Special Commission of Inquiry

into Healthcare Funding

Before: The Commissioner,
Mr Richard Beasley SC

At the Wagga Wagga Court House,
Wagga, New South Wales

Monday, 18 March 2024 at 10.00am

(Day 011)

Mr Ed Muston SC	**(Senior Counsel Assisting)**
Mr Ross Glover	**(Counsel Assisting)**
Dr Tamsin Waterhouse	**(Counsel Assisting)**

Also present:

Mr Hilbert Chiu with Mr Christopher Chiam for NSW Health

THE COMMISSIONER: Good morning, everyone.

I'd like to begin today by acknowledging the traditional custodians of the land on which we are meeting today, the Wiradjuri people, and of the lands across the Murrumbidgee LHD, Wemba Wemba, Barapa Barapa, Yorta Yorta, Nari Nari and Muthi Muthi nations. I would like to pay respects to the elders both past and present and extend that respect to all First Nations people who might be present here today,

Yes, Mr Muston?

MR MUSTON: I announce my appearance. I'm appearing with Mr Glover and Dr Waterhouse for this particular hearing block.

THE COMMISSIONER: For health?

MR CHIU: Commissioner, my name is Chiu and I appear with my learned friend Mr Chiam for NSW Health.

THE COMMISSIONER: Thank you, Mr Chiu.

MR MUSTON: Throughout this week we will be taking evidence from a wide range of people, with insight into the delivery of health care in the Murrumbidgee Local Health District. It will include clinicians, individuals involved in educating future members of the medical workforce within the region, a range of people involved in the operations of the various bodies that collaborate in the delivery of health care within the region, and individuals offering a particular perspective from both a consumer and local government perspective within the region, which, from the perspective of local government, we will come to hear, I think, is one of the important collaborators in addition to those which we might think of more readily, being the LHD and the primary health network.

This hearing block follows on from a tour of the local health district which the Commission took last week, facilitated by the LHD.

I should pause to observe that the Murrumbidgee LHD is vast, it covers an area of 125,243 square kilometres, which takes in parts of the Snowy Mountains to its east, the plains of Hillston and Hay to its west and the a large

stretch of the New South Wales/Victorian border to its south. It is not only a diverse group of physical landscapes but it incorporates a wide range of different communities from very small communities to the state's largest inland city, where we are today, and all of those different communities are served by a wide array of different health services.

As part of our tour we were shown a range of services delivered through smaller facilities, in towns of Batlow, Tumut, Finley and Berrigan, but also had the opportunity to view a range of the services delivered through the recently redeveloped Wagga Wagga Base Hospital.

We also visited RIVMED, which is an Aboriginal community controlled health organisation based in Wagga Wagga, who provide health care to First Nations communities both in and around Wagga Wagga and interact importantly with the various other entities that deliver health care throughout the region.

Now, what we discovered is that each of those communities faces a range of unique challenges in the delivery of health care, and each attempts to meet them in their own unique ways.

Whilst those challenges are unique, underpinning all of them are some of those themes that we identified in opening the Commission late last year.

Significantly, workforce shortages and maldistribution are a real issue across the LHD. They operate in different ways throughout the LHD, though, in the smaller rural areas, attracting primary healthcare work force and attracting a workforce to the hospitals and medical services settings is a challenge.

In the larger parts, the regional area within Wagga, the challenges exist not only in that area but also in attracting a specialist workforce, and we will explore some of that throughout the course of the hearing.

The second theme that has emerged or reoccurred in our discussions and our tour is this divide between the Commonwealth and the state funding of health care and the way in which that has presented two different structures for the delivery of different parts of the health system,

the primary health care, the outpatients, specialist services and the acute and hospital-based health care.

The next theme which underpins all of it is the ageing population, particularly in some of the smaller communities within the LHD, and the increased burden of chronic illness which we have heard a lot about and we've been able to see through our tour of the regions and discussing the day-to-day challenges faced by clinicians, the way in which that really does bite in particularly smaller communities, and also changes in medicine in the way health care is delivered.

So those issues all combine to manifest themselves in a number of different ways. There are real challenges, we are told, in accessing and maintaining continuity of the delivery of primary and specialist care, particularly in the smaller communities that we visited, and as we've already heard, this has a range of significant knock-on effects within the wider health system.

The availability of a full range of acute care services in smaller areas is a challenge, and information barriers between the primary care setting and the acute care setting are a particular issue which has been raised with us a number of times, in two particular respects.

The first is the ability of those working in the two settings to access medical records of the same patients who cross between them, sometimes within a very tight setting, within a small community, presents challenges. In larger communities, but equally in the small communities, there are some real issues that have been raised with us regarding what are described as discharge summaries, which is the communication which occurs between the acute setting and the primary care setting when a patient is released from an acute care episode back to the care of their GP. Real problems, we are told, emerge both in terms of the content and timing of that communication, which has real impacts for the ability of the patient to receive care in a continuous and perhaps seamless way.

These themes and challenges were also front and centre last Thursday when, over roughly seven hours, the Commission had the benefit of speaking to a wide range of people - clinicians, community members, consumers - who shared with us their various experiences of the health

system locally and shared their views on the way in which it might be changed in order to better deliver health care within the region.

Importantly, what we observed last week, both through our tour of the various locations and the discussions we had with the individuals last Thursday, was that there is no single solution to any of the challenges. Each community is slightly different and will require a different approach. Our task is to consider whether there are systemic changes that might be made which have the capacity to better facilitate this more bespoke process, community by community, to work out within each of them just what the best way of meeting the challenges might be.

Which brings us to our first witness, Dr Rachel Christmas, who is the president of the Rural Doctors' Association NSW and a rural generalist practising in Temora. I will call Dr Christmas.

THE COMMISSIONER: There was nothing you wanted to say briefly in opening of these hearings, Mr Chiu?

MR CHIU: No, thank you.

<RACHEL CHRISTMAS, affirmed: [10.09am]

THE COMMISSIONER: Mr Muston will ask you some questions and maybe Mr Chiu will after that.

<EXAMINATION BY MR MUSTON:

MR MUSTON: Q. Could I ask you to state your full name for the record?
A. I'm Dr Rachel Christmas.

Q. And you are a rural generalist, as I understand it, who practices out of Temora?
A. That's right.

Q. And also the president of the Rural Doctors' Association?
A. Rural Doctors' Association NSW, that's right.

Q. Can I ask a little bit about your particular qualifications - you are a general practitioner?

A. That's right. So I'm a general practitioner in Temora. I've been there for the last 10 years. Prior to that I was working in Wodonga, where I did my further training in obstetrics, so for general practice obstetrics, and prior to that I did my junior doctor training in Hobart.

Q. Could I ask you a little bit about the obstetrics training?
A. Mmm-hmm.

Q. What did that involve from the perspective of a GP?
A. So that was a 12-month position in a hospital system part time, so I was doing general practice, finishing off my general practice training and then doing the Diploma of Obstetrics through the Wodonga Hospital at the same time, so sort of doing it half-half, as part of my GP training advanced skill.

Q. What does that give you the ability to do professionally?
A. So professionally I can manage antenatal care and low-risk obstetrics in my hospital. So I don't do operative obstetrics, I haven't got caesar skills. I do assisted caesar skills, but I do low-risk intra partum and post partum care.

Q. How does that actually work in the context of a delivery within your community?
A. So I can manage - our facility is a low-risk facility anyway, so we consult quite freely will Wagga Base Hospital. Any of our higher risk women we automatically confer with Wagga and transfer women as would be appropriate. So I manage women who are considered low risk, if there's such a thing, because there is always a risk with every woman, to deliver in Temora, with the facilities that we have, which are variable. Sometimes we have a caesar team available, so we have a theatre team with the anaesthetist, the GP obstetric surgeon and myself, and then we know that we can manage any situation that arises. But we may not always have that available.

Q. I might take it back a step. You run a private practice in Temora; is that right?
A. That's right. I'm an associate, so that means I own the practice with my two colleagues and we are a training practice as well for GP registrars who are coming through.

Q. Would you tell us a little bit about Temora in terms of its population in health needs?
A. So Temora is a town of about 4,000 people in the town. We service an area of about 7,000 people. We have an ageing population, as you referred to, like most country areas do, we have two nursing homes in the town as well. But we have a very stable population. Lots of young families, working people, so we do the whole gamut from childbirth through to palliative care and end-of-life care for our aged population as well. So it's very much the full general practice family medicine.

Q. I think you said you have two colleagues within your practice?
A. That's right.

Q. Are you the only practice in Temora or are there others?
A. No there are two practices. One is a solo practitioner, so he's our a GP anaesthetist and a GP obstetrician and he works by himself doing full general practice care as well. And then in my practice we have the three associates, and then we have varying numbers of registrars who come through, and we also have a part-time contracting GP who works with us two days a week.

Q. You referred, I think earlier, to your facility, which I take it is a reference to Temora Hospital?
A. Mmm-hmm.

Q. Would you tell us a little bit about Temora Hospital and what it encompasses in terms of its size and services?
A. That's right - so I can never remember exactly how many beds we have but we have - so we do inpatient medical management, so inpatient care of our medical patients, we do emergency care, so 24-hour emergency cover, and we also do obstetric care.

Q. So in terms of the clinical workforce, there are nurses who are employed within Temora Hospital?
A. Yes.

Q. In terms of the medical workforce, in particular, who delivers the care by way of a medical workforce?
A. So the medical workforce is provided by the GPs in the town. So we do the 24-hour on-call for emergencies, and we

do the inpatient care of the patients who we admit. So if I see a person on a Sunday night who needs to be in hospital, I see them again on the Monday morning and through the week. Every town works their on-call and their inpatient management differently depending on their own preference needs, you know, staffing and so on. But we have 24/7 nurse cover and we are considered an acute hospital.

Q. Do all of the GPs in town have a role within the delivery of acute care in the hospital?
A. Yes, they do. Some to more of an extent than others. So some might only do one on call a month or one or two on calls a month, just as their contribution, at the end of their careers, and others are doing, you know, maybe six or seven on calls in a month.

Q. In a practical sense, how are decisions made around the extent to which those services are delivered in terms of rostering between you?
A. That's a really interesting question, because there is no - because we're contractors to the hospital, we don't have a certain number of hours that we have to do. There's nothing that says that I have to do on call at the hospital, as a GP in the town.

We, as a town and as a practice, encourage anyone who works with us to work in the hospital because we see that as being important but there's nothing that says someone has to work in the hospital. The advantage of that is that we kind of just manage it amongst ourselves and we fill the roster. The disadvantage of that is there's no impetus from the hospital point of view to watch how many hours we're working, to replace us or to offer us leave or to support us in that way, because we don't actually work with them under a contract that gives us a certain number of hours. So we are VMOs. So what we work, we go in, we do the work and come out. So what that side of the equation doesn't see is what we're doing in general practice. So the two don't talk.

We have a good relationship with our hospital and our management, but what we're seeing now is we're having to use remote services a lot more often because the demand is just too great and it is just too much.

Q. Can I ask you to just describe what those remote

services involve?
A. So that involves having a doctor on the end of a phone or perhaps video, I think we don't use video so much in our town, we tend to use more phone call. So our nursing staff will see a patient who comes in, they will assess them as they normally would.

Q. Just pausing there, this is patients who come into emergency?
A. Into the hospital, that's right, into emergency, that's right. So if someone comes into emergency, they are assessed by the nurse, they're triaged, what category, and then, instead of calling us as the on-call doctor, the on-call doctor is in a remote location, they take the phone call eventually because they are looking after several hospitals at once, so the time frame could be uncertain, and then the management is negotiated at that level.

Then they're admitted to the hospital under the remote doctor, they might ring back in to check on how the patient is going, and then the next day or whenever the doctor is back in the hospital, they will hand that over to the doctor that's in the hospital.

Q. Is this happening at times when neither you or any other doctor within Temora is able to attend?
A. That's right. So this is a way of work - managing our fatigue and managing the stress of our jobs. So we will have someone who is second on call and they will be available. So if it's me, I might have already done an on call on Friday and then on Sunday I will be second on call and we'll have the remote service and I will be available for emergencies, cat 1, cat 2, where there's immediate threat to life. So we will get called in for that, and they're not very common, but at least we are available for those without having to come in for all of the other cat 3s and belows that can be a full-day's work.

Q. Just for the benefit of those of us who are not within the health system, could you give us a very basic run-down of the difference between cat 1, 2, 3, 4 and 5?
A. Of course. So a cat 5 is a "I've cut my finger and I need a band-aid." So that's general practice, low acuity, you've got time to wait before you see someone, there's no danger to your health imminently and so that has a very low priority.

Then cat 1 is the opposite, and that's someone who has immediate threat to life, cardiac arrest, respiratory arrest, so someone who is very, very unwell. We don't get those very often either. Cat 2 are the ones that could be - go one way or the other, and so we get a few of those. That's chest pains, you know, acute shortness of breath, something that can immediately threaten someone's life.

Q. So I gather from what you said a moment ago that those cat 1 and 2 presentations tend to be dealt with by the doctors in town --
A. Yes.

Q. -- on an on-call basis? But when the telehealth service or the remote service is in operation, it picks up the 3, 4, 5?
A. That's right. And that's a way of us managing fatigue and our workload.

