Around two thirds (67.7%) of members surveyed in our Workforce Survey said their Department or Hospital engages locums. Members from regional or remote locations were much more likely to report their Department or Hospital engages locums (78.1%) compared with responding members from metropolitan areas (61.0%).

These figures generally reflect data published by the Sydney Morning Herald in 2019, which showed the extensive use of locum doctors throughout NSW. Locum use is especially high in areas outside of greater Sydney; in 2019, an average of 16.5% of doctors in the public system outside of Sydney were locums.[15] The Herald also reported that "Locum usage runs as high as 38.4 per cent of the medical workforce in Southern NSW Local Health District, near Canberra, and 22.9 per cent in the Far West district, which includes Broken Hill".[16]

Many of the members surveyed said they were unsure (35.8%) why Locums were being used, but other respondents said Locums were engaged to cover planned leave (25.9%) or unplanned leave (16.3%). Nearly 1 in 5 (18.8%) members said the use of Locums was standard practice in their Department or Hospital.

[15] Fitzsimmons 2019.

[16] Fitzsimmons 2019.

Responses from members in our Workforce Survey draw attention to the lengthy use of locums as a stop-gap measure for repeated issues with recruitment, or instead of attempting to recruit salaried full-time Staff Specialists.

Quotes from Members:

> *"Sometimes we actually spent more money hiring separate Locum for 2-3 months each over a year when we could have hired a salaried doctor for that entire year. That would improve continuity of care and have better engagement with other staff and the patients."*

> *"Prefer never to use locums - but this is becoming inevitable as being able to recruit and retain Staff Specialists on the current funding is getting harder."*

> *"We are chronically understaffed but also have no vacancies. [...] We believe we are about 4 or 5 full-time equivalents short of what is needed to run our service at all times. We sometimes employ locums because it takes SO long to recruit to a vacancy that we would not be able to operate our service without the locum."*

> *"On multiple occasions my department have had to maintain a locum contract whilst NSW staffing contracts where delayed resulting in significant detriment for the department (by cost) and the employee (who was unable to qualify for maternity leave due to insufficient length of employment on contract)."*

> *"Locums work for temporary arrangements. Unfortunately the role they fill is never temporarily empty. Fundamentally they are being paid for a full-time service"*

> *"My workplace seems extremely resistant to employing VMOs (including fly-in/fly-out VMOs), instead preferring to continue employing changeable locums. FIFO VMOs would be preferred as at least they would provide some consistency and could become more meaningfully embedded within teams."*

Locums have a valid place in any hospital staffing model, especially for leave relief. However, ASMOF is concerned that the overreliance on locums across NSW Health, especially in regional and remote areas, is a costly and ineffective attempt at filling empty vacant positions. Thus, the widespread use of locums and temporary staffing engagements should be seen as a red flag of NSW Health's ability to recruit and retain a steady, permanent workforce of medical practitioners (due to the above points in Section 1 regarding eroded working conditions and stagnated salaries for Staff Specialists).

2.2. Bidding and potential "price gouging" in contract and temporary staff recruitment

Hiring locum doctors through external medical locum agencies introduces a layer of private involvement or the outsourcing of contracts in the provision of healthcare services within the public system. When hired through medical locum agencies, locum doctors may be employed by the agency rather than directly by the hospital or NSW Health. Outsourcing temporary staff recruitment in NSW Health introduces a private employment model and raises concerns about transparency, compliance, and accountability in decision-making processes.

The Sydney Morning Herald recently reported evidence of potential "price gouging" by third-party medical locum agencies in NSW.[17] The Garling Inquiry of 2012 showed evidence of LHDs "bidding" against each other with the result of driving up locum costs.[18] Thus, these are longstanding issues that require investigation and solutions. The July 2023 report by the Sydney Morning Herald cited included evidence that:

> *"Third-party firms sometimes seek to avoid filling vacant positions within the health system until a higher rate is available. [...]*
>
> *In one exchange between a doctor and a recruitment agent, [...] the company's representative appears to suggest delaying a placement until more lucrative "crisis rates" are offered.*
>
> *Documents also reveal that in some cases the contracts between doctors and third-party agencies discourage health workers from permanently filling roles in the public hospital system by including breakage fees."13*

Our Workforce Survey has also revealed further evidence which suggests LHDs are engaging in "bidding wars" and potential price competition in the recruitment of locums or VMOs into public hospitals. ASMOF is highly concerned about these practices.

Quotes from Members:

> *"Address the competitive price war between LHDs to attract VMO/Locums which have driven up prices dramatically. NSW Health should set a non-negotiable fee for VMOs/Locums and fine LHDs who negotiate outside of this."*

[17] McGowan 2023.

[18] Special Commission of Inquiry: Acute Care Services in NSW Public Hospitals and Garling SC 2008, 20.

"Stop unhealthy price competition to bid for locums - the rates are going higher and higher that make locum work far more attractive than permanent roles."

"We need to stop the locum game. Agencies will have locum doctors available but the doctors hold back from confirming until the health service offers higher rates. This can be $400 an hour."

"Without clear MOH guidance, Districts are being held hostage to negotiated fees. Sessional VMO roles are very difficult to hold accountable so accountability needs to be clear and robust."

The Sydney Morning Herald report also highlighted that the costs paid to the 59 medical locum agencies in NSW (which can be up to 15 to 20% of the doctor's placement fee) are not included in NSW Health budget reporting on expenditure on locums. These are significant issues for transparent health spending. The Inquiry must investigate these issues further to ensure health funding is effective, efficient and equitable for the community.

2.3. A "two-tier" system of unequal pay and unequal work

The use of VMOs and locums can make it more difficult to recruit and retain salaried doctors within NSW Health. Simply, VMOs and locums are typically paid more than salaried doctors, and in some cases are paid on a fee-for-service basis (which means that they are paid for each individual patient they see). In contrast, salaried Staff Specialists continue to be paid a fixed 40-hour contract, regardless of how many patients they see, and without adequate overtime compensation or recognition.

Many of the members who responded to our Workforce Survey raised concerns – as well as frustrations – that locum and VMO staff earn a significantly higher wage to complete clinical work *only* (and receive payment for on-call callbacks), while Staff Specialists complete clinical *as well as* non-clinical work for lower remuneration. In short: Staff Specialists receive less pay for more work and no pay for overtime, while contract and locum staff receive substantially higher pay for less (non-clinical, administrative) work. Many respondents to our Workforce Survey felt this system was unfair. Many also felt that their non-clinical load increases when VMOs and locums are hired, without a respective decrease in clinical load to even-out their workload.

Quotes from Members:

"The non-clinical load on Staff Specialists increases and it does not decrease clinical load."

"Short Locum VMOs are paid large amounts but only do select amounts of work, increasing the organisational and system work on their FT [full-time] peers."

"VMOs mostly have only face to face sessions funded - no clinical governance, teaching, research contribution. VMOS should make a contribution to these other aspects. Plus SS [Staff Specialists] can resent that VMOs are paid twice as much per hour for sessions and are paid for callbacks while SS aren't."

Some members responding to our Workforce Survey pointed out that this arrangement has instituted a "two-tier system", where team members in the same position (in general) are afforded different contracts and different remuneration.

Quotes from Members:

"We're working in a two-tier system. The same job but two different contracts and vastly different remuneration. [...] Sometimes almost twice the daily rate. It's annoying, it's soul-destroying and it's inherently unfair. New grads are going straight into private practice or VMO work. They are 'crowing' about how much more they have 'negotiated'. LHDs have no choice - they have to staff wards and clinics. So it's cowboy country."

