09-01-23

The Commissioner,

Firstly, I hope may late submission may be accepted- I have emailed this morning but figure it is better to send it rather than wait for an answer- which if in the affirmative, would further delay my late submission!

My name is Jonathan Gibson. I have worked in NSW Public and Private hospitals since 1984 in a variety of roles.

I started as a student General Nurse in 1984. This was at the (now defunct) Royal Newcastle Hospital. I continued working as an RN (in the public system) until my first day as an Intern (Jan 1997).

During the intervening training period (in anaesthesia) I worked in public hospitals and also worked as a locum in public and private hospital (to aid our family income).

When I became a specialist anaesthetist (2005) I had a fractional Staff Specialist position at Westmead and also worked (as a VMO) at Blacktown and in the private.

From 2011-2019 I was also a part time Medical Adviser (then Medical Director) for NSW Ambulance. I had also worked in the prehospital arena for Careflight.

I began my foray into medical management/leadership in 2021- first as the Director of Medical Services for the Lower Hunter Sector, then Concord and now Bowral and District Hospital. I also work as a VMO at a number of sites (public and private).

Although I'm an administrator, my allegiance is to the clinicians.

Although my submission is somewhat freeform, I will approach it from the perceived challenges of being a clinician and administrator.

First and foremost, I have no 'axe to grind'. I have read a number of the submissions and advocating for ones service is expected, however I feel the remit of this Special Commission is to gain an understanding of what (resources) goes where and how useful it is.

A:As someone who is involved in the investigation and review of complaints, I can say with some certainty, that the overall care provided at no direct cost to residents of NSW is very good. The process to investigate is uniformly vigorous and fair. I feel it would be fair to say that care is not equitable, this is largely based on geographic reasons- high level services cannot be provided by every site (for reason of safety/volume of practice and the inability to attract the right people to the more distant (or less attractive) sites. Whilst I believe there care is patient centred, there is a large amount of waste in terms of lack of funding (relatively) for primary and preventative care (and any other hospital avoidance programmes eg Extended Care Paramedics) as opposed to hospital funding. I don't think the data has changed much in decades concerning the % of budget spent on people in the last few months of their lives. There is often a lack of pt/carer and team discussion around treatment goals, and it has been my experience that it often easier to do a procedure than discuss not doing it.

There is also a huge amount of waste in terms of disposition- we have many patients taking up acute care beds awaiting NDIS,RACF etc etc.

B: The LHD's mostly run day to day operations without too much interference from the Ministry. This seems to be an administrative behemoth which outputs inordinate amounts of policy change etc – all

of which has to be read and actioned. I don't feel there is sufficient autonomy of the LHD's to decide what is pertinent or not.

I have been personally involved in public in private work. The private sector is generally far more efficient in performing less complex cases. The ethos is fundamentally different there- it may be because 'the more you do, the more you earn' mentality. An obvious difference is there is no (or little) training being provided (ie no students / trainee doctors involved to a large degree). This is very different to a teaching hospital where there are trainees providing the bulk of 'coal face' clinical care.

There has been a huge expansion of community consultation- not all of it useful, and often it a 'tick a box' exercise.

In terms of B.v, if you ask clinicians, they want the governance structures to support them doing their clinical work, and 'stay in their lane'- most administrators have little contemporary clinical experience. They need the governing structures to support them. Accountability, however, is certainly lacking in certain areas (eg how exactly people spend their work time – which, I believe the Productivity Commission looked at years ago)

D. There is a huge amount of duplication and time wasted in certain administrative processes. For example, the way locums are managed- each LHD requires the same voluminous amount of information. Country sites (like ours) rely on the same locums- who can only have a 3+3 month appointment. Each 3 months there is another submission to the LHD MDAAC….There should be a statewide 'casual pool' for all professions. One lot of credentialling and then free to work wherever.