Q. That would be a positive aspect of the remote doctor service?
A. Yes, but it's not a perfect service, of course, because we know that - well, it's not a cheap service. Actually, GP VMOs are a very cost effective way of running a health - you know, running an ED and running the health service for a town.

From a hospital perspective, I know from our nursing staff, they find it very stressful because often they can have patients waiting a long time to be reviewed by the remote service. So they might be three hours in the department waiting for a review by someone, so they've got to manage them in the meantime and have them in the department. There might be others waiting.

Some nurses can cope with that better than others, and I think some of our nursing staff find that very stressful and I don't like seeing my nursing staff stressed, I like to look after them because they do a great job. And the other thing, it can mean we see perhaps more transfers out that might be managed better if we were there doing it ourselves, because we know the patients, we often have knowledge of what their past history has been, discussions before, you know, we bring a lot with us when we see patients in the ED.

Q. Is that because the patients who you are seeing in the

ED tend to be patients who are regular patients of your practice?
A. Absolutely. We have a small population, we know the population well. You know, you often have someone come in, "Oh, hello Joe. How are you today? I saw you last week. How are things going ?" And then we've got access to our records down at the medical centre as well. So I can go on to my phone and I can access their files, I can look at what their medications are, I can look at what their last blood tests were, I can look at what has been happening with them, if they're from our practice.

Q. While we are on records, I gather from what you've just told us, that's an important part of your ability to deliver good continuity of care to a patient?
A. Vital.

Q. If they don't come from your practice, are you able to get access to their primary health care records in any way?
A. No. So the access I have is through the eHealth record, which may give me a health summary if it's available. Often what we - if that has been uploaded. And I know that general practice has been incentivised to make sure they are uploading eHealth records. But if that's not available, sometimes we just get the medications that have been dispensed from a pharmacy, so we know what medications they might be on. That might be all we have to go on.

Q. What challenges does that present in the context of delivering care to those patients when you are encountering them in the acute or emergency services?
A. Oh, understanding what their base line is, especially for blood tests and so on; understanding what their previous presentations have been; understanding the context of their chronic health conditions - have they had investigations, have they seen specialists, what sort of level are we dealing with? Some people are very well informed about their own health conditions and they're able to tell you quite a lot and a lot are not well informed. They don't the medication they are on, they don't know what the specialist said, they don't know where they're at with things, so it depends.

Q. So how do you deal with that information deficit? What are the consequences of it in terms of the way in which care is delivered?
A. Fundamentally, if you are dealing with an acute

problem, you deal with the acute problem regardless of all that background stuff. You just have to do, "This is what we're dealing with now", and then we look at what happens the next time.

The next day often the usual doctor is around, and so you can talk to them about it or hand over the care to the usual doctor, if that is a negotiation that happens.

Yeah, it just depends on the patient, how acutely unwell they are and what is the priority right there and then. Often, there's time. A lot of the time we're not dealing with life and death; it's just, "Oh, this person is unwell", we treat what we think is going on, we admit them and we get the information the next day.

Q. You mentioned a moment ago a baseline and test results that you're able to obtain where it is your own patient by looking at their records. Do you, where you don't have access to those records, think that there is perhaps a need to do tests that may have been done in a primary setting earlier that could have been avoided?
A. I think we are pretty good at not doubling up on tests too much. We are pretty - I think because we are GPs, and we understand that - you know, we are pretty rational with our ordering of tests, we are used to uncertainty and we're used to having time to wait. We can do certain bedside tests to assess the acuity of the presentation but often we're okay to wait and get something the next day.

We can always ring the laboratory and get the latest lot of tests if we need to, if that's something that's going to be meaningful right there and then, but often we've got time to chase that up. Because if a patient is really unwell, then often they're not right for our unit anyway, and we send them out somewhere else.

Q. Is the ability to chase them up a function of the fact that it's a small population of GPs in your town whom you know, so you're confident that the next morning --
A. Absolutely.

Q. -- you'll be able to find out whose patient it is?
A. We always - "Yes, I'm a patient of Dr Kurtzer", "I'm a Dr Smith patient", and you say, "Who do you see?" Or they might say, "Oh, we just go to the medical centre", and so you know they don't have a regular GP that they see all

the team, they see whoever, which means that they probably don't have a chronic health condition of significance so you can usually work your way around it.

Q. So that's the information one way. Information going the other way, out of the hospital setting back into primary care, as a GP in the town, do you find there are any issues in relation to knowing what may have happened to one of your patients in the hospital setting?
A. From within our own hospital, no, because we usually look after them and we see them again the next week and we know what's happened, so the continuity is there and that is really valuable.

Yes, there can be issues from the larger hospitals, especially outside of our health district, because of the electronic systems that we have within the MLHD, we will get a discharge summary. Some are better than others, but generally I would say that has improved markedly with the eHealth record, and that's something that I think is really good because you often get information that you wouldn't have got before from the junior doctors.

The issue is the timeliness of it. So I think that can be improved by an actual phone call to the doctor to say, "This person is being discharged. We would like them followed up within a few days, and these are the issues. Are you able to arrange that", rather than a patient coming in and then you haven't got the discharge summary and you don't know what has happened and they don't know what has happened, and that's not easy.

Q. Within your small community of clinicians do you find that those phone calls happen in a rather organic way?
A. Yeah, they don't happen very often at all. I think the GPs aren't communicated with enough, actually, and especially from the point of view of getting information from us when there is a patient admitted. We know our patients really well. We know what medications they have been on, we know what has been tried before. We're a really good resource for the teams in the bigger hospitals, and I think they tend to forget that sometimes.

Q. So when you're talking about it not happening, maybe if we break it down into two scenarios, first, where the patient has presented at Temora Hospital and it's one of your immediate local colleagues who's potentially dealing

with the patient, do you find that the communication happens in that context?
A. Yes, it's good.

Q. Is that because you all know one another so well?
A. We know one another and also we do our discharge summaries. We have to. It's part of what we have to do. But I get - you know, I'll come in on Monday or a Tuesday, I check my results and there are some discharge summaries and I read them. "Oh, yeah, so and so has been in hospital", "What has he said? Oh, yeah, doctor has said that I need to follow up on this and this and this", and so you do.

Q. Your comment about the delay in the discharge summaries and perhaps the failure to pick up the phone at times, when it would be useful, is more directed at occasions when patients of yours have been admitted to, say, Wagga Base Hospital or another hospital?
A. Yeah, yeah, that's right. So, you know, they have a high workload, the junior doctors, and so you might not get that discharge summary for a week or so.

Q. Do you as a VMO working into the system have an ability to access the electronic medical record of your patients within the LHD?
A. Yes.

Q. Wherever they may have been admitted?
A. Yes, within the LHD, yes.

Q. Do you find that that's a useful resource?
A. It can be. A bit time consuming, but it can be. So I can access the - from in the hospital system, I can do that very easily. From my practice it's just a bit more of a log-in process which just takes a bit of time, but yes, I can.

Q. In terms of the time, when you say it's "time consuming", there's the time to go through the actual logging in through your computer; in terms of the ability, your ability to use the information that's there once you've logged in, is that a significant resource?
A. It's - well, it's just like opening up the patient's file in front of you. You've got exactly what's happened from the moment they went to the hospital, every nurse review, every doctor, ward round, everything, all the

results, everything is there unless they have been in ICU or in surgery. So I can see all of it, just like if I'm in the hospital dealing with the patient.

So it is useful, but if I've got a patient in front of me who has been booked in for a review after being in hospital and they've got a 15-minute appointment, taking time to log in - the log in is not so time-consuming but it is all those little chunks of time. It might take two minutes to log in.

Q. So would I be right in assuming that access to the medical records would not be, in and of itself, a substitute for a good discharge summary?
A. Absolutely not.

Q. But it might actually supplement a discharge summary in a way that could be quite useful?
A. It shouldn't have to. But it can. So if I - and I only have that privilege because I'm a VMO. So if I were a GP in Wagga who didn't work in the hospital system, I wouldn't have access to that. I would only have the discharge summary.

Q. I think you said at the outset that you're also involved in providing training through your practice to future GPs?
A. Mmm-hmm.

Q. What does that actually look like in the context of the way that you run your practice?
A. So that involves us being available for our GP registrars 80 per cent of the time. So we have to be around to give advice, to supervise, to answer questions, to sit in with them to supervise consultations, to see how they're going, and generally just being available. If they're at the hospital doing on call, we need to be available if they're not - if they need advice or if they need a second opinion or if something is too much for them to go in and, you know, help out.

If they've got a huge patient load, we'll go in and just help to get through some of the ones to make it easier for them; doing rounds on the ward with them in the mornings, if they've admitted patients, "How are you going", talking about who they've seen, are they happy about how things are going, do they need to talk about it -

you know, that kind of thing. It's quite a flexible, very organic, I suppose, relationship, and it depends on the relationship between the supervisor and the registrar. Some registrars are very independent, very capable, very confident and competent, and require less input and less supervision than someone who is lacking in some confidence or feeling insecure in that role and needing a bit more support.

Q. How many trainees would you have at any given time at your practice?
A. Never enough. So we have one currently. We have had four.

Q. The other practice in town, do they train --
A. He's not a training practice, no.

Q. Is that a function of the number of doctors who are working through that other practice?
A. No, and that's interesting. I do believe that GP has tried to have trainees come to his practice before and hasn't had them come. He had one that I know of in the time that I've been there, which did not last very long. I'm not sure of the Barriers there. You would have to inquire of him.

Q. You mentioned a moment ago that the trainees might be on call at the hospital. What is the role that the trainees have within the hospital setting? They're presumably not VMOs?
A. They are. So they act as VMOs. They do the same role that I do; it's just that they are under supervision. So functionally it makes no difference. They are on call, like we would be on call, they see everything that comes through, they spend their hours in the middle of the night getting up and going doing it, and coming back to the practice the next day.

It's quite a stressful job for them and it is very - there's a lot of responsibility, they've gone from being in a big hospital like Wagga, where they're in the emergency department with a load of other doctors and nurses around, to being the only doctor with one nurse. So it is quite a responsibility. So we try to support them as best we can in making sure they understand that we are there, we're happy, we're on the end of the phone and they can ring us. But they are so sensitive to the fact that we are all

working very hard as well that sometimes they might be disinclined to call, and that's something that we need to really work on with them, that it is okay.

Q. So what are the consequences of that disinclination?
A. The consequence could be that they're dealing with a situation that they may not be fully equipped to deal with. Having said that, the registrars that I have are a very high calibre and I think are very impressive in what they know and what they can do.

They can also be very well supported by Wagga. So we have a very good relationship with the district - with the base hospital, the emergency department, through the patient flow system, which is really - makes it very accessible, and I feel very well supported, and I think our registrars do too, that we can ring up and speak to an emergency physician and get an opinion or speak to the physician or speak to a surgeon and get some advice from them, so then we're not needing to use our local resources as much.

Q. You said a moment ago that there are too few trainees, at least within your area. Do you think that's a recent trend or is it longstanding?
A. No, sadly this is a longstanding trend. General practice is undersubscribed nationally, rural general practice is undersubscribed again, the reasons being, well, myriad. I think that's a very complex question. General practice has long been the poor cousin in the medical fraternity. It's not remunerated as well as other specialties, and I think rural general practice is seen as an intimidating, big, hard job to do.

Q. How has that manifested itself within your community over the time that you've been there? Have you noticed there has been a drop-off in the number of GPs in town or has it been --
A. Interestingly, like, for a long time there were three GPs in our town and that was it, and they did on-call for a week at a time each. That is phenomenal. And they work incredibly hard and I wouldn't say they always worked safely, because the hours were just so long, and when I speak to one of our recently retired colleagues, he just says, "Gosh, I don't know how we did it." There were no safe working hours, there was nothing like that. They just worked and worked and worked, and I think, now, we have

more trainees coming through, but there is the understanding that that's not acceptable. You can't work people that hard.

I also think the nature of general practices training, where, what general practice is - the nature of general practice is changing, so what we're expected to do in general practice is increasing, there's more complexity, chronic disease, the more research is done into different health conditions the more we're supposed to manage things so it's getting bigger and bigger. Our days in general practice are more complex, and then we're dealing with people who are living longer, with more complex conditions that we're managing that take longer to sort out. So it's just a snowball.

Q. Presumably that's not unique to your little corner of New South Wales?
A. Absolutely not. Absolutely not. I think also, the idea of moving to a small town, if you're a young, 27-year-old, single person, what's going to take you to a small town like mine? Why would you go there unless you had family connections or you had some reason to go there, because it's really hard. How do you meet a partner? Or how does your partner work if they're not a nurse or a teacher or another doctor?

Q. Do you have a view about what the system might be able to do to better incentivise rural practice and rural generalists in particular?
A. Yeah, I think so. One is that people need to understand that if they move somewhere they bring skills with them, that they can actually use those skills, that they have the resources available to use them, that the facility that they're working in supports them. I think they need to be guaranteed leave, because they see people in my role and they see others - these are their role models - working very, very long hours and I don't think they really want to sign up to that.

I think there needs to be an understanding of these people need guaranteed leave, they need to be supported in taking that leave, because there's the obligation factor that comes in. If I take leave from my practice, my colleagues are working harder, and no-one likes seeing that of their colleagues who are already working hard.

They need to be supported in keeping their skills and upskilling if necessary. So they're some of the things that would incentivise. I think people are worried that if they go out and do this job, that they're going to end up burnt out, bitter and twisted and have no work/life balance.