"Stop the two-tiered system. Sometimes it's even more complex than that - it's 3 or 4 tiered. Like locums or 8hr vs 10hr VMOs. Either way, once you start paying people differently for the same job, you're going to get people voting with their feet."

"Two-tier payment structure, sense that VMOs are being paid double, inequity."

In sum, the current remuneration model – which appears slanted in favour of VMOs and locums - not only impacts the attraction and retainment of salaried doctors within NSW Health, but also underscores the urgent need for reform of the Staff Specialist Award. Recognising and remunerating the dedication of salaried Staff Specialists through a fair and equitable approach is essential for fostering a thriving and sustainable healthcare workforce.

2.4. Financial and lifestyle incentives for VMO and locum work are contributing to the workforce exodus

As noted in the section above, locums and VMOs are contracted to perform clinical work only in a fee-for-service structure. It is unsurprising that many salaried staff are influenced to consider locum or VMO employment options when one can receive higher wages and greater work-life flexibility without the expectation of completing non-clinical and administrative work.

Many members responding to our Workforce Survey suggested these incentives were contributing to the exodus of salaried doctors from the public system to the private sector, or to take up locum or VMO positions instead of salaried roles.

There are instances of staff specialisits being told by their managers the only way they can pay them more is for them to resign and be rehired as VMOs – something that the staff specialists in question did not want but had no alternative to.

Quotes from Members:

> *"The more VMOs we use, the more Staff Specialists are tempted to leave to work as VMOs because they see VMOs being paid more and often having less responsibilities."*
>
> *"Fewer Registrars apply for Staff Specialist jobs because they see appeal of good money and reduced commitment of VMO life."*
>
> *"They [locum staff] are a symptom of the problem not a solution - many of my colleagues have left NSW health to do the same job as a locum and earn up to 5x as much as me, have less overtime requirements and do the same job!"*
>
> *"Understaffing has burned out a lot of my fellow juniors and pushed them towards locuming so they have a better work-life balance and better remuneration."*

2.5. The essential, non-clinical work in a hospital suffers

Locums and contract staff play a vital role in ensuring the cover of clinical care in the face of staffing absences. However, their increasingly standardised use across the public health system may have negative impacts on clinical governance, long-term hospital planning, teaching, community care work and research. As noted in the *National Medical Workforce Strategy 2021-2031:*

> *"Locums are also rarely expected or able to contribute to teaching, supervision, administration and clinical governance of health services. Permanent staff must fulfil these roles; these aspects of quality care may be lost if the service only employs locums."19*

In our Workforce Survey many members raised concerns about the inability of VMOs and locums to contribute to the broader functioning and culture of the hospital or department. In contrast, Staff Specialists carry responsibility for a range of non-clinical tasks, such as instructing medical students and registrars, conducting research, creating care models, participating in hospital committees, examining adverse incidents, administrative work, and offering guidance to non-clinical health managers. Some members expressed a perception that VMOs and locums may have a different level of investment or commitment to the

[19] Australian Government Department of Health and Aged Care 2022, 39.

hospital, public health, and the local community, because they do not or cannot engage in the non-clinical work that is vital for a well-functioning public hospital.

Quotes from Members:

> *"Locums are by definition short term; hence they cannot engage in planning matters. VMOs on a 5 year contract are different, but the expectation is that they are only clinical, so [they have] less attendance at meetings etc. and they are rarely replaced 1:1, so there is less clinical cover. Both tend to lead to less teaching time, and essentially no research."*

> *"Demoralising to see huge amounts of money spent on Locums (some for years and on a regular basis) instead of paying better wages to those committed to the hospital and living in the community. Incredibly shameful to pay more per hour for JMO Locums than the Staff Specialists supervising them."*

> *"Most of the VMO contracts are oriented purely to service provision- no requirement for teaching or contribution to departmental administration. The end result is poor learning outcomes for trainees, less competence in new specialists, attrition of departmental function and culture as poorly paid Staff Specialists are either overworked or seek extra employment and lose focus."*

Non-clinical work – properly referred to as clinical support work is crucial to the overall functioning and success of a hospital and public health system. It supports the education and development of healthcare professionals, drives medical advancements, ensures efficient operations, provides governance and oversight, engages with the community, and contributes to ongoing quality improvement efforts. The continued loss of salaried Staff Specialists is thus a serious problem for the long-term good of the hospital and overall care for the community.

2.3. Potential risks to the continuity of patient care

Maintaining the continuity and quality of care must be a critical consideration for public hospitals. The *National Medical Workforce Strategy 2021-2031* notes that the use of contract or temporary doctors in public hospitals can have an impact on the continuity of care for individual patients, and hospital teams.[20] Continuity of care often relies on a consistent and ongoing doctor-patient relationship, allowing for better understanding of the patient's medical history, preferences, and unique healthcare needs. Continuity of care is also closely

[20] Australian Government Department of Health and Aged Care 2022, 39.

tied to the establishment of trust between patients and their healthcare providers, and across hospital care teams.

Members who responded to our Workforce Survey raised concerns about the potential for "fractured" or reduced patient care with an increasingly temporary locum and VMO workforce.

Quotes from Members:

> *"Locums and VMOs provide vital service. However, they can impact on continuity of care. Quality of care can also be an issue if they do not know the system well. The focus should be to retain and competitively remunerate registrars and Staff Specialists."*

> *"Locums and Visiting Medical Officers do not have a commitment to the local community in [the] hospital. It is difficult for them to develop a relationship with senior hospital staff, they are less familiar with local policies and protocols, and their rostering results in them not engaging in clinical teaching and involvement in quality improvement activities. They also generally cannot provide significant consultation services in outpatient clinics and cannot provide continuity of care."*

> *"Poor continuity of care for hospital. Senior doctors contribute SO MUCH MORE to their departments than just 'seeing patients' that is not adequately considered in the VMO/locum model. VMO/locum model does not encourage good care, accountability or engagement with education."*

Given their temporary nature, short-term doctors are largely unable to develop the kind of long-term relationships that bring most benefit to patients. Additionally, locums or short-contract doctors may not be as familiar with the specific systems, protocols, and workflow of a particular hospital, which may result in delays, issues in communication or information transfer across teams, inefficiencies, and potential errors in delivering care.[21]
There is some international evidence of frustration among patients with long-term or chronic illnesses who may have to repeatedly explain their condition to temporary or short-term doctors who failed to sufficiently review their patient information beforehand.[22]
Improper onboarding or inductions of temporary staff may also exacerbate these continuity and quality of care issues.[23]

Temporary doctors may also be unavailable for follow-up appointments or less likely to provide continuity in post-treatment care, which could result in gaps in follow-up or

[21] Waibel et al. 2012.

[22] Waibel et al. 2012.

[23] Ferguson and Walshe 2019.

potential delays in addressing evolving health conditions. Some international evidence suggests the use of temporary physicians, as a short-term solution to fill staffing shortages, can "considerably reduce" patient's satisfaction with the care they receive.[24]

2.4. Potentially fractured or inconsistent training outcomes for junior doctors

Our Workforce Survey also raises concerns about the consistency and breadth of Junior Medical Officers' (JMOs) training and supervision. Current JMOs responding to our Workforce Survey were asked about their experiences of training and supervision with VMO staff and Staff Specialists. Many of those JMO respondents who had received supervision from either solely VMOs or a mixture of Staff Specialists/VMO supervision reported no difference in the quality of supervision. Some JMO respondents reported that they had *only* received supervision from VMOs (due to staffing models, especially in regional hospitals).