The complex funding arrangement between state and federal governments leaves some winners and some losers. For example, the NSW Staff Specialist award has 5 levels- if you are in a profession that can bill Medicare (Privately Referred Non Inpatients-PRINIP's) eg gastroenterology, cardiology a Senior Staff Specialist can earn approx $500k pa but a specialist who cannot will earn $320k pa. In addition , the Level 2-5's can access private billings for Medical Indemnity insurance (ranging from $6-200K pa depending on the specialty) and other costs of generating income and access funds from the No2 account for conferences etc etc. This is one of the reasons specialists are moving away from staff specialist jobs to the 'expensive' VMO model.

F. Whilst there is enough work in metro areas, it will always be a challenge getting people out of the cities. Some LHD's have successful programmes that focus on the community enveloping the practitioner and their family. Retention is often the issue and throwing money at it isn't universally successful. People stay for the job, the people at work and the community.

We use a lot of locums. The motivation for being a locum varies – to be honest, at a specialist level, money isn't one of them. The daily rate in NSW is LESS than I get as a sessional VMO. As a non specialist doctor, you do earn more than your counterpart. The fees charged are egregious – agencies charge 20% for specialists and 12-16% for non specialists. This should be rejected and a statewide negotiation occur. VMO's are increasing because the NSW Staff Specialist Award is 25% less than other states (some exceptions eg Emergency Physicians). It is more than just money though.

Engagement with NSW Health agencies will need to be collaborative and meaningful. I suspect many consider NSW Health/MoH a real life version of 'Utopia'. Most do not want non clinicians involved in their day to day work.

I'm sure there is room for scope creep for a number of non medical practitioners , but I'm not convinced across the board- a pharmacist is not a specialist GP, nor should be a replacement for one.

Their level of training is not comparable (I worked with a doctor who was a pharmacist previously who described their medical training in the pharmacy degree as equivalent of 'one day of medical school' versus 4-6 years). This option runs the risk of events due to people ' not knowing what they don't know'.

G. Training is a major issue and my experience is that Colleges see their role as training not jobs. We need middle grade doctors to run the public hospitals. The issue in some specialties (eg Cardiothoracics, ICU) is that there is an exit block- insufficient specialist posts at the end of training- thus they either leave or 'tread water' in Fellow positions (great for the hospital as they get Specialist level care for trainee level money). Whilst the LHD provides employment, if the hospital loses accreditation for a particular specialty training programme, this can have disastrous consequences for the junior doctors and patients alike- eg Westmead lost Radiology accreditation- overnight all registrars had to be found other posts and they were replaced by Senior RMO's (junior and without any radiology experience often).

The LHD's often find it hard to accommodate the training requirements of the Colleges eg computer access, on call rooms, non clinical spaces. This can cause disharmony given no other non medical groups gets treated with such care!

There are many barriers to getting international medical graduates working. AHPRA,visas etc . This would be much better done centrally – along with credentialling etc. There is so much administrative duplication as each LHD (and often hospital) has teams doing this work- often inefficiently as they do it infrequently.

H. I feel there is a disconnect between those in the MoH and those clinicians. There are undoubtedly great innovations that would benefit greatly, but they need to sold differently. They need to be applicable in the real world and be implementable with a minimum of extra work. In the nearly 40 years I've been in healthcare, the amount of time taken away from clinical care by process (including the rise of the computer as the primary focus) has been very disappointing. As a patient my experience was that you rarely saw a nurse other than wheeling a WoW/CoW around. There is insufficient time for actual clinical work due to the compliance requirements. Undoubtedly they arose due to patient safety reasons, but the proponents mustn't have either worked on the wards or been a patient.I'm sure many nurses would rather provide care than type. Consultation with front line workers is essential on all matters that concern us.

Sorry if it is somewhat rambling but it is a major undertaking you have embarked on, and those of us who provide actual hands on care to our patients do have a voice and would like to be heard.

Thanks!

Jonathan