Q. Can I ask you about the use of skills and upskilling. What does that actually require of the system in order to enable a practitioner to use their skills and upskill themselves in a way that you say might incentivise more people?
A. It's a very good question. So, for example, I'll use my example of being an obstetric person. So I do the low-risk obstetrics. I don't deliver many babies now because if I have anyone who is high risk they go to Wagga. So the women that I have who end up delivering in Temora, I deliver there, but I might be lucky to get 10, 12, 13 deliveries a year.

I don't tend to have women who have had - who are having their first baby deliver in Temora if there's no surgery back-up, because I don't know how they're going to go and they might need an emergency caesar and I don't like sending women out in the middle of labour needing emergency caesar to Wagga.

Q. When you say "sending" out, you mean sending them to Wagga?
A. Sending them to Wagga, that's right, which I have had to do. So what is useful - what is useful for me is being able - because the volume is so low, my confidence starts to drop, the confidence of the nursing staff starts to drop. So if I have a practice that's not - like, within the hospital that is not able to do regular inductions of labour, increase the acuity of what we're dealing with, increase the risk locally and get used to managing more risk, then we tend to think, "Ah, well, we'll just send that away." So we do less and by doing less we get less confidence.

So what we need is a system where we can say, "Okay, I'm going to be supported to go back to Wagga to do a week in the labour ward, get my skills up again, get talking with people again, see how things are being done ", so then I take that back with me.

If that's not supported in a systemic way it doesn't happen. And by "supported" I mean, how do I take a week out of my practice to do that? Because I still have to pay my reception staff, I still have to pay my practice costs. And I still have to somehow see my patients. So it's a big dilemma and this is facing all sorts of procedural doctors all over the place.

Q. I pose the question: how do you think that could be done?
A. How do you? So this is where having a good relationship with the local hospital, with the base hospital, is really important; having a good understanding of the peripheral services and then having someone coordinating, saying, "Okay, who have we got out in these communities that need upskilling? So can we offer that person a locum to come into their practice, run the practice, while we get them back in doing their anaesthetics lists for a week?" "Can we get them back into birth suite for a week. How can we do that?" But that needs to be coordinated and it needs to be a priority because if it's not, it won't happen.

Q. In terms of that coordination, is there value, do you think, in an assessment being made at a more central level, perhaps at an LHD level, of what specialist services might be required and useful in particular settings?
A. Absolutely.

Q. For example, your example of obstetrics, is there a value in saying, "Which communities within our LHD would actually benefit from having a GP with that obstetric specialisation within the town?"
A. Absolutely. It's a very complex organism. To do obstetrics properly, you need an anaesthetist. To have an anaesthetist, you need surgical lists, because they don't do anaesthetics just for obstetrics, they need all of those skills. So you need a coordinated approach to make sure all of the services are being carried out in that hospital regularly.

Now, what is the motivator for the LHD to do that? If we're not measuring that and if we're not making LHDs accountable for those services being done in those peripheral hospitals, then there's no motivation to actually see it through and make sure those services are actually provided. Part of that is funding. So we've got

services that are block funded. So there's no activity based funding going on in smaller hospitals. So what's the motivation for them to run more lists to have those surgical services come out? I don't think there is any. They can easily take staff and say, "Well, they're not doing theatre this week. We need these staff in the emergency department" or "We need them for our general nurses ward. Oh, we haven't got them for theatre. We won't have a list this week."

If they're not accountable - if we're not saying you need to run these service, we have KPIs around how many people are being operated on in those peripheral hospitals - then there's no impetus to make it happen. And that's what I see. I see that we have people willing to do the job, we have GP anaesthetists who want to do it, we have who are nurses trained up and wanting to do it. We have specialists who want to come and do it, but for some reason it's not happening. Why is that? Where's that block?

Q. So other than an ability to enable practitioners within that community to maintain their specialist skills, are there other benefits to continuing to provide those services within the smaller hospital settings?
A. The benefit is that at the moment, there is a big push from the Commonwealth and from state levels to increase the number of rural generalists, so if we - and that's trainees, that's GPs who train up with extra skills in lots of different areas.

If we're not pushing for those services to be maintained or encouraged or improved in smaller areas, we're not going to get the doctors moving to those places with their skills. So there is an impetus, there is a motivation to improve that so we can get new people coming through with their skills and somewhere to practise them.

Q. So one of the incentives to get rural generalists to come to more remote and smaller hospitals and communities is to expand the scope of what they can do when they are there?
A. Absolutely.

Q. Are there others? Other incentives?
A. I think that's probably more around general practice

and service in general practice, because one of the things that we forget when we're training up rural generalists, or sometimes in training, the rural generalists themselves might forget, is that predominantly they're going to be GPs, so we need to make general practice attractive. It's all great to be an anaesthetist and doing lists and things, that's the fun side of it, but the bread and butter work is the general practice work. And we have to be careful not to be training "hospitalists". We want people in the communities, because the most important thing in rural communities is by far and away the GP.

Q. Let's look at that. To what extent do you see challenges in the delivery of primary health care within smaller communities like yours?
A. Workforce. Absolutely workforce. So if we don't have enough GPs we can't see the people we need to see, waiting lists blow out, people don't have their health conditions treated appropriately. We've got nursing homes we need to look after: are they being cared for adequately in the nursing homes? It just has flow-on effects. People don't go to the doctor because they can't get an appointment. So things just - and that flows off into the hospital system, so then we're dealing with people in the hospitals who have conditions that aren't being treated well and these presentations could have been prevented if they'd had their conditions dealt with better in general practice.

So the other thing in general practice that I think is an area for improvement is the upskilling of our nurses in general practice and paying them, allowing them to actually bill for some of the things they do in general practice, which is not the case currently.

Q. When you say "allowing them to bill", is that through --
A. Through the MBS. Yes.

Q. Do you have any views about how to better incentivise people to come into general practice within the rural setting?
A. That's a really difficult one. It's a complex area. I am vexed between - I'm vexed when it comes to communities providing support - so I think councils feel a lot of pressure to attract people and they provide housing, they do all these wonderful things to try to improve the situation for people coming to their towns, and I don't

really feel that that's their responsibility. That's my personal view.

The Albanese government introduced the bulk billing incentive for rural areas, which is tiered for how rural you are. That actually has been a significant improvement because it does mean that general practice is better reimbursed for bulk billing their population. Bulk billing is important. A lot of people do not prioritise paying for their general practice things, consultations, and some can't afford to. But I do know, having run a practice myself, that general practice is expensive and it's becoming more and more marginal. So if you can't make a good living in general practice, doing what you do, with the value that you are adding to a community and the responsibility of that, then why would you do it?

So to incentivise coming to rural areas to practise, I think people need to feel well supported, they need to be well remunerated and they need to be socially supported. The social support one is really difficult. Simple things, such as if you are an overseas trained doctor, having to pay for your children to go to school in the primary - in the local primary school, is one barrier. Adequate jobs for spouses is another one, because professionals usually marry professionals and they bring their partners with them and they need work.

Q. How, systemically, can that problem realistically be solved?
A. Yeah, I don't know. That's a question that many people have looked at, and I don't know and I don't know where the responsibility lies for that, but it's certainly part of the picture.

Q. Is part of it, perhaps, being more selective about recruitment and identifying that as an almost unsolvable problem in the case of some potential recruits and making clear to them that that's an issue and potentially, on that basis, not recruiting those people?
A. I tell you what, we're so desperate for recruiting people - this is the trouble. You don't want to put anyone off coming because we want anyone to come. I guess that's the question that an individual has to ask themselves, is this for them for all those different reasons, but, yes, look, I think that is a really big question and I don't have the answer for it.

Q. Is that part of the current challenge, though, that the dire need to recruit means people are being recruited who may objectively, and perhaps in a predictable way, be unsuitable for the position?
A. We only recruit people --

Q. Do you know --
A. Yeah, yeah. We only recruit people who put up their hands to come. We can't coerce people. So, you know, we open our books and say, "We are taking registrars" and we wait for people to apply. So we do get some applications for people who are just spending their six months in rural areas and you know they're only coming for six months and they just are ticking the box to say, "I have done my time in a different practice", and you know that that's what you're getting and that's okay, they come and they spend six months and then they go again.

The disappointment is when we have people who come for a few years but then realise, after that time, that it's just not working for them and their family and then they go again and they are the ones that are disappointing. That's heartbreaking when they go.

Q. Do you see any recurring themes in terms of the push factors, that push those candidates away after a period of years?
A. The two that come to mind in my town are two people from - they were both overseas trained, different culture, and fitting in to a small community which is very, you know, monocultural really, is challenging, and so that has been - family calls them away, community calls them away, so they want to be somewhere where they have other people around them that they are comfortable with.

Q. Do you see anything that the system could do to overcome some of that particular challenge?
A. From a systems point of view? That's a difficult one. Not - I can't think of any that come to mind at the moment. That would be a long reflection and talk to people type answer.

Q. In terms of the delivery of primary health care service within rural settings, do you see any role for the state to step in and deliver primary health care within some rural settings?

A. I think it's going to happen inevitably. There are certain communities where they don't have GPs, and so - and that's going to become more prominent, I think. So it will fall back to the primary - to the health districts, I think, to provide some of that primary health care, whether that be in a fly-in/fly-out sort of model or employing someone, a GP through the health district, to come out and run clinics, I think that is probably going to happen. I don't really want to see that happen in my town but I think it's probably going to happen.

Q. Let's sort of break it down into the pros and cons. In terms of the benefits of that sort of system - that is, state-based delivery of primary health care in a community - what would you see some of the potential benefits of that?
A. Getting primary health care. So you're getting someone out there. So you're seeing people - if that sets up a regular pattern and especially if you're a similar - you know, you've got a team of practitioners who are coming that may then enable there to be some continuity, then that's a benefit.

If you're getting people's blood pressures down and if you're getting their AF managed and you're getting all of those things done that you need to do, their diabetes well controlled, it doesn't really matter how you do it as long as you're doing it. That's one of the benefits.

The disadvantage is continuity --

Q. Can I ask you a little bit, a question about a potential benefit first and tell me if it is or isn't. Do you see that there are any benefits in terms of recruitment to rural generalism through a state-based primary health care system --
A. Yes.

Q. -- of the type we're talking about?
A. Yes. So the advantage of that is for the person doing it, if that were me, I would think, "Okay, I don't have practice costs, I don't have o worry about paying my staff I just go, do the job, I get paid, I come home."

Q. You mentioned earlier that one of the important things is --

THE COMMISSIONER: What's the difference between that and a locum, what you're proposing, in reality?

MR MUSTON: Potentially the cost and continuity.

THE WITNESS: Yes, so --

MR MUSTON: That is a question better directed to the witness.

THE WITNESS: That's right. So a locum is someone who would come in to do a job for a certain period of time and do a job and go again. Whereas an employment situation, if you're in an arrangement that that's the contract you have, you would be going back on a regular basis and being paid as an employee of the service. That's slightly different, I think.

The difficulty is when you're looking at it being a hospital system, again primary care versus emergency and inpatient care, and that's where there's sort of a blur. So it will depend on the type of employment arrangement and what you're - what the contract is.

MR MUSTON: Q. So that's some potential pros. You said you wouldn't like to see it happen in your town. What do you see as some of the cons?
A. The cons is that loss of the relationship. So the advantage of being a GP in a rural town is I know my population, I know the people, I know their context, they know me. The ease of communication and the understanding of what is happening with the people in my town just means that caring for them is so much easier.

So it's just one of those privileges of general practice, I think, having that understanding of the patients that you see and knowing the challenges that they have and understanding them. It's as simple and as difficult as that.

Q. Do you see any potential cons to that state-based system insofar as - well, from the perspective of someone running a GP, a viable GP business within a town?
A. If you have both systems running in a town - so a private general practice and a hospital one - I think there could be the potential for conflict.

Q. What's that conflict?
A. I think it would depend on whether the general practice side of the public funded one is doing hospital care or not, whether they're just doing general practice based care. It would depend on the patient experience of what they are getting. And then I think there is the potential for devaluing what the GPs in place are doing.

Q. Can I ask: you said it might depend on what a service was providing in terms of hospital-based care.
A. Mmm.

Q. Can you just expand on that a little bit?
A. Yes. So as a GP now I do my general practice patient care, so just in my rooms, doing what I do, I see them in the nursing homes, and I'm going to the hospital and doing my work there. So that's a big lot I'm taking care of.

If I'm a fly-in GP that works from 9 till 5, and I'm being paid a salary, and I'm not doing any of that extra care, I'm not doing a hospital-based care, and I leave on time every day, and my patients think, "Great, I turn up, I get it for free", and, you know, "the doctor is lovely", and that's all fine, there's the potential there for a bit of resentment growing between the two services because I'm also trying to run things in the hospital.

I don't think a primary care - that system would work doing on call as well at the hospital and doing the inpatient management as well. Because then you're looking more at, like, a locum situation where you've got someone who is employed to come and work their 24 hours in general practice, do general practice and cover the on call at hospital.

Q. And why would that be, to your mind, more like the locum situation?
A. Oh, because that's what locums often do. So if we employ locums at my practice, we have a locum who's employed on the understanding that they work in general practice as well as in the hospital, just like I do.