In general, there was a view among JMO respondents that Staff Specialists are more available and provide more consistent supervision with an ability to undertake research, compared with VMOs. There was a sense among some JMO respondents that VMOs appear comparably less invested in supervision tasks than Staff Specialists. Other JMO respondents noted that VMOs are often less available for supervision because they rarely carry a non-clinical workload and are only on site on a short-term, often fractured basis.

Quote from Member:

> *"We only have VMOs. I believe this has impacted my training and formal learning opportunities. Very few VMOs participate in our teaching program. Has resulted in an almost entirely registrar led teaching program with zero oversight from a senior doctor. There is no active research."*

These responses from JMOs point to potential inconsistencies in, or detrimental impacts upon, JMO learning opportunities and outcomes, which are likely to be exacerbated should the Staff Specialist workforce continue to decline.

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[24] Oppel et al. 2017.

3. Opportunities to ensure future sustainability

The status quo is unsustainable. Hospitals and districts are chronically understaffed. Inadequate doctor staffing at one hospital creates ripple effects: from the entire operation of an emergency department or specialist ward to the entire LHD in that district. Staff are overstretched and burning out. Working conditions are worsening, while salaried Staff Specialists' remuneration remains stagnated and unreflective of the actual hours worked.

In this context, it is unsurprising that more than three quarters (76.5%) of members surveyed reported that they had considered resigning from their role in NSW Health. Similar proportions of metropolitan (77.7%) members surveyed and non-metropolitan (74.5%) members surveyed reported they have considered resigning from NSW Health. One HNELHD Staff Specialist, who has worked for NSW Health for over 10 years, said:

> *"Any day now. I'm going to leave to do private only. I can no longer work in these conditions. My GP has advised me to resign due to stress from abusive colleagues, poor support and unrealistic workload."*

Put simply, the NSW public health system must address the structural employment issues raised in this submission.

3.1. Factors impacting recruitment and retention with NSW Health

To date, NSW health has done little to address the ongoing recruitment and retention issues affecting its workforce.

Salaried doctors feel that NSW Health is not committed to retaining the current workforce. In our Workforce Survey, nearly half (47.1%) of members surveyed felt NSW Health's commitment to retaining salaried doctors was *weak* or *very weak.* A notably lower proportion of members surveyed (15.0%) felt NSW Health's commitment to retaining salaried doctors' roles was *strong* or *very strong*.

There are a raft of financial and non-financial factors impacting NSW Health's capacity (or lack thereof) to recruit and retain salaried doctors and other essential healthcare workers.

Our Workforce Survey directly asked members about the financial and non-financial factors that would encourage them to remain employed with NSW Health if they had considered resigning. The vast majority of members pointed to workload, conditions and remuneration as the key factors that would influence their decision to resign or remain in their roles. Thus, these are among the factors that require urgent attention to improve and ensure the retention of the current salaried workforce.

Around 8 in 10 members surveyed reported that better staffing levels and workload management (81.1%) and competitive salary and benefits (80.1%) would encourage them to stay employed with NSW Health. More than 6 in 10 (62.5%) members surveyed said that

improved work-life balance initiatives would influence the decision to stay in their role. These results are unsurprising given members' concerns about the current working conditions, stagnated salaries and chronic understaffing in NSW Health.

Stagnated wages are a particularly significant issue in the context of Australia's cost of living crisis. For example, many members in our Workforce Survey noted that they made the decision to accept external VMO or locum work – often on top of or in conjunction with their FTE salaried role – in order to cope with the cost of living in Sydney or to better support their families financially.

Quotes from Members:

> *"I'm a locum because it's the only way to afford to live. I locum about 10-20hrs a fortnight on top of my full time reg role. The ED [emergency department] I locum in needs staff, and I need income, so it works for us."*

> *"My salary in my public health Staff Specialist appointment would be insufficient to service my mortgage if I didn't take on external work as a VMO, due to the high cost of living in Sydney."*

> *"The workload and the cost of living is increasing yet NSW Staff Specialists remain the lowest paid in the country. This has forced me to pick up Locum VMO work in order to take off the financial pressure of living in Sydney. Increasing Staff Specialist remuneration will go a long way toward retaining current staff and attracting the next generation of doctors who now turn down public appointments for the more lucrative private work"*

> *"The pay being so low and the increase having been frozen during the peak of COVID-19 very negatively affected Doctor morale. The pay also pushes more people to locum as it is insufficient to cope with costs of living in Sydney, especially if they ever want to be able to afford a house. We also lose doctors to better remunerated states."*

Other factors influencing retainment cited by members in our Workforce Survey included enhanced professional development opportunities (37.2%), the ability to access Time Off in Lieu (TOIL) (35.9%), Opportunities for teaching, research, and other activities (35.9%) and Enhanced workplace safety measures (19.4%).

Our Workforce Survey also asked members to rank, in order of preference, a number of listed measures or strategies that they thought should be implemented to maintain safe staffing levels for doctors across NSW Health. "Improved pay and conditions" was the highest ranked measure or strategy, ahead of "collaboration with doctors to determine staffing needs" (see Table 1). These findings echo the vast majority of members surveyed

(81.1%) who reported that better staffing levels and workload management would influence their decision to continue working for NSW Health.

Table 1: Possible measures or strategies to maintain safe staffing levels for doctors, ranked in weighted order of respondents' preference

1	Improved pay and conditions
2	Collaboration with doctors to determine staffing needs
3	Improved recruitment and retention efforts
4	Enhanced resource allocation and budgeting
5	Enhanced influence of doctors in leadership roles
6	Clear guidelines and policies on safe staffing levels
7	Effective workload management and scheduling
8	Innovation in models of care delivery
9	Amendments to current Local Health District governance structures

It is crucial for the Commission to recognise that fair and nationally competitive salaries are key to retaining our workforce of dedicated salaried doctors (or what is left of it). As shown in AIHW data from 2021-22,[10] the average salaries for full-time equivalent specialist salaried medical officers in NSW ($304,159) lags significantly behind South Australia ($467,511), the ACT ($465,931), Queensland ($462,721) and Victoria ($459,528). Thus despite its world-class healthcare, NSW Health is not offering nationally-competitive remuneration for salaried specialist staff.

Many respondents to our Workforce Survey highlighted that comparably low pay was factoring into their decisions whether to take up temporary (locum) work or to shift interstate for better remuneration.

Quotes from Members:

> *"My colleagues are currently planning on moving to QLD and WA due to much more impressive financial incentives in these services."*
>
> *"There is minimal financial incentive to remain in NSW Health. You have more job flexibility and better pay with locum work. From my work near*

the NSW/QLD border it was very clear that our pay is a very obvious reason to leave NSW Health."

"I'm underpaid compared to my interstate colleagues [...] I can't afford to provide for my family without locuming in addition to my full time hours."

NSW Health must commit to improving the Award and remuneration package to ensure the best doctors stay in NSW, rather than consider alternatives interstate or in the private sector and so that public hospitals can be adequately staffed.

In line with fair remuneration principles, NSW Health must commit to paying workers for all time worked and spent on call and to address the current deficiencies and inefficiencies with TESL.

As cited by over 6 in 10 (62.5%) respondents to our Workforce Survey, the lack of work-life balance is a key factor impacting the retention of salaried doctors. In free-text comments throughout the survey, respondents consistently noted the need for flexible hours, TOIL and part-time arrangements. Limiting a worker's ability to access flexible working arrangements undermines strategies to retain existing salaried doctors, as it hinders workforce participation and progression.[25]

Put simply NSW Health, and medicine as a profession, can no longer afford to retain structural barriers that disproportionately affect women.

Not only are flexible working policies an important measure to manage workforce burn-out and fatigue, but these arrangements are a mainstay of the gender equality policy of government and non-government organisations in Australia and internationally.

Adopting flexible working arrangements or other initiatives to improve work-life balance for salaried doctors may help to increase the inclusion and retention of women in the medical workforce – an issue identified in the 2023 Gender-based Occupational Segregation National Data Profile, released by the University of New South Wales Social Policy Research Centre ("UNSW", "SPRC") and the Fair Work Commission.[26] The report found that the workforce of Anaesthetists and Surgeons (working in Hospitals excluding psychiatry) had an especially low representation of women.[27]

For example, the report showed that out of the 4,538 anaesthetists in Australia, 37 per cent were female (1,618), and 63 per cent were male (2,857).[28] Furthermore, female surgeons only represented one quarter (25.0%; 1,114) of the national cohort (4,398), compared with a vast

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[25] Cooper and Hill 2021.

[26] Cortis et al. 2023.

[27] Cortis et al. 2023.

[28] Cortis et al. 2023.

proportion of men who made up 74.7 per cent of the national surgeon cohort (3,284).[29] Data from the Australian Institute of Health and Welfare ("AIHW") similarly shows sizeable differences in the gender make-up of the Australian medical workforce: there were 64,446 FTE male medical practitioners in Australia in 2020, compared to 43,329 FTE female medical practitioners.[30]

The inability to access flexible working arrangements, along with the intense working conditions and stagnated remuneration, may each be contributing to the lower representation of women in these sections of the medical workforce.

Workers, especially women and primary caregivers (most of whom are women), who are unable to access the appropriate flexible conditions and opportunities in their chosen profession are more likely to accept positions below their skill level or leave the sector entirely for another field where they can access those opportunities, despite these roles typically offering less remuneration and less workplace security.[31] Federal Minister for Industrial Relations, the Hon. Tony Bourke MP, similarly raised this issue in a statement on the Secure Jobs Better Pay Bill in 2022:[32]

> *"Women still carry the main responsibility for caring work and are more likely to request flexible work arrangements ... In order to access the flexibility they need to manage work and care; they are often forced to drop out of the workforce or to take lower-paid or less secure employment. This plays a major role in widening the gender pay gap."*

Flexible working arrangements that accommodate parents and carers is a key strategy for efforts aimed at reducing gender inequality. [33] This point was noted in the NSW Budget 2022-23 – Women's Opportunity Statement:[34]

> *"While flexible working arrangements can benefit all employees, such arrangements are a particularly important enabler of women's workforce participation. Access to flexible working can allow workers to remain in or re-enter the workforce while balancing their personal commitments, such as caring responsibilities."*

Without a genuine and considered effort by NSW Health to ensure that workers have access to: genuine flexibility arrangements, including flexible hours; part-time arrangements that work, including standardised and fair on-call arrangements; paid on-call, recall, and overtime;

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[29] Cortis et al. 2023.

[30] Australian Institute of Health and Welfare 2022.

[31] Australian Institute of Health and Welfare 2022; Workplace Gender and Equality Agency 2023.

[32] Norman and Haydar 2022.

[33] Workplace Gender and Equality Agency 2021.

[34] NSW Ministry of Health 2022.

the ability to take their leave entitlements then efforts to retain the existing workforce will continue to remain inadequate.

3.2. Factors impacting the recruitment and retainment of JMOs in a career with NSW Health

Beyond recruiting from the existing pool of doctors in the state who have likely opted out of the public servicing model due to renumeration, lacklustre working conditions and burnout, it is little wonder why JMOs and doctors in train are opting for other states who provide better renumeration and respect, or who simply choose to work in the private sector for those same reasons.

Results from our Workforce Survey indicate that the current working conditions and remuneration for Staff Specialists in NSW Health are factors in the career plans of junior doctors in the NSW public health system.

In our Workforce Survey, similar proportions of JMO respondents said they would choose the Staff Specialist (46.8%) or VMO (40.9%) career path following the completion of their training. In free-text responses, many noted that they would be likely to pursue a mixture of VMO and SS roles or would specifically move to the private system.

There is also anecdotal evidence that many medical students undertake their training in NSW Public Hospitals due to the perceived quality of the training, only to move interstate to take on a Staff Specialist role in a state with more lucrative conditions.

Listening to and addressing the concerns of JMOs is crucial to ensure a stable pipeline of skilled professionals and to maintain the quality and continuity of healthcare services for the community.

The median cost for a degree in medicine in NSW is approximately $180,000.[35] Between the national cost of living crisis, a rental crisis in NSW, and the indexation of HECS and HELP loans to 10% in 2022-23, students and JMOs are seeking private employment to compensate for vast economic factors set against them in the pursuit of career in medicine. [36]

In 2022 the Federal government launched the HELP for Rural Doctors and Nurse Practitioner scheme, an incentive that would see eligible workers who stay in remote areas of Australia, for a specified length of time, to have their student debts fully paid off.

Prior to June 2015, hospital trainees received reimbursement of HECS for working in rural areas under the graded HECS Reimbursement Scheme, where trainees received more reimbursement the more remote their employment. [37] This was essential for junior doctors to

[35] UNSW Sydney 2023.

[36] Maguire 2023.

[37] Australian Government Department of Health 2015.

offset the costs of moving and incentivise trainees to relocate to a rural area, however it ceased on 30 June 2015.

In a 2021 submission to the first inquiry into 'Health Outcomes and Access to Health and Hospital Services in Rural, Regional and Remote New South Wales' ASMOF recommended that a similar reimbursement scheme be reintroduced to incentives junior doctors to RRR areas of NSW. [38]

In 2023, given the compounding effects of inflation, similar initiatives should be considered to support all prospective and junior medical officers in NSW – especially as it relates to unpaid placements (not withstanding fourth year arrangements).

ASMOF acknowledge and appreciate that there have been federal and state government attempts to improve the recruitment and retention of doctors in NSW. In September 2023, the NSW Government announced 'study subsidies' for medical and healthcare students, who are willing to stay in the public sector for 5 years.[39] According to the eligibility criteria, new medical students will be able to apply for $4000 annually, and existing students can apply for a one-off $8000 payment. However, the scope and application of the subsidies for junior doctors and students is ambiguous as this 'bonus' is only available to a minority of medical students in NSW - up to 400 subsidies.

Given that JMOs in NSW are now the lowest paid in Australia, a one-off payment for a few does little to address the remuneration and cost of living pressures for all. It is also ill-suited to doctors who move during training to ensure that they can train in their chosen field.

Further, the scheme and one-off cash bonus does little to compensate for the mounting costs of living in Australia, nor does it target non-financial barriers impeding recruitment and retention, such as workforce bullying, burn-out and fatigue, and prohibitive clinical placement requirements.