Q. So in the context of a state-based system, why would it be problematic if the individual employed within that state-based system was delivering care through both the hospital setting and --
A. If they were, then that's good, but they might not be

under that kind of system because I imagine that would be a come out, do your general practice primary care and then go again.

Q. So your point is, or is your point, for it to work, it would really need to be replicating, in effect, what you are already providing?
A. Mmm.

Q. That is, that wholesale service --
A. Wholesale service.

Q. -- hospital, aged care, primary care to patients within the community?
A. That's right. Because that's what GP - rural general practice is about. Mmm.

Q. If that sort of system were considered, do you have a view about the features of a community that might make it appropriate for that sort of service other than no doctors, as the starting point that you told us?
A. Mmm, mmm.

Q. That is, the community - a small community that might have a small rural hospital, no in-town GP, may well benefit from a system like that?
A. Absolutely. I think so.

Q. As you move away from that --
A. I don't know. I haven't actually thought of that. That's not something that was part of our discussions before, so I'm thinking on my feet here and I'm trying to imagine the situation where that would be - how you would apply that outside of those sort of two sort of particular criteria. I think it would depend.

As all things, as you mentioned, every country town is different and what they need is different. So I think it would depend on what is identified by the town as an issue and as a priority and then working within that to work out how to address that priority. Flexibility is really important. So I don't have a specific answer for that question, because I think you have to look at every case very individually in a community, because they're all different. I think there is room for some flexibility and some creativity when it comes to providing services in rural areas, and funding models don't always allow for

flexibility and so I think that's where there's room for looking at different models.

Q. Could I ask you about the Rural Doctors' Settlement Package?
A. Yes, you can.

Q. Can you explain to us what that is?
A. So that was a contract that was developed back in the '80s for rural doctors so they could be paid for the work that they were providing in the hospitals. Rural GPs, like me, going into the hospitals, were not really paid for the work they were doing at that time. And so there was a big strike and they came up with the Rural Doctors' Settlement Package and now there are a certain number of hospitals around the state, 130 or something hospitals around the state, that - whose doctors work under this contract, which is the way by which they are paid for the services that they render, and it's a fee for service contract.

So I get to see - I see a patient and I get paid depending on the time of day, what else I might do at that presentation, whether I, you know, do a certain procedure at the time, and then I bill those item numbers and I'm paid according to that.

Q. Do you see that as working as an incentive to draw people in to rural generalism?
A. It has its benefits. It pays quite well. It's a good model for the work that I do. It works well for me because the more you see, the more you get paid, so there's no ceiling, really, to how much you get paid, depending on what you see. So there is that, you know, getting up in the middle of the night, "Well, at least I'm getting paid for going out and doing this." But it doesn't pay you well for other aspects, and it's swings and roundabouts, and most of us who know it and use it realise that, "Okay, I'm not going to get paid so well for that, but if see three kids with a cold and I can see them pretty quickly in the ED then, I get paid nicely for those, you know, because it doesn't distinguish between complexity.

The issue is where we have situations where there might be low acuity, not many patients being seen, but you're still on call for 24 hours providing a service, and so you might only see three people in the emergency department, but you're still in that town, you're there,

you have your phone on, you're providing - you are there on a retainer, essentially, and you might not get paid well at all for that. So that's not very incentivising. We're actually working to look at different models at the moment for doctors to be paid in rural - in settlement package hospitals under different employment arrangements. So that might be a fixed daily rate where, in this hospital, with this activity, we're going to round it up to being paid this much in a 24-hour period, regardless of what comes and goes.

Q. That's working at, in essence, the financial push and pull factors?
A. Mmm.

Q. Do you see any opportunities through training or changes in the way doctors are trained which might encourage more people into rural generalism?
A. Yes. I think the more exposure junior doctors have to rural areas, the more likely we are to put that in the front of their minds about choosing a career. What we know is that general practice - exposure to general practice in a rural or an urban setting ceases pretty much after they join the hospital system.

We know that there is a lot of negative talk about general practice within the hospital system, so those juniors who go from being medical students into the hospital system, where they're being exposed to a cardiology term, a surgery term, all the fun that goes with, "Come with me. Let's go and look at this", "This is fun. Let's go and do that", and you say "I'm interested in general practice," "Oh, why would you do that, you can do anything you want". That's the kind of attitude that we hear.

We know that if junior doctors are exposed to a good general practice term where they see - where they actually can meaningfully contribute to that general practice, not just sitting in as a med student watching and learning but actually sitting in, making decisions, assessing people, coming up with diagnoses, following them through and, in rural areas, doing some of the hospital work as well and working in with the GPs and seeing the work we do and taking responsibility for that, that suddenly, their experiences change and they start thinking, "Oh, this might be a career for me." It's not going to be for everyone.

We all understand that people have what they like to do, but if you're not exposed to it, you're not going to consider it.

Q. Can you see there being a sweet spot, in your observation, in terms of how long you need to be in that setting for that to start to gel?
A. Yeah, look, I think you need to be there for three to six months. You need to get over your initial - you need to have the initial kind of novelty, then you get to that kind of six to 12 weeks where the novelty is wearing off and you're in the middle of the finding it hard.

Q. Missing my friends?
A. "I'm missing my friends, It's all too hard", you're seeing everything for the first time. And then you come out of that and you start to think, "Oh, I'm starting to understand, I'm starting to see some people back again, I'm starting to get people liking me as their doctor, I'm starting to understand how it works." So that's a really important part of training.

Q. Before I finish, can I ask you to put your president of the Rural Doctors' Association hat on. Is there anything that we have not covered that you think is an important issue that the Commission should be thinking about in terms of the way in which we go about dealing with some of these challenges, particularly in the rural setting?
A. I think we need to actually look at measurable outcomes. If we are really serious about improving health care delivery in rural areas, we need to actually be measuring things and we need to be accountable for the services that we provide. So, how many women, Aboriginal women, are birthing on country, how many women are birthing in the smaller hospitals, so then we're actually accountable for the outcomes in those areas and then they're not just pushed to the side. Looking at funding that can encourage services to be provided in those smaller hospitals, as I've talked about.

Other things is training positions for specialty training. That's not my big area of knowledge, but I do know that we have difficulty with getting specialists, non-GP specialist training positions in rural hospitals. There is funding provided, that's devolved from federal to state to the hospital level. Making sure that those funds

are going to those training positions, that that's transparent, and that we're having people training in regional areas where they're more likely, if they get the good training there, to stay there.

Q. What's the blockage in terms of the training, the specialist training, so far as you are aware?
A. I don't know.

MR MUSTON: I have no further questions for this witness, Commissioner.

THE COMMISSIONER: Q. Can I just ask before Mr Chiu does, Mr Muston finished with some questions for you about with your president of the Rural Doctors' Association hat on. The submission this Inquiry received was signed by your predecessor.
A. It was.

Q. No doubt, it's a submission that's statewide rather than specific to Murrumbidgee LHD. A large part of it talked about feedback to the association from GP VMOs not feeling that they were valued by hospitals and, in particular, issues regarding payments for seeing patients being rejected and/or delays in getting paid?
A. Mmm.

Q. Is that something you can speak to from your own experience?
A. Not from my own experience personally but, yes, as my - in my role as RDA, we do get lots of questions and complaints from members of ours who say, "I've had these payments rejected. I don't understand what's happening." It comes down to communication. Problems all come down to communication, and about checkers understanding what is being billed and why, and then the communication that follows amongst that. So, you know, people are reluctant to pick up a phone --

Q. Communication with whom, so between the VMO and --
A. Between the VMO and the manager who is responsible for signing off on things. I think --

Q. The manager in the hospital?
A. Well, it's different in different places.

Q. Or the LHD - yes.

A. So some places it might be the local manager who signs off, and in other places it might be taken to a higher level where they sign off. I'm not sure of all of those patterns in different hospitals and LHDs, I think they're all a bit different.

I don't have any issues in my hospital. We're very good, we have great communication within my local hospital. But I do know of other hospitals where that's not the case and so --

Q. In this LHD?
A. In this LHD.

Q. And from your members that are talking about other LHDs as well?
A. And from my members across the state. And that does cause a degree of stress. GP VMOs are overworked, they are tired and they don't want fuss. They just want to get paid for the job they do and they want to be appreciated for the work they do.

Q. Is it common that the - let's just call it payment dispute - is it common that they are ultimately resolved but it just takes a while or --
A. I think there are probably lots of little ones that happen and get resolved without us being aware of them. Usually by the time we hear of them it's a litany of woes. So it's not just one thing. It's a repeated - repeated rejections of item numbers or being very picky about detail or - there is other things feeding into it. Dissatisfaction --

Q. When you say picky about detail, that means?
A. So someone, for example, a surgeon getting called in to do a list of the middle of the night, the registrar writes their notes and does all that, the surgeon was there, but because they haven't written a note in the file, they are not getting paid.

Q. Right. They ultimately no doubt do get paid but there is time spent convincing someone that's meant to be arranging the payment that "I was actually - I am the surgeon and I was actually there even if I didn't write the notes"?
A. "I was there"; that's right.

Q. That's what you mean by communication problems, I suppose?
A. That's what I mean by "communication problems", and there's a lot of - because people are tired and working hard, they can't be bothered chasing this stuff up because it's time consuming.

Q. In relation to those issues that your members are having, what would make the system work better?
A. Training on both sides and communication - improvement in the way we communicate. I think there are big barriers to good communication within LHDs and that's very dependent on individuals. That's a hard one, because certain managers have --

Q. Managers should be trained, though, shouldn't they?
A. One would think so. I'm not a manager so I don't know what training they have. But that doesn't always flow down to the experience of those who are communicating with them.

Q. And the real problem with this is that it's - don't let me put words in your mouth, you can tell me whether you agree, disagree or say anything else you like, but the problem I think, coming from the submission, is that these issues are causing a disincentive for GPs to actually want to be VMOs in the remote rural hospitals?
A. Yes, they can. Probably more - it's providing a good excuse or reason for people to withdraw their services.

Q. It's not worth it?
A. It's not worth it. And so if you've been providing a service in a town for 20 or 30 years and you're still having pay disputes and they're bringing - you know, your integrity as a --

Q. Yes.
A. -- is being called into question after so many years of service and when you --

Q. It's very frustrating.
A. It's very frustrating and, you know, sometimes people just say, "It's not worth it".

THE COMMISSIONER: Thank you.

Did anything arise out of that?

MR MUSTON: No.

THE COMMISSIONER: Yes, Mr Chiu.

<EXAMINATION BY MR CHIU:

MR CHIU: Q. Dr Christmas, I might take you back to some of the evidence you gave earlier about a hospital like yours actually wishing to do more procedures?
A. Mmm.

Q. Besides delivering babies, what other kinds of procedures did you have in mind?
A. So more surgical procedures. So we have a surgeon who comes once a month to provide basic surgical services, low-risk, low-acuity, things that just need to get done, skin cancers and so on. They come once a month at the moment. There is capacity within the hospital from the nursing staff point of view to do more lists, and I know there are surgeons who want to do more lists, and I know the anaesthetists would be happy to do the anaesthetics for those lists, but they're not happening.

Q. I see. So there is a demand from the community for more of these types of procedures to be done locally; that's correct?
A. I'm not thinking so much from the community point of view. The community does love having things done locally, and we get people from other towns coming, so not just from Temora, but sometimes people from the Wagga lists who may see, well, if you go and get it done in Temora or Young or Cootamundra, you might get it done sooner than if you're on the list at Wagga Base. So there is a demand for it, because these lists take away pressure from the base hospital.

Q. So although - I think you described it as a snowball - there is an issue with chronic health, chronic illness in the community, which GPs are working very hard to deal with --
A. Mmm.

Q. -- despite dwindling numbers, there is still a role in these small hospitals for providing the acute procedural type care?
A. Absolutely. I think so.

Q. And you see that as continuing well into the future?
A. I would like to see that, yes. And you know, that's seen by the optimism of building a new hospital in Temora which is going to have two theatres.

Q. And is that in itself potentially an incentive for some GPs with additional skills such as yourself, and such as the GM anaesthetist, to move into a place because they're not just dealing with primary care; they're also dealing with hospital care?
A. Yes. And that's the hope, by training up more rural generalists, that we'll have more GP anaesthetics, we'll have more GP, hopefully, surgery and obstetrics, and to incentivise people to come or to give them a job to look - you know, to have at the end of it, you need to have somewhere for them to do it, so yes.

Q. The other issue I think you raised earlier was the problem with the RDSP being that there is - the clinicians are not reimbursed sufficiently for what they provide to the hospitals; is that correct?
A. It can be. So generally, the RDSP is not a one size fits all, it's now 40 years old nearly, so it is having to - as the nature of the work we do changes and the work pressures are different in different centres, we're having to look at different models by which we pay our VMOs. So I don't think it's outdated, as such, but it does need updating in certain areas and we do need other options.

Q. One of the other options that you were asked about was actually the LHD employing general practitioners. That in some ways is the other extreme?
A. That's a different extreme entirely - that's a totally different model and a totally different question because then you're not talking about VMOs; you're talking about an employee model.

Q. What I'd like to explore with you is whether there's something in between whereby the VMOs or GPs cede some of their autonomy as sole practitioners running their own businesses but in exchange get more certainty from the hospital as to: these particular days I'm going to be working at the hospital and I'll get paid a fixed amount for that. I don't have to deal with billing?
A. Yes.

Q. Has that been something you have considered or looked

into?
A. It's certainly a model that has its appeal, and that's what - the single employer model, I guess, is what you're talking about. You've probably all heard about the single employer model, which is doctors being employed by the health system to provide general practice care as well. So --

Q. I'm actually thinking of something a little bit short of that.

THE COMMISSIONER: You used the expression "cede some autonomy". What does that mean precisely?

MR CHIU: So the general practitioner is still self-employed, so has a practice in town, but the general practitioner signs an agreement with the LHD that says three days a week, and it's always going to be these three days, I'm going to be working at the hospital for these hours and I know that and I know what I'm going to be paid for that, so I don't need to worry about balancing my lists, et cetera, I can organise my life, and I know that three times a year, I'm going to have to go to Wagga for this additional training. Is that a model that has been developed --
A. That sounds fabulous. It's a model that I think can work in some places. The trouble is, you may not have a full day's work at the hospital.

Q. Sure. But the hospital takes the risk of that, if --
A. Yes, but then what happens is you're taking a GP out of the town, who is being underemployed in the hospital and not seeing people in the community.

Q. So there may need to be more flexibility built into that?
A. Yes. So it's not a one size fits all and it depends. But that is the sort of model and that's the flexibility I'm talking about, that sometimes you're going to have people who say, "Right, our ED is very busy. I'm going to be employed as a GP in our ED for my 10-hour shift. I will go from 8 in the morning until 6 at night and I'll just be in the ED and I will do that three times a week", if you've got enough people coming through that ED to make that worthwhile for the LHD and to make it worthwhile for you being taken out of your practice.

Q. Dare I ask is there anything stopping GPs and hospitals negotiating that sort of flexible model?
A. Probably will, understanding that that can happen, having the conversation. Current contract models. I don't believe there's a reason not to be able to do that. I can think of a hospital off the top of my head where that would be ideal, that situation.

THE COMMISSIONER: Q. It might require some experimentation as to --
A. Yeah, and I think that's where - when I was talking before about having creative solutions to problems, that's exactly one of them: What is our town facing? What do we need right now and how can we do that in a way that actually values the service and gives the GP that certainty, I suppose. Certainty of hours, which is nice; certainty of income, that's nice; and then that further support for upskilling, fantastic.

MR CHIU: I have no more questions.

THE COMMISSIONER: Thank you. Nothing arising?

MR MUSTON: No.

THE COMMISSIONER: Dr Christmas, thank you very much for your time it is greatly appreciated.

THE WITNESS: You're welcome.

THE COMMISSIONER: You are excused. Thank you.

THE WITNESS: Thank you.

<THE WITNESS WITHDREW

THE COMMISSIONER: Shall we start with Ms Hull --

MR MUSTON: Yes.

THE COMMISSIONER: -- before taking the break?

MR MUSTON: I think so.

THE COMMISSIONER: We will take the break at 11.30 but we'll give it a start now.

MR MUSTON: Yes.

THE COMMISSIONER: Come forward, Ms Hull.

<KAY ELIZABETH HULL, sworn: [11.17am]

<EXAMINATION BY MR MUSTON:

MR MUSTON: Q. Just give us your full name for the benefit of the record, please?
A. Kay Elizabeth Hull.

Q. Could you tell us a little bit about your background within the Murrumbidgee region?
A. I've been the - I've been a Wagga Wagga city councillor, 1991 to 1998, and deputy mayor in that time. Then I became the federal member for Riverina in 1998 and retired, voluntarily retired, in 2010. I have worked significantly in the health sector with constituents right across the Riverina region, and I continue to do so on the - I sit on the oversight council, the UNSW medical school oversight council, and my main focus has been on GPs and access to GPs, and their benefits and their recognition.

I've also done a lot of - I sit as the chair of the Palliative Care Enhancement Council, for which I'm advocating here today. So I'm pretty connected to most of the areas of health, and I'm just currently involved in engaging in writing a history of health in Wagga Wagga and the Murrumbidgee region for the last 40 years, of advocation, activism and delivery of health benefits.

Q. Before we come to the Palliative Care Enhancement Council, can I just ask you in terms of work you have been doing to try and encourage greater access to GPs, what does that actually involve?
A. Well, we started with, in 1996, we had 49 per cent of our graduates across Australia were entering into GP practice, okay? So I was very active in Wagga Wagga City Council at the time and we were relying specifically on OTDs for many of our regions, but particularly here in Wagga Wagga as well, and I became really interested in the fact that we were losing that connection to GPs, and perhaps we were losing that respect for GPs. We were bringing in a lot of specialists but our GPs seemed to be diminishing and, of course, you need a GP to refer to

a specialist. So I then worked with Jack Best and Sue Morey. Michael Wooldridge was the then health minister at the time, under the Howard government, and we started working on what we needed to do to upskill or to deliver services into rural, regional and remote Australia, as far as GPs went.

So we - I worked with them whilst I was the deputy mayor and then, of course, as soon as I was elected into the federal parliament, it became my number one objective.

Michael Wooldridge, John Anderson, at the time, who was the Deputy Prime Minister, undertook a regional tour and came back, and we determined that we would implement clinical schools - and I listened to the former speaker here, presenter - and the clinical schools were designed to train generally country kids in country locations. We felt that if you trained them in the country - they live in, come from the country, you train them in the country - they'll stay in the country, right, in the rural and regional areas.

We implemented 11 clinical schools, and ours was the first one, UNSW clinical school, under the stewardship of Professor Mohamed Khadra. Our intention was - we went with UNSW at the time simply because they had a medical degree and we needed somebody - we needed to roll out very quickly. Charles Sturt University wanted to do that but they didn't have a medical degree so it would take some time to get that.

So basically, we started this practice of trying to educate and involve our students in rural and regional communities, but unfortunately all their training wasn't done in, say, the Wagga Wagga one or the Bathurst one or wherever, it was done - two to three years were done in the city, and that's where you lost them, because they generally were told that, you know, "GP practice or being in the country, you won't progress." So generally it's a tutorial, it's the professors that have a very different view of what their students should be doing, and sometimes - and mostly, we lost them.

We're now doing that, we're now being converted to a full medical school where your whole practice is done, your whole degree is done here in Wagga Wagga, except for one year where you can go and do what you really want;

like, you can do sort of an elective and choose to do that. So it's been fairly intensive ongoing work just trying to get an understanding and a respect for GPs and the services that they provide, particularly rural and regional remote Australia.

Q. Going back to something you said a moment ago, I gather, based on your observations within Wagga Wagga and through your role with UNSW, that a strike rate of keeping these rural students who were being trained at least partially rurally has not been great?
A. No. We've gone - as I said, we had 49 per cent Australia-wide in 1996, we have 13 per cent now, going into GP practice. That is - I was worried about 49 per cent. I said, "That cannot service rural and regional remote Australia." We're 13 per cent. Something is wrong.

Q. Within a community like Wagga, do you think there is something that could be done differently to better incentivise students who train here to stay within the region and practice as rural generalists within the region?
A. I think for a beginning, you know, the students get great tutoring here in Wagga Wagga. Honestly, the specialists here are dedicated and the GPs who present to our students are dedicated, and I think we can capture them. And particularly if they meet a partner here, that's a big plus, because they - you know, they sort of have somebody with a base here, that makes a big difference.

But the cost to the student is fairly significant, as well, to do their - you know, travel out into the regional communities, to stay there, you know, to be allocated to a GP. We try and pick up that, a lot of those areas, in housing and things, but lots of them have got part-time jobs and, you know, casual jobs to pay for their degree, so if they've got a job in Wagga Wagga and - like, say a hotel/motel type job in Wagga Wagga, after their studies, and then they have to leave and do, say, six weeks in Temora, they've got to come back from Temora back to Wagga to do their job to pay for their degree and, you know - so it's a bit of a dilemma, the cost to the student is significant. So I think it becomes a little bit more difficult for them to get that feel that that's not always going to be the case for them. They are not always going to struggle like this.

I think the incentive that I would say is to ensure

that when you've got students in here that are wanting - you're trying to convert them into GP practice, you give them a great experience but you also assist them in the management of the financial cost of being able to get that great experience. And then I think that, you know, generally, they will really enjoy it, they really love it.

And I think there's also this - you know, this hierarchy of GP/specialists thing, and I think there has to be more respect for the GP. I'd like to call them primary health care specialists. I think "general practitioner" seems to think that they are less than - you know, less than a specialist when, in fact, they are a specialist. They're a specialist right across the board, and we need respect for that and I think that's one of my biggest problems with the health system.

Q. Can I take you to the Palliative Care Enhancement Council?
A. Mmm.

Q. What are the origins of that body?
A. We had intended - we had put in to have a hospice. We don't have access to a hospice.

Q. When you say "we"?
A. That's combined - probably, we were developing with the former member for Wagga Wagga, Darryl Maguire, and myself years ago, and then the new member - or not new now - member for Riverina, Michael McCormack, and we were - everyone was involved in looking at a new base hospital. Wagga Wagga City Council, the state government, everybody was involved.

But when you've sort of been engaged in this health journey for a long time, you kind of get dragged in to all of this. You might think you're retired but all of a sudden you're dragged back in, and we were looking at a hospice unit at the Wagga Wagga Base Hospital, new build, and then it disappeared and so we - it was a bit of a, you know, sort of a bit of a difficulty for the region again, and thus, we formed a - well, Professor Gerard Caroll AM, who is a cardiologist here, started advocating with Calvary Hospital to deliver a palliative unit at the Calvary Hospital site.

Eventually, he won. We both actually went in to that

game and he won very, very solidly, and we had an eight-bed unit delivered, which also has a rehab side as well. But that's where families can sleep day and night; that's where they get fed; that's where they can stay with their loved one. It's a management - it's a palliative management system. So you may have a, you know, life-limiting illness diagnosis and you might want to be at home, but somehow your treatment, something's just gone a little wrong, you come in there, you get a specialist team, the specialist team manages that, they work out, you know, some kind of process that you can then undertake and go home and live at home for as long as you want. It's more designed to manage that palliative process for them and to let them live their life not die their life.

So we are in - you know, so when that was delivered, the Calvary Palliative Care Enhancement Council, which I chair, and I'm the inaugural chair of that, we decided that we would raise funds to enhance end of life experience for patient and family.

Q. So that's enhancing outside of the context of the eight-bed unit at the Calvary?
A. It's enhancing the experience inside the unit, right? So over and above what a hospital would have to provide and should provide, we have put in place enhancements. Like, you have good hospital beds, but we had world's best practice beds, at 140,000, eight beds, put in there for patients so that they don't have to be turned; so that if you're having an extreme difficulty with your body, it's easier on the nurses and it's better on the patient, much less discomfort for the patient. So we raised funds for that.

We've put in sort of things like, you know, benefits to - like, big TVs, sorry, very big TVs, because the general TV is only this big, so we've put in massively big TVs in there. So we've put a lot of enhancement into the unit and beds into the unit for family members to enable them to experience a warm, comfortable, respectful, dignified end of life process or journey toward it.

MR MUSTON: I note the time, Commissioner. We might take the break at this time.

THE COMMISSIONER: Certainly, yes. We'll have a break until 10 to 12.

SHORT ADJOURNMENT

MR MUSTON: Q. So you have told us a little bit about some of the enhancements within the palliative care setting at Calvary. Has the council taken a role in the delivery of palliative care service outside of the Calvary Hospital?
A. Yes.

Q. What is that role?
A. Our role is that we provide a public forum and we produce booklets on palliative care, understanding it, all the services that are required, and that you can access, because people don't know this. It's a very difficult time.

So we run a public forum and we have, each year - it's a free public forum, we have a whole range of various aspects of palliative expertise on the stage. They give a presentation, whether that be emergency department or night-time palliative specialists, oncologist, Dr Jane Hill, David Palmieri, oncologist, as well, and we do - we have a whole host of various specialists and they give presentations, and then the --

Q. In terms of the public forum, so it runs like a conference; is that right?
A. It runs - we have a presentation, so it's just - it's always in the evening, about 6.30. We have a presentation on the stage of various aspects of palliative and capacity for, you know, getting access to services, et cetera. And then we have a Q&A from the audience, and we get about 200 people, different people, every time.

So if there's around 200 people that are experiencing this - because you don't come to a palliative care forum unless you've got some issue that you - in palliative care. It is just not a sexy topic. It's not a topic that is like - you know, as we know, we all need to have a focus on brain cancer and melanoma and bowel cancer and breast cancer and prostrate cancer, and it gets a lot of publicity, and it should - and it should. But when you're - "palliative" is more a feared term, it's more a term that you don't want to really embrace or know too much about. But unfortunately, we all go there at some point, and so that's why, you know, we do hold public forums and have public education on it.

Q. So the forum is intended to educate the 200-odd people who turn up --
A. Yes.

Q. -- about the options and the way in which they might navigate the palliative care landscape?
A. Yes.

Q. Is that right?
A. It is. And also, you know, teach - it gives them the idea, the understanding of their advanced care directive, why they need an advanced care directive, why they need - why the ED needs their advanced care directive. All of those various - what's your accountant? We have an accountant sheet on that, we're just updating it now, all the things that you need to do, you know, to get your affairs in order and then you can relax and live your life.

Q. So in terms of your observations during the forums, particularly the Q&A sessions, are there reoccurring themes that come up?
A. Absolutely.