Case Study: Placement Induced Poverty

> Clinical placements are an essential feature to prospective students' educational prospects. They are also compulsory and unpaid. Universities and medical schools are forced to compete against each other to secure clinical placements for their students. For the NSW Health Workforce to meet the growing health needs of the community, JMOs, prospective doctors and those who are keen to enter the healthcare workforce need to be proactively supported to do so.
>
> In the context of a national cost-of-living crisis rental crises in NSW, and a chronically understaffed public health system, it is little wonder why NSW Health struggles to

[38]ASMOF NSW 2021.

[39] NSW Health 2023a.

recruit young doctors, and healthcare workers, where the prerequisite for their study is a conduit for student poverty. [40]

Unpaid clinical placements are innately prohibitive; they disadvantage a prospective workforce with unnecessary and inequitable financial burdens, combined with the pressures of completing these studies, thereby risking their ability to complete their degrees and enter the workforce that so desperately needs them. [41] Moreover, unpaid clinical placements further disadvantage trainees and students from diverse social, economic and geographical backgrounds, and especially those in remote and regional areas of the state.

ASMOF notes that in 2020, the NSW State Government, then led by former Premier Dominic Perrottet, announced a policy of 1,000 part-time positions annually for final-year trainees to work alongside doctors as paid "assistants in medicine" (AIM) in city and regional hospitals. [42] While this is a step in the right direction, it does little to support those students and trainees not-in their final year.

ASMOF notes that very few medical students have taken up AIM positions.

The overreliance on outsourcing temporary (Locum) or contract (VMO) doctors will continue to impede any efforts NSW Health makes to recruit and retain salaried Doctors. NSW Health urgently requires recruitment and retention strategies to fill Staff Specialist roles.

3.4. Concerns and challenges regarding expanding the scope of practice for other related professions

In our Workforce Survey members shared their views on the concerns, challenges and opportunities in expanding the scope of practice for pharmacists, paramedics, allied health workers, nurses, or midwives within the healthcare system. Respondents shared a range of diverse views on this complex topic.

Overall, most members argued that any such initiatives must ensure that those working in these positions: work within a very specific and clearly defined role; hold the relevant responsibility to fulfil that role and be accountable for their work and decisions; undertake extensive further training; and receive extensive oversight through an effective governance model.

Beyond pharmacy prescribing powers, many responding members raised several concerns about expanding the scope of practice. The foremost concern was for the quality and consistency of patient care. Many members were also concerned that expanding the scope of practice was a short-term “band-aid” solution, or another attempt at “cost-cutting”

[40] Yoldas 2023.

[41] Dragon 2023.

[42] Roe 2022.

through outsourcing – both of which do not address the root issues contributing to the issues of chronic understaffing and excessive doctor workloads.

Quotes from Members:

> *"It's ok as long as the roles are well-defined and carefully monitored. The danger is always that it becomes a quick and dirty way to cut medical staffing costs or solve medical staffing shortfalls."*
>
> *"Expanding roles for these staff at the expense of providing inadequate medical staffing resources is both inappropriate and unsafe for patients."*
>
> *"This seems like cost cutting instead of dealing with the staffing crisis. In a limited number of circumstances this is helpful (e.g. in my speciality expanding the amount of psychiatric nurses to do entry level ED consults has been immensely helpful)."*
>
> *"There are no doctor shortages in the population. The issue is conditions and remuneration in the public system. Improve these and alternative models of care will not be required."*

Relatedly, other members responding to our Workforce Survey shared concerns about the unintended consequences of expanding the scope of practice, which may in fact *increase* doctors' workloads rather than reducing them. Some members argued that other, more straightforward solutions are available that would help to reduce doctors' workloads, such as increasing funding for medical clerks and addressing IT system issues.

Quotes from Members:

> *"I see roles for expanded scope for some positions, but they should be supervised and directed by qualified medical practitioners. We have our JMOs essentially doing paperwork and administration when they could be doing clinical medicine. The real need in the system is for administrative and logistical support for all health care practitioners to allow them to work to their scope. The incredibly poor quality of our IT systems (eMR etc) create unnecessary administrative burden on all staff. NSWH makes very bad IT decisions because these are not made by the users. I am sure the new EMR will be no different."*
>
> *"[The] Key is task substitution, not role substitution. Would be great to offload some tasks that do not require senior doctor skills (e.g. scribes) or other special skill sets (e.g. ED pharmacist). But lots of problems with role substitution."*

4. Existing governance structures, practices and culture

Letters Patent items: B(i), B(iv), B(v), F(viii), F(x).

The fractious relationship between medical staff and management of LHDs and the Ministry of Health has been an ongoing concern for ASMOF. ASMOF consistently receives feedback and complaints from members detailing maladministration of workforce policy directives, opaque administrative decision processes and lacking consultation from NSW health agencies on issues and activities that impact their work.

As shown in this section, doctors also have concerns about the extent to which their expertise is considered – or even heard – in decision-making. In our Workforce Survey, more than half (57.7%) of responding members disagreed or strongly disagreed with the statement "Management at my LHD/network consults doctors about issues that affect them". Further responses from our Workforce Survey highlight doctors' concerns about the functioning, transparency and accountability of the existing NSW Health and LHD/Network governance structure. Around 6 in 10 (61.8%) members surveyed disagreed or strongly disagreed that the current governance and accountability structure of NSW Health Local Health Districts supports the delivery of health services that meet the community's needs.

4.1. Consultation, accountability and transparency within the "siloed" existing structure

Many of the results from our Workforce Survey point to a fracturing relationship between medical practitioners and executive management at the departmental and LHD level. Six in 10 (60.7%) members surveyed *disagreed* or *strongly disagreed* with the statement, "I feel that my contribution is properly appreciated and valued by my LHD / network and not taken for granted". There was a sense among many members in our survey about a growing disconnect between management and clinical staff and a frustration about the seeming prioritisation of budgets and KPIs over the support of healthcare staff and patient outcomes.

Doctors are increasingly feeling like they are not engaged with by LHD management or by the Department. Doctors have crucial insights from their profession that should be listened to and respected. In our Workforce Survey, many members felt their insights from the frontline work with patients, and their insights into the workings of hospitals and public health systems, are not being heard or included in governance decisions or planning. Around 6 in 10 (57.7%) members surveyed *disagreed* or *strongly disagreed* with the statement, "Management at my LHD/network consults doctors about issues that affect them". A substantially lower proportion of members felt LHD management does consult with doctors on key issues (18.0%). In free-text responses, many members called for more genuine, substantive consultation processes and to improve lines of communication between medical practitioners and management.

Quotes from Members:

> *"Despite being at the coalface, I don't think a manager has ever asked me how systems could be improved or what is a barrier to good efficient patient care. I would like to see admin have to be embedded in care teams to see some of the challenges we face."*

> *"I believe administrative/managerial staff and leadership are too far removed from the reality of clinical work. I believe they should be rotated through or required to complete the occasional shift on the floor. The vast disconnect creates inefficiencies and missed opportunities for positive change."*

> *"Management needs to understand what goes on in the wards. They are too far removed and are making inane and insane decisions about things that don't even affect their workflow but are punishing to the JMOs on the ground."*

Many of these concerns about consultation and the fracturing relationship between clinicians and management were raised in the Garling Inquiry of 2008. Among the recommendations, Garling called for the creation of a position entitled "Executive Clinical Director", to be held by a qualified medical practitioner.[43] Part of this position's function would be to provide independent clinical advice, and to "conduct regular forums (or similar consultation processes) with all clinicians, including with Medical Staff Councils", in order to provide a mechanism for two-way communication between management and clinicians on health systems, policies and practice improvements.[44] Medical Staff Councils (MSCs), the Medical Staff Executive Council (MSEC) and Clinical Councils were offered as a structural-level solution to issues of clinical representation and engagement on LHD boards and within the Department.