Q. What are they?
A. Absolutely. Being lost, with no access to - you know, "Can I get better" - you know, "Does my GP - if I have a GP if my community, does my GP have access to the best possible palliative specialist?" Right, "Can we get a better understanding of the illness?" "Can my loved one live longer with a specialist care attached to a GP?" And "How do we get an inpatient, 24/7, when I'm exhausted?" You know, you're sort of - you're exhausted and you can't do anymore but you just need a little rest, "Where can I get inpatient care for a palliative patient rather than just somebody that may have a disability?" So it is very difficult to access those things right across rural, regional and remote New South Wales.

Q. What has, if anything, your council done to try and create opportunities for that sort of access within your region?
A. What we're trying - you are a very good start. Well, not a - we're trying to bring attention to this, because you will hear a lot of evidence and a lot of people's views and a lot of expertise will come before you during this Inquiry, but I will hazard a guess that you'll have very

few people come specifically about palliative care, right? I've been chair of New South Wales Can Assist, president of New South Wales Can Assist for many years. We had 66 branches across New South Wales.

What I do with the Palliative Care Enhancement Council is just another arm of ensuring that we can get better access to our GPs, funding for our GPs, funding for specialists for face to face or, where not possible to have face to face, have, you know, online access, so that people are able to know that they have explored and been given the respect and dignity.

So what is the answer to the question? All that we do, we're a small group of people, there are three or four - four doctors on there and just some - a couple of volunteers, an accountant, so that we can give best advice to, you know, people in our publications; and a lawyer, so we can also understand the issues and give that best advice as best as we can to people, because many people don't have access to all of these services.

I've done six at home and they've all been very different. I have access to great support, and I think how it was so hard, when I have intimate access to great support for at-home palliative care: how does the general person do it? It is an extraordinary honour, but it's just also draining as well, for everybody, and so I think what we - our task is to get as much information to as many people through these publications, in doctors' surgeries, in accountants', in lawyers', to get them all to understand that there is a need for better information for palliative care but, most of all, there's a need for better access to a palliative care specialist for a GP and funding for online, for palliative specialists.

Q. Eight palliative care beds at Calvary, relative to the wider population of the district, seems like a small number. What other palliative care services are available?
A. We've got our palliative cares that run out of our nurses, our support services that run out of Murrumbidgee Local Health District, and they cover an enormous region. So if you have a look at the geographic coverage of the MLHD, which is quite significant - and they do an amazing job. They are incredibly - I think, I would imagine they are incredibly busy and they do a lot of travel, you know, in order to service. But as far as inpatient, across our

region, you go to hospital, okay? But you're just - you're a patient. And then, if you have an after-hours issue as a palliative patient, you go to ED. So you're in ED, you're, you know, a dying patient and you require that attention, but you are simply an admission in ED. It's not considered - there's no particular - everyone's going to care, of course, but what we're saying is, end of life needs to have equal dignity, respect and celebration as the beginning of life.

Q. The experience of palliating as an inpatient, both for the individual and their wider family, would be different, I assume, in a very small --
A. Yes.

Q. -- regional MPS as opposed to, say, Wagga Base Hospital?
A. Oh, absolutely, but then you've got to have that 24-hour funding for palliative. Palliative is a 24-hour process. So, you know, your areas, centres, will have - maybe they might close at 8, you know, close at even 6, but you've got to have - they've got to be funded for - when required, for a palliative patient to have that 24-hour care when they're in their local community.

Q. In a practical sense, what is it that you think is required in addition to what is already available?
A. We would advocate that, in smaller regional communities, funding be provided, should it be required, for a palliative patient to have your facility open, to have somebody with that patient 24/7, not just ship them into Wagga Wagga, right, from - I heard some of the discussion before - Temora.

So instead of just shipping them into Wagga Wagga Base Hospital because they've got 24, that you would have a pool of funding available, that was an additional pool of funding, to the local health district, to be able to have that facility open longer, to be able to have the local GP, if there is one, able to come in and be funded and be able to deliver that service, but also for that GP to have access to a specialist, a palliative specialist, that they can contact and that specialist is funded as well.

So I would say that would be a great start. But the next big thing we want is for funding for face-to-face palliative specialists, to be able to travel into the

regions, do face to face, and work with the GPs and the other oncologists and specialists in other areas and be funded appropriately for it, for that --

Q. Are you aware of any GPs within the area who have specialist palliative care training?
A. No, I'm not aware of - I'm not aware of those who - no, who have specialist - there is, they can do it, but if they go in, they do - they're a GP palliative specialist, they go into hospital, they will be rebated by Medicare as a GP, right? So they'll do the additional, but their rebate will be as a GP, not as a palliative specialist, right? So there's not a lot of incentive.

Q. I'll just make sure we understand this. I think the GP palliative care specialist who is delivering treatment in their rooms to a patient is being remunerated by Medicare?
A. Yes, as a GP.

Q. As a GP, through the MBS. The same individual who might be providing treatment as a VMO through the hospital is not being remunerated by Medicare, are they?
A. I'm unsure - yes, they would be if they've got - if they've got VMO, yeah, at the hospital, they will get that baseline remuneration, right? But if they're a palliative specialist, I don't believe that they will be remunerated as a palliative specialist; they will be remunerated under the GP VMO.

Q. Are there any other additional services that you think rural communities would benefit from in terms of the provision of palliative care support?
A. Far more localised palliative nurses, but we have a nurse shortage as well. So it's very difficult, you know.

Q. Pausing there, more palliative nurses, is that to assist people palliating in their home?
A. In their home. Most people would prefer to palliate in their home, and that's the idea of the specialist unit, is to get them in, have a group of specialists come in, manage that, work it out. Example: my husband, pancreatic cancer, had - they said, "He's going into a diabetic coma", at home. So I was able to get him into the interim hospital up at Calvary, we had an interim palliative ward up there at St Anne's, and within 24 hours, you know, they

had sort of managed him, stabilised him, filled him up with insulin and a whole host of other things. He came home and I got three weeks more of quality of life, living every moment of that life, not, you know, "I'm just waiting for you to die." So - but I had access to that. But how - you know, the ambulance just wanted to take him to ED and I refused, and then I was worried that I would be prosecuted if I refused my husband to go in an ambulance when - and, you know, he passed away. It was a dilemma.

But I was able to get him at midnight into Calvary because I had support that I could call on. But that's not every - that's very rare for the general public. So what I'm sort of saying is that you literally have an experience at home and you would prefer to be there, but if you have this - if you have ability for a patient to be managed and get back on track again, it's a win/win for everybody. It's a less costly situation.

Q. To the extent that you're aware, based on your discussions with people involved in either experiencing or delivering palliative care within the region, do you have a sense of the extent to which the existing specialist nursing team is sufficient to meet the --
A. No, it's not sufficient.

Q. What leads you to that?
A. I know the travel and the, you know, the workload that goes in to our palliative - they do an amazing job. Our palliative care nurses here do an absolutely sensational job. But the miles that they have to travel to get there - you know, this is a very big local health district. The miles, or, you know, the kilometres that they have to travel to be able to deliver, you know, just some comfort or some information, et cetera, is pretty significant. So you would be better if you could have more funding and more incentive for palliative nurses to sit - to work with the local GP and to offer that service locally.

Q. To the extent that it's delivering information, is there opportunity to use virtual or remote services to deliver that information?
A. Well, there is in some cases, but you have to have affordable access to technology, which is outside some of our boundaries and areas, you know? We are getting better access, but it's still certainly very patchy in many areas, and yes, it is an option, but my fear is that, you know,

there was a recommendation from an upper house inquiry that - I think recommendation 24 - the Far West model be rolled out, and it's very online and very important.

Q. Could you just describe for us what the Far West model involved?
A. Well, it's very hard for us to get access to understand that, but I understand that the palliative care system works online with exactly what I'm talking about, like, with specialists and others to work with a patient and the family member. I don't have the detail of that, but I just read in the recommendation that there was a recommendation that that could be rolled out.

My worry with that being rolled out is that you roll out all this online, on palliative, and you think you've done your job. You think, "Okay, everyone's got this online access now." But that's the fallback if you can't have face to face. The best option for the GP and the palliative patient is to have access to a specialist, a palliative specialist, that can give clear understanding of options that may be available. And I think that's the most important thing at the moment. If you want to just - yes, there is - to answer your question, yes, there is a place for it, but it shouldn't be the only place. And VAD, the introduction of that in November, has left us in a very significantly different, difficult place.

Q. "VAD" - I take it that's the voluntary assisted dying?
A. Yes, the introduction of voluntary assisted dying. You know, if you live in the city and you have access to a hospice, your GP has access to a specialist, et cetera, for you, and you have, you know, voluntary assisted dying to consider, you have a choice, you actually have a choice. But when you live in rural, regional or remote New South Wales - or Australia, really, but we're talking New South Wales at the moment - you have very little choice, and if you are not going - if we're not going to think of end of life as a health issue that needs funding and needs support and needs access to specialty, you know, services, then, you know, we're not doing our job in that we're not giving those rural and regional and remote New South Wales residents a choice.

So what do you do? You're under - everyone's stressed around you, you're the patient, you know it is such a heavy load. You feel like you're a burden to everybody, and you

say, "Okay, well, I think it's time that I just drop this burden."

THE COMMISSIONER: Q. Sorry, we flipped to voluntary assisted dying from online palliative care. When you said "There is a place for it but it shouldn't be the only place", were you referring to the Far West New South Wales palliative care model or something else?
A. No, I was actually referring - there is definitely a place for the Far West model but it shouldn't be the only option, you know.

Q. Do you know what that model is exactly, though?
A. Well, it's - I've got it on my - I didn't bring it with me. I've got it on my computer. It's hard to understand, but it is certainly accessible.

Q. Whatever information you've got on it, I would be grateful if you supplied it, because --
A. I will.

Q. This isn't a criticism, but if you read the legislative council report with that recommendation 24 you spoke of, it doesn't really give an explanation --
A. It doesn't.

Q. -- about what this model of care is. It gives a reference to a submission that was made by the Western New South Wales PHN, but - and again I don't mean this disrespectfully - that, when I read it, didn't really set out what the model of care is either. So I'm curious to learn what it is we're actually talking about in a specific sense. No doubt it's some form of online palliative care, to the extent that you can do that, for very remote towns, but the details - it might be my fault but I haven't seen how it actually works in practice.
A. And we're the same. I've been trying to access it as well, but I do have a little bit more information I can provide.

Q. That would be great, thank you.
A. And the link to it. And we are on the same - but I'm clear about the detail is that the local palliative nurse works online with specialists.

Q. With a doctor?
A. With a doctor.

Q. Right, I see.
A. To deliver to her local patients. It's pretty much confined to a small area, right, but she - but that is what is happening. So she has access - they have access to her 24/7, right, and she has access to online support and advice in palliative for those community members who are undergoing those treatments.

Q. All right. We would be grateful for anything further you have got on it, because I just haven't - it might be my fault but I haven't actually been able to find out. It may just be - well, I won't say that.
A. No, and I agree, because I found it really hard to find, and again, I'm finding this - I'm not a paid employee, I'm a volunteer, and I'm finding it really hard to pull that together. But I do have information. I will share it. But my worry is that if that's going to be considered to be rolled out, then I don't think that's addressing the issue that it requires.

Q. Again, I don't want to be critical, but there is this recommendation to roll it out and I don't understand what is being recommended to be rolled out. But that could be me.
A. And I guess that's why I'm here.

THE COMMISSIONER: Yes. Sorry, I interrupted you, Mr Muston.

MR MUSTON: As it happens that exchange has teased out the last issue that I was going to raise with the witness. I have no further questions.

THE WITNESS: That's good, thank you very much.

THE COMMISSIONER: Just wait, Mr Chiu might have some questions for you, Ms Hull.

MR CHIU: Just a few questions.

<EXAMINATION BY MR CHIU:

MR CHIU: Q. Ms Hull, my name is Chiu and I represent NSW Health in this Inquiry. I just wanted to ask you a few questions to clarify some of the history of your work in this local health district.

As I understand it, back in 2004, you were part of the Palliative Care Enhancement Council; is that correct?
A. In? No, I have been - we've only been since 2016, I think, for the Palliative Care Enhancement Council.

Q. Were you part of a group that recommended --
A. Yes. Yes, we were a doctors group.

Q. A doctors group in 2004?
A. Yes, I was, sorry, yes. Absolutely. We had been working on a whole host of medical issues. I've always been a part of the doctors group here.

Q. Back in 2004, that group recommended a four- to five-bed hospice at Wagga Wagga hospital --
A. They did.

Q. -- for the redevelopment?
A. They did.

Q. What happened there was that when the clinical services plan for that development came out a couple of years later, they didn't adopt that recommendation?
A. No.

Q. And was it the case that that clinical services plan recommended that palliative care be community-based instead, with physicians, nurses and GPs, and access to inpatient hospital beds as required?
A. That was the idea of - that was the reasoning behind it. However, that's not realistic.

Q. No, okay. But you did give some evidence earlier that most people do prefer to palliate at home, if they can?
A. If they can and we have a great model at home, although, our model here in Wagga Wagga - I now know that we don't have a palliative - our palliative care nurses are not able to go out at night because of safety, of course. They are prevented from going out at night. So you then go to ED and that's --

Q. In an ideal world -- sorry to interrupt you. In an ideal world, you would have the workforce and the capacity for people to be seen at home?
A. Yes.