However, responses from our Workforce Survey indicate potential issues in the workings or effectiveness of these clinical representative councils or other NSW Health consultation processes between clinicians and LHD leadership. Consultation processes and mechanisms should be standardised across the public health system. To improve collaboration between clinicians and management, these consultation processes and their level of use across LHDs may warrant further review.

Quotes from Members:

> *"Listen to clinicians. There is massive disconnect between executive and clinicians. We are given lip service only and are offended by this."*

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[43] Special Commission of Inquiry: Acute Care Services in NSW Public Hospitals and Garling SC 2008, no. 137.

[44] Special Commission of Inquiry: Acute Care Services in NSW Public Hospitals and Garling SC 2008, no. 137 (e).

“There is a growing tendency within Hospital executives to limit/exclude doctors from decision making - including planning of clinical services. Hospitals and LHDs must consider Staff Specialists as assets and not liabilities.”

"In Victoria where I have worked at previously, Hospitals and Departments within their hospitals are run by doctors with input from senior nursing/allied health staff. In NSW the system is run by an administrator whose goal is to balance the bare minimum for service provision with cost. The expansion of these administrative roles has now caused a huge cost increase in staffing for arguably none, if any, gain.”

“Some real ability to shape the system and improve the system. The gross expansion of management and centralised administration has sidelined people who have years of relevant experience and who know what needs to be done to improve the system. Most of this new managerial class have no understanding of public hospital medicine and how to fix it.”

Doctors want substantive and genuine engagement with management about clinical decisions and improvements for the community. Many of the members who responded to the survey called for greater transparency, accountability and responsibility by the Ministry, Department, LHDs and hospital management. Many held the view that the existing structure and decisions made within it are not always transparent or given appropriate, independent oversight. In this context, some respondents called for: independent auditing; greater representation of clinicians Councils on boards and executives; Clinical Councils playing a substantive role in decision-making; and also a shift towards more localised decision-making at the hospital level. These views relate to the finding (above) that many members surveyed felt their contributions and expertise are not valued or being heard, and that the executive remains “disconnected” from frontline medical practice.

Quotes from Members :

“The conditions for medical staff are horrendous and possibly the worst I have seen. Whilst yes, the system is desperately in need of funding reform, one of the major issues is the default to hire managers and non-frontline staff. As an example, we have a burgeoning executive stratum, project managers, and others, while our FTE clinical staff dwindles and disappears. I come to work to be bullied relentlessly by a non-medical manager who interferes in patient care, directs spending and hates the patients we serve. It’s destructive. Even when allocated money it is directed to insane things – a new business manager has been sent to three conferences all expenses paid for example – yet we are instructed that no money exists for any medical uplift.”

Case Study: Pathology

NSW Health Pathology was established in 2012. Before 2012, pathology services were primarily managed through individual LHDs. By centralising NSW's pathology services, NSW Health sought to improve cost and operational efficiency, and to standardise pathology service across the state.

Centralising NSW Pathology and separating pathology from LHD governance has led to a wasteful duplication of shared services such as human resources management, quality management, finance and information technology. Efficient pathology results drive accurate diagnoses, reduced length of hospital stay and improved patient outcomes. Inability to utilise administrative support and entry level technical assistants previously drawn from LHD casual pools has led to increased labour costs. Unnecessary centralisation has increased turnaround times due to transport delays.

Additionally, some respondents to our Workforce Survey also highlighted that different LHDs and Networks have different governance structures and policies. Uneven governance structures across the state may act as a barrier to transparent comparisons or audits across jurisdictions.

Some members in our Workforce Survey raised further concerns about the internal complaints review process. Some members shared experiences of poorly executed internal investigations as well as investigations which felt like "targeted" them or another member of staff, while others shared experiences of bullying.

These are ongoing concerns for ASMOF. Between December 2022 and January 2023, ASMOF surveyed 600 members on their experiences of workplace investigations within NSW Health, particularly in relation to allegations of misconduct, bullying, harassment, and clinical complaints against clinicians.

Overwhelmingly, respondents to the 2022-2023 ASMOF survey were dissatisfied with the process of workplace investigations, as led and undertaken by LHD Workforce teams. This 2022-2023 survey revealed several key themes relating to the investigations process, including: a lack of transparency, secrecy, information hiding, lack of communication, and a lack of procedural fairness. Most respondents' experiences of workplace investigations raised issues around transparency, secrecy, communication, and perceived bias. One respondent described it as "Vindictive, malicious and not a fair hearing about the issues of complaint", while a notable number of respondents described the nature of the investigations as a "witch hunt". For example, one respondent wrote:

> *"[The] Outcome was a travesty, where SMO complaint recipient was eventually vindicated after being dragged through unjust process, however lost job, and had conditions put on medical registration in interim. Was all refuted by medical board and found to be exactly what it was - a witch hunt, bullying, appalling spiral of vindictiveness by a local health district and its lackeys - who themselves suffer no censure*

for their collective bullying and driving clinicians to brink of suicide. Never a satisfactory outcome in my experience if investigation team is HR and administrator unless experienced practising SMO is part of investigation team at the start - this can rapidly sort out appropriate complaints from the many unjust or uninformed ones."

Additionally, ASMOF's July 2023 survey of Remote, Rural and Regional Doctors showed that over four in ten (41.8%) respondents reported witnessing bullying and harassment, while a further four in ten (40.0%) reported experiencing bullying, harassment, discrimination or racism within NSW Health. The most commonly reported culprits of these behaviours were Hospital Management/Administrative Staff (51.4%), followed by Senior Medical Staff (40.5%), and Patient and/or patient family/carers (21.6%). These figures are likely to be an underrepresentation of the true prevalence of bullying, harassment, discrimination and racism against doctors in remote, rural and regional areas. Of the 27.7% of respondents who experienced or witnessed bullying and/or harassment and who reported the incident to senior management, the vast majority (73.3%) said their report was never followed up.

These issues thus continue to be under-reported due to a culture of silence and concern with how workplace concerns and grievances in NSW Health are addressed.

Similar findings were evidenced in the 2022 *Medical Trainee Survey (NSW)*. In response to the findings, Dr Anne Tonkin, Chair, Medical Board of Australia highlighted the endemic culture of bullying and harassment in medicine:[45]

"The culture of medical training needs attention. It is totally unacceptable that 55% of Aboriginal and Torres Strait Islander trainees experienced and/or witnessed bullying, harassment, discrimination and racism. It is inexcusable that 34% of all trainees did. [...] We no longer have to speculate that trainees are concerned about the consequences of reporting, we know this is true. Of those who had experienced bullying, harassment, discrimination and/or racism, 70% did not report it. Of these trainees, 55% were concerned about the repercussions, and 51% said nothing would be done if they did make a report."

Despite NSW Health's longstanding "zero tolerance" policy towards bullying, it remains common knowledge that healthcare, particularly medicine, is an industry rife with bullying and harassment at all levels.[46] These findings indicate the recommendations made in the Garling Inquiry to institute a workplace culture of respect and recognition within NSW Health have yet to be successfully implemented.[47]

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[45] Medical Board of Australia and AHPRA 2022.

[46] ASMOF NSW 2021; Australian Medical Association 2021; ASMOF NSW 2023.

[47] Special Commission of Inquiry: Acute Care Services in NSW Public Hospitals and Garling SC 2008.

4.2. The creep of privatisation and outsourcing

ASMOF supports increasing, maintaining and enshrining public ownership of all public health services in NSW.

Privatisation refers to the transfer of public services or assets to private ownership and control. In this section, "privatisation" also includes Public Private Partnerships (PPP). ASMOF opposes the privatisation of public health services.

Much of the discourse surrounding privatisation is "efficiency" and assumptions that profit-driven businesses are always more efficient and better able to deliver outcomes than a well-run public sector. Following this view is the assumption that a private operator is better placed to deliver increased efficiency and value for money than the Government.

These assumptions have been repeatedly proven incorrect. Privatised public health services have a long track record of failure, including in NSW. Private, for-profit, organisations have shown time again that profit will always be their primary aim – not the provision of quality services. ASMOF holds the firm view that profit should not be the core motive in the delivery of quality health care. Private companies are required to meet their legal obligations to their shareholders first and foremost, which may conflict with the public interest. It is folly to expect a public benefit to emerge from private profit seeking.

Privatisation risks public health outcomes and erodes the public service. Our experience is that private operators predominantly provide far less training, education, research and quality improvement when compared to public hospitals. These cost-cutting measures have the potential to undermine the public health system and put at risk the patients in the communities who rely on medical care. Without urgent intervention to cease the privatisation of public assets, and a concerted effort to compete with the private sector, private organisations will continue to profit off the failings of NSW Health, while patients remain languishing in hospital corridors as they wait to be seen by a doctor.

A 2013 report by The McKell Institute found that the privatisation of hospitals in NSW had led to an increase in waiting times for elective surgery and a decrease in the quality of care.[48] The report also found that the privatisation of hospitals cost the NSW government more money than if the hospitals had remained in public ownership.

Additionally, a report from the McKell Institute in 2014 showed that privatised hospitals are a "risky business", and that the efficiency argument does not stand up to scrutiny. The report was based on 2009 research from the Productivity Commission, which showed that public and private hospitals had similar average costs across Australia, although public hospital costs in both NSW and Victoria were lower than private hospitals. The authors note:

> *"The assumption that privatisation and outsourcing will deliver better services at a lower cost can be an enticing drawcard for policy makers*

[48] Torpy 2017.

seeking to reduce expenditure in healthcare. However, the evidence examined in this report finds that the expectation of budgetary savings is rarely met. Notably, decisions to privatise and outsource are often reversed at a later date once it becomes clear to policy makers that the strategy has resulted in a net negative impact on state balance sheets."[49]

The McKell Institute argues that the resurgence of policy interest in public-private health partnerships, which largely fell out of vogue following the disasters in the 1990s, can be attributed to a resurgence in the belief that the market will provide more efficient healthcare more efficiently. Policy decisions must be based on solid evidence, not belief.

In January 2018, ASMOF, alongside the other Health Unions, pressured the then Berejiklian Government to back down from plans to privatise five regional Hospitals in NSW. The statewide campaign targeted on Goulburn, Wyong, Shellharbour, Maitland and Bowral. A key reason for the success of the campaign was the continued pressure on the Government to produce evidence of successful public-private partnerships in NSW hospitals; evidence which the then-Government could not produce.

Lack of transparency and accountability

ASMOF also holds concerns about the accountability and transparency of both private health care services and public-private partnerships. These types of arrangements obscure accountability and oversight.

The insertion of commercial confidentiality clauses into contracts effectively limits the public's access to information, thereby jeopardising the chance of informed public debate and healthy public accountability outcomes, which in turn is a threat to good governance and public accountability.

The privatisation of public hospitals diffuses political accountability because it increases the distance between political decision making and the actual provision of services.

Long-term contracts

Long-term privatised contracts reduce the ability for future governments to affect change or introduce flexibility into the health care system. Long-term contracts deny the sovereign government of the day the ability to revise operations in response to changes in need and understanding of good practice. While political and economic contexts might change, these long-term privatised contracts stay the same.

A rationale for privatisation is that it "transfers the risk" of aspects of system performance, including failure of management to achieve efficiency targets, from the public sector to private sector managers. However, there are many risks in the delivery of health services. Long-term privatised contracts are frequently worded in such a way that basically the

[49] The McKell Institute 2014.

government is “boxed in”, such that if any of the deal assumptions ever need to change, the public is going to have to be the one to pay.

In Workforce Survey, nearly half (46.8%) of respondents indicated that their hospital, LHD or Network has contracted or outsourced some of its services and functions. While respondents noted that some of the outsourced services were non-clinical in nature (i.e. administration, cleaning and recruitment), the qualitative data suggested an overreliance on locums and outsourcing as a stopgap for alarming workforce shortages. Locums and after-hours specialists (particularly pathology and radiology) were consistently cited as clinical functions that had been outsourced.

Remarks about the outsourcing of pathology and radiology should not come as a surprise given the Minister had to intervene at Concord Hospital in August 2023, as the Sydney Morning Herald reported that the hospital had a backlog of thousands of unreported and unchecked scans. Among a raft of issues at Concord, successive budget cuts to the radiology department were highlighted as a central reason for this backlog. [50]

The history of privatisation in the NSW Health system is not a good one. While attempts have been made by Governments to develop an adequate private/public health care model that maximises public benefit we would argue they have yet to adequately succeed.

Case Study: Northern Beaches Hospital

In December 2011, the NSW Government signed a $600 million dollar contract with Healthscope to design, build, maintain and operate the public-private (PP) level 5 Northern Beaches Hospital (NBH).

In a 2013 media release, Minister for Health and Medical Research, Jillian Skinner MP, said: “This innovative model is a first in NSW, reflecting our commitment to doing things smarter to deliver better services to the people of our state […] Partnering with a private or not-for-profit hospital operator will allow the hospital to be built faster, delivering better value for the taxpayers of NSW.”[51]

At the time, then-general secretary of the New South Wales Nurses and Midwives Association (NSWNMA), Brett Holmes, said the arrangement raised concerns about staff pay and workplace conditions. Holmes said he feared it would lead to a situation "where shareholders' needs come before those of the community".[52]

Holmes was right.

Within the first few weeks, nurses were forced to drive between Manly and Mona Vale Hospital to raid skip bins to obtain basic equipment supplies that were

[50] Thompson and Fellner 2023.

[51] NSW Health 2013.

[52] ABC News 2014.

unavailable at NBH.[53] Worse still, in evidence provided to the inquiry investigating the operations of NBH it was noted that there were more bodies than body bags available in the hospital morgue.[54]

Since inception, the operation, development, and funding of NBH was shrouded in secrecy.

Following many months of pressure by ASMOF, essential Health Education and Training Institute (HETI) site reports were released to the public in 2019.

Following a site visit in 2018, HETI highlighted several key areas of concern in NBH, such as inadequate staffing levels (particularly after hours), inadequate planning and preparation for the opening, and a lack of policies and protocols to support safe work practices.[55] In the report, HETI said that "NBH was only 'working' because of the commitment of JMOs who continue providing a service under adverse conditions".