Q. Rather than hospices and EDs?
A. Yes.

Q. As I understand from the outline that you provided to the Commissioner, currently there is a palliative care alliance; is that correct?
A. There is, yes.

Q. That's a collaboration between the local health district, Calvary, the primary health network and the Forrest Centre --
A. Mmm.

Q. -- is that right?
A. That's right. It came about as a result of that 2004 committee that I was on, with the mayor at the time, et cetera, and it then came about to get an MOU together for the care of the palliative care, and moreover, to ensure that duplication wasn't happening. But the Forrest Centre hospice is ACAT assessment, which makes it a little bit more difficult as well, but it's a very good working collaboration, it works very well. The Calvary palliative specialist unit provides some care, then bills MLHD and MLHD pay the bill for public patients.

We've got 90 days - we have 90 bed days at the unit for public patients, and we're able to, you know, manage that, but I mean, I would like to see any public patient that requires that specialist management - the idea is specialist management to go home. But the difference, sir, is that you can have end of life in the unit, and your family is with you all the time.

Q. All the options are open?
A. Yes.

Q. Because the alliance means that every facility is available for it?
A. Yes, yes.

MR CHIU: No further questions, Commissioner.

THE COMMISSIONER: Thank you.

Just for the purposes of the transcript, the recommendation 24 that Ms Hull referred to is from the legislative council report on Health Outcomes and Access to

Health and Hospital Services in Rural, Regional and Remote New South Wales, which is a report number 57, and the submission I referred to by Western Health Alliance, Western New South Wales PHN, is submission 346 to that inquiry.

THE WITNESS: Thank you.

THE WITNESS: You are excused. Thank you so much for coming in. It is greatly appreciated.

THE WITNESS: Okay, thank you.

<THE WITNESS WITHDREW

MR MUSTON: I think the next witness is Associate Professor Ayman Shenouda. Mr Glover is going to be taking this witness.

<AYMAN SHENOUDA, sworn: [12.21pm]

<EXAMINATION BY MR GLOVER:

MR GLOVER: Q. State your full name for the record, please.
A. Ayman Shenouda.

Q. You are a general practitioner?
A. Yes.

Q. You practise here in Wagga Wagga?
A. Yes.

Q. You're a fellow of the Royal Australian College of General Practitioners; correct?
A. That's right.

Q. And you're a past president of that college?
A. Yes.

Q. When were you president of that college?
A. I was president and - I was vice president of that college at the end of - Harry Nespolon was the president and Harry unfortunately passed away, so I had to take over presidency for about six months when he passed away.

Q. When was that?

A. 2019.

Q. And you're the chair of the rural faculty of the college; is that right?
A. I was ex - I'm the immediate past chair of the chair of the faculty, yes.

Q. You held that role for about six years?
A. Yes, exactly.

Q. When did you cease in that role?
A. The same time, 2020, yes.

Q. Can you just in general terms describe the function of the rural faculty of the college?
A. Well, the rural faculty represents rural GPs, which is about 95 per cent of rural GPs, and it represents them, advocates for them, enables them and gives them education, if needed, and among other things.

Q. Can you just tell us a little bit about your practice here in Wagga? How many doctors are in practice with you?
A. I've got about eight to 10 doctors, variably, so eight doctors at the moment, and I've got all allied health professionals under the same practice, so we've got a dietician, we've got a diabetic educator, we've got an exercise physiologist, a psychologist, and a pharmacist sometimes, too, so all - majority - podiatrist, too, sorry.

Q. In providing care to your patients, I take it that you have cause to interact from time to time with the acute care setting; is that right?
A. Absolutely.

Q. And are there any particular challenges you find in interacting with the acute care setting in the management of your patients?
A. Yeah, there's a lot of - there's some issues about the acute care setting. I can tell you a story, maybe that would make it easier.

Q. That's easier.
A. Three of my patients have been through the system.

Q. First of all, perhaps just if you wouldn't mind identifying some particular challenges, and then by all means with some examples, it would be very helpful.

A. Yes, so challenges with the - in terms of handing over patients. So in the health system at the moment, they call - the handover is the discharge summary, which we are in principle against the idea of a discharge, because --

Q. Just before you go on, this is a summary that comes from the hospital back to you as the general practitioner?
A. That's exactly right.

Q. When one of your patients might have been admitted or presented to hospital?
A. That's exactly right.

Q. What is the particular difficulty with the discharge summary?
A. There's two things about discharge summaries, they are very delayed, so we don't get them when the patients present back to us.

Q. When you say "very delayed", what sort of in your experience, just --
A. Some times --

Q. These two ladies here are taking down everything we say, and if we speak over it each other it makes their --
A. I'm sorry.

Q. No, I'll be guilty of it as well but we'll both have to try hard to let one of us speak at a time. So what is the particular difficulty that you have experienced with discharge summaries?
A. Delay in having the discharge summaries, and that can be up to a week or two, sometimes.

Q. And what challenge does that pose to you as a general practitioner in the management of your patients?
A. That I would need to know what has happened to the patient during the stay in the hospital, so I can appropriately continue managing their disease or their illness.

THE COMMISSIONER: Q. Do you know why it takes a week or two to get a discharge summary?
A. I --

Q. Are you given any reasons, for example?
A. I think that the hospital relies on the interns to do

that job. They are the most junior doctors and they have a lot of other things that they need to do, and that's another dimension of how a problem is, that you get a discharge from a junior doctor that doesn't necessarily have all the context that you want to have as a GP.

Q. They're reading from notes and they may not have seen the patient themselves; is that right?
A. Sometimes it's like that, but other times, their understanding of the complexity of the patient is very, very low. So their discharge summary is based on their understanding rather than based on what the issues are.

THE COMMISSIONER: I see, thank you.

MR GLOVER: Q. So there are two challenges or two difficulties in your experience with discharge summaries. One is timing?
A. Yes.

Q. They're not coming through as quickly as you would like; correct?
A. Correct.

Q. And two is content; is that right?
A. That's exactly right.

Q. Any others?
A. Again, naming it "discharge summary", for me, is a difficulty, because I'm used to "handover of care", and handover of care is a doctor calling a doctor. So I'll give you the other way around.

Q. Yes.
A. If I want to send the patient to the hospital, which I think they are seriously ill, then I would call the emergency department, talk to the admitting doctor, say, "I've got this patient, this is the issues, this is the situation I'm facing. I need this and this and this to be done, and I think that's how, and if you please inform me about the outcome of what happened to this patient." This is specifically in seriously ill patients. So there are ill patients that not require me calling and I might write a letter to the emergency department. But in seriously ill patients, I would definitely call the admitting officer and let them know what's going on.

Q. And do I understand you correctly, that the challenge with the discharge summary that comes back to you from the hospital is that you don't see it as a handover of care; is that right?
A. Yes. I see it like we've finished with the care of this patient, where there's still some responsibility to - the doctor who is delivering the care is to hand over this care rather than discharge the care from there.

Q. Is this an issue that has been taken up by the college, to your knowledge, with --
A. Yes, absolutely.

Q. In what forum?
A. In the college forum, discussions within the college, discussions in conferences and in documentation by the board of the college to what needs to be done..

Q. And has it been raised with, for example, where we are here, with the Murrumbidgee Local Health District?
A. I believe it did, because we have the faculties. So the rural faculty represent, and national faculty more of, but we've got the New South Wales faculty, we've got the Queensland faculty, and with all of those faculties, their job is to liaise with their acute setting, whether it's Queensland Health or NSW Health or Western Australian Health.

Q. What changes, if any, could improve the process from your perspective?
A. There is a couple of things that I would mention there. The patient understanding of what happened to them in the hospital is very, very limited, and I think I rely on the patients, and quite often I will tell the patients, "What happened in the hospital? What sort of things happened?" And they say, "Look, they were very good to me. They dealt with me in a very good way", and I say, "Do you understand which medication they started you on, what is the effect of this medication on you?" No understanding whatsoever about their illness, the challenges they are facing and how they're going to continue on their care.

So part of it, for me as a doctor, is a document that will give me an idea, a good idea, of what happened in the hospital. Maybe, if it is a serious-enough condition, I would need the specialist or a senior doctor within the hospital to give me a call to say, "Are you aware of this

patient coming out today? Can you please see them within 24 hours?"

And the third one is, the third dimension is, the patient's understanding about what happened and their illness within the hospital system. We talk a lot about patient-centred care but we are still so disease focused.

Q. Just explain that last concept to me a little bit more. When you say that there is a lot of reference to "patient-centred care but we are disease focused", who is the "we"?
A. I think in the hospital system mainly. I think general practice is so, you know, patient centric. We discuss issues with patients about their health, we educate them about their health. They understand what their options are and they have the choice of where to go further.

Q. Do I take it that some discharge summaries might be better than others, that you receive?
A. Absolutely. You will have some discharge summaries that are better than others.

Q. Are there any other challenges that you face in your caring for your patients in terms of interaction with the acute care setting, other than discharge summaries?
A. Yeah, I find that acute care setting, again, is disease focused. So I can give you some examples, as I said before.

Q. Yes, please do.
A. I had a Miss Grace, she was 80 --

Q. Well, don't mention --
A. No, not mentioning any specifics.

Q. Yes, just anonymise them. No names.
A. Yeah. She was now a 90-year-old lady. She has been my patient for 20 years. A few years ago she presented to the practice and she had shortness of breath. I wasn't there at the moment because I was on leave and the locum was there. The locum had assessed her and, given her acuity, he said he thought the best thing is to refer her to the hospital.

So he referred her to the hospital. She's been

admitted under a respiratory physician. They did some scans for her and some respiratory tests that they do, respiratory function tests, and they couldn't find any reason for her shortness of breath so they got the cardiologist involved. The cardiologist came in and they've done an echocardiogram, they've done some other tests and tried again to find out the reason for the problem and they couldn't find the problem.

The first day I'm back, she was in my rooms, waiting for me. She booked the first appointment. She was very frustrated and very anxious about what happened to her during this period, and I didn't have a discharge summary, so I heard the story from her, and I noticed that in her body language she's a bit anxious. I know the patient, so I had longitudinal care for her for a long time, and I felt that she was stressed more than anything else. So I put my hands on her hands and said, "Are you okay?" And she went into tears and crying about her abusive ex-husband that is dying in the hospital and her priest is telling her that she needs to visit her ex-husband before he dies and she didn't feel very well. As a matter, she had some very bad experiences with her husband and all those experiences were brought on with the priest's intervention.

At the end of the day, this lady suffered from anxiety, and no-one would have picked on that because no-one has asked her what her story is. For me, it was this, counselling, a couple of sessions after that, and she was okay. There was no shortness of breath anymore.

Q. But do I take it you were able to identify those circumstances because, as you say, you had the longitudinal care of the patient?
A. Absolutely, and I ask the patients, too. I'm not only focused on the shortness of breath; I'm focused on the personal issues. I tell the registrars and the young doctors to learn how to treat - not to treat disease in patients but to treat patients with disease.

Q. Is that perhaps a function of the difference between the role of a general practitioner and the role of the acute care setting?
A. Oh, look, I understand the acute care setting has got its own challenges, but that doesn't mean that we don't get the patient involved in their care and understanding their care.

Q. Can I ask you about the interaction between general practitioners, and we'll use the district at the moment, in terms of implementation of what might be described as community care initiatives? Do you understand what I'm asking you about?
A. Yeah. I think there's a lack of this collaboration between the two systems.

Q. Why do you say that?
A. I think this is something that everyone knows about, that we have got two funding sources, two health systems that are working together and not talking to each other.

Q. Just break this down a little bit.
A. Yes, I will.

Q. What are the two systems that you're referring to?
A. I'm talking about the state government and the Commonwealth government. So as a GP I'm funded by the Commonwealth and all the funding comes to patient care through the Commonwealth. Whereas the state is funded by the state and the delivery of care, even in the community, comes through the state. So if there is initiative by the state to deliver something within the community, then they don't communicate with general practice how to deliver this the best way.

Q. Do you have any particular examples you can call can to mind?
A. I can give you a positive example rather than a negative example.

Q. Yes?
A. And the positive example is the recent urgent care clinics. So there was money funded by the state to deliver - to develop some urgent care clinics around the country, to give access to patients, with some acute patients to be seen as soon as possible, and that was initiated last year.

The model in some areas was based on a new clinic, that, you know, a doctor will come in that clinic, an employed doctor in the clinic, or whatever arrangement, but a new infrastructure to deliver the care.

In our situation, we got this to us, as GPs. We got

all the GPs together with the help of the PHNs and we designed a care that's based on all GPs in town we'll make two appointments available every day for this urgent care.

Q. Is this something different to the urgent care clinics that you've just mentioned?
A. Yes. So this is a new model that hasn't been done before in any part of the country. So the model that was supposed to happen is to create new clinics that would --

Q. Let's just break it up a little bit. So we started this passage by a positive example of collaboration between the district and general practice being a reference to urgent care clinics?
A. Yes.

Q. What was good about it?
A. That was good that the funding - the state funding is spent into general practice --

Q. I see.
A. -- and delivers a good quality at the end of the day that would reduce patient admission at the end of the day, so --

Q. And how does it do that, from your perspective?
A. So as I said, the state was happy - or we're still in the - we haven't started delivering the care yet, but the state was happy to pay money to general practice to be able to do this care for those patients.