In 2019, the Guardian reported that a patient at NBH had the wrong side of their bowel removed requiring corrective surgery; it was alleged that this was the result of incorrect pathology results from a private provider.[56]

In a subsequent 2019 report, HETI reported that many of the 2018 issues remained:[57]

"NBH has problems with workforce stability; they have a CMO group and a seconded group of junior doctors (PVTs and registrars). There seem to be significant problems with the stability of the allocated numbers, and gaps then have to be filled with locums."

ASMOF President Dr Tony Sara said the December 2019 report "completely vindicated" its threat of industrial action, and warnings to HETI of significant concerns for patient care and staff safety.

In ASMOF's submission to the Legislative Council's Inquiry into the operation and management of the Northern Beaches Hospital it submitted:[58]

"The inadequacy of preparation to plan and set up the hospital, and failure to genuinely consult doctors, has had lasting impacts on service delivery, patient care

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[53] Australian Associated Press 2019b.

[54] Legislative Council Portfolio Committee No. 2 - Health 2020.

[55] Australian Associated Press 2019b.

[56] Australian Associated Press 2019a.

[57] Health Education and Training Institute (HETI) 2019.

[58] ASMOF NSW 2019.

and staffing not just at NBH, but across the broader Northern Sydney Local Health District."

In the 2020 final Committee Report on the Operation and Management of the Northern Beaches Hospital, the committee found:[59]

"That the public private partnership model underpinning the Northern Beaches Hospital, resulting in public patient services being delivered in an otherwise private hospital, has the potential to negatively affect people from lower socioeconomic backgrounds residing in the catchment."

From the outset, ASMOF, and numerous industry groups and stakeholders shared significant concerns about the privatisation of public assets. Chief among these concerns were the inequitable access to healthcare services, increased costs (for both taxpayers and patients), and potential risks to patient care. ASMOF has and will continue to be an outspoken advocates for the doctors who at the time transitioned to NBH, or have been subsequently employed at the Hospital.

Other Case Studies

Unfortunately, hospital privatisation has been attempted by numerous state governments over the past 40 years. There is yet to be a successful hospital privatisation in Australia.

I. Port Macquarie Base Hospital (NSW)

The first privatisation of a public hospital in Australia happened in Port Macquarie in 1994 by the then Coalition State Government. In 1996, the then (newly elected Labor) NSW Minister for Health, Dr Refshauge, reported that the running costs of the Hospital were between $4.5 million to $6.5 million more than the costs of running a public hospital of the same size and providing the same services.

Dr Refshauge said that Port Macquarie Base Hospital was an "unmitigated disaster". It was a dismal economic and health policy failure. It had one of the worst performances of any hospital in state with long waiting lists and concerns about the services it provided.

Following extensive community backlash, Port Macquarie Base Hospital was re-nationalised by the state Labor Government in 2004 at a cost of $80 million. Port Macquarie Base Hospital was described by the NSW Auditor General as a hospital where the public had "paid for it twice and then gave it away".

II. La Trobe Valley hospitals (VIC)

In 1996, the Latrobe Valley's Moe and Traralgon hospitals were merged into one privatised service. Within 6 months, the private operator sought more money from the

[59] Legislative Council Portfolio Committee No. 2 - Health 2020.

government, and within four years the hospital reverted to public control, with the company reporting losses of $6.2 million in 1999.

III. **Modbury Hospital (SA)**

In 1995, Modbury Hospital was contracted to a private provider for 10 years, with an option to extend this to 20 years. The private provider reported experiencing financial losses within two years, and lobbied the government an increase in the contract price, which the government agreed to. In 2007, the private provider handed back the service to the government.

IV. **Robina Hospital (QLD)**

In 2000, Robina Hospital opened as a privately owned and operated public hospital, but was brought under public control at taxpayers' expense following mismanagement by the private providers.

V. **North West Regional Hospitals (TAS)**

Set up under a PPP arrangement in the 1990s, the North West Regional Hospital encountered significant cost over-runs that resulted in the Tasmanian Government buying out its contract and returning it to public control.

4.3 Values and Patient Care: Non-Affiliated Health Care Organisations

Public patients attending publicly administered, government-owned and operated hospitals are entitled to the full breadth of healthcare options legally available to them including care regulated by the Abortion Law Reform Act 2019 [60], and Voluntary Assisted Dying Act (VAD), which comes into effect 28 November 2023. [61]

This care, however, can be denied to patients based on the values of the private organisation running publicly funded public hospitals.

Take for example those residing near St John of God Hospital in the Hawkesbury.

From the 28 November 2023 terminally ill people in New South Wales will be able to make a request to end their own lives, under the voluntary assisted dying (VAD) legislation enacted in 2022.[62]

To be clear, VAD is a complex social issue the assess,emt of which is beyond the scope of this submission. ASMOF respects the right of medical practitioners being able to make personal

[60] NSW Government 2023b.

[61] NSW Government 2023c.

[62] Hyland 2023.

decisions about what services they provide, in alignment with their conscience and personal moral beliefs.

The issue, we submit, arises from the provision of publicly funded public health care services by private providers allowing the provider to create barriers to the equitable access to lawful healthcare.

St John of God has submitted, in separate position statements, that they do not support or provide services related to the provision of VAD.

St John of God Health Care - Position statement on assisted dying:[63]

> “As a Catholic health care provider, St John of God Health Care welcomes all patients and caregivers to our services, respecting their views and beliefs. We have a commitment to excellence in end-of-life care, demonstrated through our palliative care and support care services . We do not support, facilitate, or provide services related to the provision of voluntary assisted dying (VAD).”

When the dominant health care provider refused to provide particular health care services patients are left to seek out support from other locations or, in many cases, may have to travel extensive distances to seek the treatment they require. NSW Health must recognise the challenges to equitable and easily accessible healthcare when different organisations with conflicting missions and values are involved in the provision of health care, whether fully private or in public-private partnerships.

Access to health services relates to reproductive healthcare, particularly for women residing in rural, regional and remote areas of NSW is already difficult. Although NSW has decriminalised abortion, it has been reported that women living in LHDs outside of Sydney continue to be turned away from public hospitals when seeking an abortion.[64] Only two public hospitals outside of Sydney provide the procedure (John Hunter Hospital in the Newcastle LHD, and Wagga Wagga Base Hospital in the Murrumbidgee LHD). Again, patients will be forced to travel significant distances, or interstate, if they cannot afford the costs associated with accessing the treatment through private providers.[65]

A report from Rural and Remote Health has also noted the barriers, financial penalties and inequitable access to abortion services for regional, rural and remote patients in NSW. Participants in this research travelled on average 1 to 9 hours one way to reach a clinic, and five women required overnight accommodation.[66] One of the research participants in this report pondered why they were unable to access the procedure at their local hospital, which was 20 kilometres from their home. They said: ”I wouldn't have had to travel, and it would

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[63] St John of God Health Care 2022.

[64] Aubusson 2023.

[65] Hitch 2023.

[66] Doran and Hornibrook 2016.

have been free". The report concluded by stating: "If abortions were provided through local public hospitals, costs for women would be reduced as services could be accessed via the system of universal health care in Australia".[67]

The above would only be exacerbated if major public hospital in a rurgal, regional, or remote areas were to be operated by private providers that refused to provide reproductive healthcare.

The government should retain sovereign control over all publicly funded public health services.

[67] Doran and Hornibrook 2016.

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