Q. New South Wales?
A. Yes.

Q. And this is a new --
A. Initiative, yes.

Q. Hasn't started yet?
A. Hasn't started yet.

Q. This is different to other clinics that have been rolled out in other places; is that right?
A. That's exactly right.

Q. We might have been at cross-purposes. So I interrupted you. You were about to tell us what it will do when it's rolled out?

A. So I think it will get all general practice engaged in those patients, where there's - you know, try to fund general practice to find spots for those patients, so it would enable that to happen. We know that patients, you know, if they are seen by the GPs, they have - how can I put that in other words? So with the Lumos, for example, data, we know that out of the Lumos data, there is data to say if patients after discharge see their doctor within - their GP within 24 to 48 hours, there is 36 per cent reduction in them re-presenting to the hospital.

Q. So under this program, you said that the GP practices will hold two appointment slots; is that right?
A. Yeah.

Q. And how does the patient come to be referred into one of those appointment slots?
A. I think Healthdirect would be involved in that and the patients would call Healthdirect. And then we are now negotiating with Healthdirect to what are the questions, what are the things that would need to be in place, and give the priority to the patient's own practice before they get into another practice.

Q. And these might be patients who either have no regular GP; correct?
A. Yes, they might have no regular GP or have a regular GP, so we would rather them see their regular GP rather than --

Q. Yes, but they may not be able to, for various reasons?
A. Yes, absolutely.

Q. And this is an example where collaboration between the district and general practice has worked well, from your perspective?
A. I think so. I think there's a lot of cases. In my view, for the patient to be assessed in the hospital, it costs the hospital system about $450 for an assessment of a patient. It costs the taxpayer money $38 to see a GP. So if this money is spent into general practice and we avoid hospital admissions and avoid the cost that we will assess a patient in the hospital, it will be a better outcome.

Q. So through Healthdirect it is diverting patients who might otherwise present to ED into a general practice, into

one of these spots; correct?
A. Exactly right.

Q. Are there any examples where community healthcare initiatives have been delivered where you consider that the collaboration or communication from be it the ministry or the district and general practice has been lacking?
A. Not a lot of those. I have to say, there is not an intent - just it's understood by the state health that general practice is Commonwealth funding, we should not spend - this is a Commonwealth problem, we should not - instead of thinking about it as a patient problem, an access problem and quality of care problem.

Q. Could I ask you about training of general practitioners. You have an affiliation with the University of Notre Dame; correct?
A. That's exactly right.

Q. What is your role with that institution?
A. I'm an associate professor with Notre Dame, adjunct associate professor, and I train young doctors or young potential doctors, students, in my practice.

Q. And so that's all based here in Wagga; is that right?
A. Yes.

Q. Before we come to some specifics, are you aware through your work of the college of the trends of people training to become general practitioners across the state and the nation?
A. Yeah, unfortunately we have a very declined amount of doctors choosing general practice as a specialty at the moment. So we went - 10 years ago it was 50 per cent of our graduates that would choose general practice as a specialty, or a vocational training, now it's down to 17 per cent.

Q. And has the college been able to identify, to your knowledge, any reasons for that decline?
A. Yeah. One of the big reasons is that the doctors, the young doctors, are not exposed to general practice during their training at all, and one of the very, very successful programs that happened beforehand was a program called the PGPPP.

Q. What's that?

A. Prevocational General Practice Placements Program.

Q. When was this program in place?
A. I cannot - it's a few years ago. It would be 15 years at least, maybe. And that meant that young doctors, while in their younger - in their RMO years, they can be located, three months into general practice, to have experience of general practice. I was able to attract 16 doctors of those in my period when I did the training for them, and 12 of them have chosen general practice after they finished.

I think there's a time where young doctors decide what specialty they're going to do, and that's in their early years of residency. That's when they choose that. So if we don't capture them and get them to be exposed to the art of general practice and to the specialty of general practice, then we lose them to other specialities. I think we are getting into a huge problem in the future where there is a lot of doctors, I think about 30 per cent of doctors, that are at retirement age, 60 to 65.

Q. These are general practitioners?
A. General practitioners. We're not attracting younger doctors to general practice, and it's going to be a huge problem for the hospitals to deal with in the future, because every time you lose a GP in a town, that means that the patients will go to the emergency department, get assessed at $400 a head, and want to have care. So we are really into a state where we need the state to be aware that investing in general practice as part of their core issues is something that they need to start thinking about.

THE COMMISSIONER: Q. Can I just ask you, sir, when you said there's about 30 per cent of doctors that are at retirement age, 60 to 65 --
A. Yes.

Q. -- is that something you have read that is an Australian-wide statistic?
A. Yes, it is Australian wide.

Q. Do you know where you might have read that?
A. I cannot recall.

Q. You can tell us later.
A. Yeah, yeah, I can give you the statistics, it's very

clear, yes.

THE COMMISSIONER: Thank you.

MR GLOVER: Q. In that last answer you said the state should be investing in general practice, do you mean New South Wales?
A. I think New South Wales, in my opinion, and there are other states that have already started doing that in some areas.

Q. Of course, the problem in declining numbers of practitioners taking up general practice is not just limited to New South Wales, it's nationwide; correct?
A. It is a nationwide problem.

Q. When you say the states should be investing in general practice, what did you have in mind?
A. A lot of things. One of this is funding another PGPPP program where they expose the young doctors to have the experience of general practice as a rotation, so as you might know, in the first year of training we have mandatory terms for our young doctors to have to do, like, paediatrics, it's actually emergency and medicine and surgery and others. So I want --

Q. So at the moment general practice is not included in that?
A. It's not included at all. If you want people to get exposed in those years to general practice, understand the art of general practice, understand the continuity of care, understand patient-focused care, understand a lot of things, there's two benefits out of this: some of them would choose general practice as a specialty; but also, when they become a specialist themselves, they would understand how general practice works, and that's a very important issue, because we have this divide between the two systems, where the state health doesn't trust general practice in delivering care for one reason or another.

Q. What do you mean by that?
A. I feel like they feel like general practice, maybe - like Kay Hull said, is not a specialty of its own.

Q. When you say "state health" have that view --
A. Because they don't have --

Q. -- what do you mean?
A. They don't have interactions with GPs as much.

Q. Who's "they"?
A. The state.

Q. The ministry?

THE COMMISSIONER: Q. Do you mean NSW Health --
A. NSW Health.

Q. -- the ministry or --
A. The hospitals, maybe the districts.

Q. -- the LHDs?
A. The LHDs themselves.

MR GLOVER: Q. And when you say "they don't trust general practice", what do you mean by that?
A. I don't - I don't - I'm not certain whether they trust or don't trust, but what I know is when they create - when they create a program into the community, they don't consult with general practice. They create a program under their own specialists to be delivered in to the community without consulting or collaborating with general practice.

Q. Is there an example that comes to mind?
A. There is a lot of examples. So there is a cardiac rehab program for patients who finish cardiac surgery. That's totally run by the hospital without involving general practice. There is a respiratory program, again, same thing, it's just run by the state department --

Q. These are programs delivered into the community?
A. Yes.

Q. Is the point that you're raising that when they were developed and implemented, from your perspective, there's a lack of consultation with general practice --
A. Absolutely.

Q. -- in that area?

THE COMMISSIONER: Q. With the example you gave, how would it have helped if - I assume when you are saying "the state", you're talking about the LHD?
A. Yes.

Q. How would it have helped if there was consultation with GPs?
A. There are two levels. Understanding what's happening in the community, because GPs are experts in what happens in the community; GPs are experts in their patients' health themselves. The patient situation, social life, everything about the patient, GPs are expert in them. So they might give advice.

But also I would take it a bit further and would like to have some collaboration, really, on the ground. So a practice like mine, where I have all allied health services in my practice, I want to utilise them for the best care for the patients. So if I'm aware of that program, then they might refer the patient to my practice, or to their own practice, where there is an infrastructure, these people are involved there, and that will save money because they are not creating a new program, not in touch with what's happening in general practice, but they're collaborating with an infrastructure that's already there. With a bit of funding to help that happen, it will be okay.

It's different from one place to another, I would have to say. So in some rural communities in Queensland, for example, they started employing nurses and allied health professionals in general practice, employed by the state, to be working in community general practice to reduce the burden of chronic disease and manage chronic disease in the community and reduce hospital admission.

So they understand if we manage better in the community and we support the management in the community, we'll have less hospital admissions, we'll have less recurrent admission to the hospital from patients with severe disease.

Q. The prevocational general practice placement program that you talked about --
A. Yes.

Q. -- when did that program cease, do you recall, approximately?
A. About 10 years ago.

Q. And how long was it running, do you know?
A. It was running for about four years.

Q. And do you know why it ceased?
A. Funding stopped.

Q. The funding was coming from?
A. Commonwealth.

THE COMMISSIONER: Thank you.

MR GLOVER: Q. On the topic of the state investing in primary care, we've heard a little bit of evidence so far about the challenges of accessing primary care, GPs included, in more remote towns?
A. That's correct.

Q. Is there a role for the state - that is, NSW Health - to deliver primary health care where there is a lack of access to it in the particular town?
A. Look, I've been involved in the development of the rural generalist program with the first Rural Health Commissioner, Paul Worley, again, and the program is talking about the pipeline of students, interns and residents, and then GPs, specialists, so GPs with advanced skill in obstetrics, gynaecology - I think you've heard one of those GPs earlier on. And I think this is a solution, again, that goes between general practice and the state.

So if we - the rural generalist pathway I think is a very good pathway that shows collaboration in training between the state and the Commonwealth across the journey, but those doctors might go out and work in both the hospital facility and in general practice. There is a risk that happened in Queensland that those doctors are more inclined to stay within the state facilities rather than going out into general practice, because they are paid well in the state, while they are not paid well in general practice. So the risk of this is, yes, we're having more doctors that are working across the two systems, which is great, because we can create this collaboration from the two systems, but the risk is doctors are leaning more towards being within the state and neglecting general practice after they graduate from the program.

Q. You mentioned earlier that there's a high number of general practitioners who were approaching retirement age; correct?
A. Yes.

Q. And that is coupled with lower numbers, trainees, selecting general practice as a specialist pathway; correct?
A. That's exactly right.

Q. From your work within the college, are you aware of rural towns within New South Wales who may not have access to any general practitioner at all?
A. Absolutely.

Q. And in towns like that, is there a role for the state - that is, NSW Health - to provide access to primary health care by, say, employing a general practitioner to service the needs of that local community?
A. I don't - I don't mind that at all. In my view, that's a good model. The only problem with this model is, those doctors need to be trained, so I will have to go to what the current issues are, is that we are relying on international medical graduates to deliver care in the most difficult places in Australia, without giving them any support whatsoever.

I'm one of those IMGs, and I came here 30 years ago, and I'm proud of what I did to be the president of the college at some stage. So I had my journey, and I think we still need to support those doctors, because we cannot get our own graduates. It's a fact that's been happening for 30 years. Our graduates don't want to go rural.

So we've got another solution there, where IMGs can be looked up in a different way, be supported, be salaried, be trained, to do general practice in rural communities. The problem is that states don't train general practice, and you have to rely on Commonwealth funding to train GPs into those areas.

So again, it could be a good solution when the state is happy to pay someone that can be trained by the Commonwealth to stay in this community, I think. Those are the solutions that we're looking at.

Q. I will come back to training of local students in a moment, but in that answer you said that more support needs to be given to internationally trained practitioners who we may be drawing and relying on to provide services particularly in rural and remote towns?

A. Absolutely.

Q. What did you have in mind?
A. Oh, look, education support, support - social support, financial support, support to navigate the system. So for me as a GP, to employ an IMG to get them from overseas, to get them into Australia, they are qualified doctors overseas, they have their pathways that they have to go through, but it will take me about three years to get - and $30,000 to pay to get a doctor in here, and then I will start looking after them and training.

I'm not remunerated for training IMGs, I'm remunerated for training Australians, but not for IMGs. But I get them as a workforce solution for me and for my patients and for access of patients of Wagga and The Rock and other places.

Q. That's within your practice?
A. Yeah, within my practice.

Q. A cost to your practice, and a training burden you take on?
A. Yes, exactly right. Yeah. So I put an extra bit to support. So I want this bit not to come from an individual that aspires to do - I want this to be, you know, regulated in a way that there is other GPs who would do that, they would be paid for the training, they would support the IMGs adequately so when they go on their own, they can go on their own and be confident in delivering quality, safe care.

Q. Where, in your view, should that support be coming from? Is it the Commonwealth, the state, the college?
A. I think health issues are health of the nation and we need to start thinking about addressing issues in a different way than we've been doing it for years and years.

Q. When you say " a different way", you're referring to --
A. Divided between the Commonwealth and the state, we need to collaborate, we need to think abut the problem and sit together and try to come up with solutions and make it happen.

Q. As a one system rather than a Commonwealth and a state system; is that what you mean?
A. I think the one system - Kevin Rudd had a go on that

and it never went through, so I don't think that there is a big hope to do that, there's not an appetite for that, there's a lot of bureaucracy - I don't know what it is, to be honest, I'm not an expert in that. But what I know is, patient care can be a lot better if there's collaboration between the two systems.

Q. Is what you're referring to that the fragmentation in the system --
A. Absolutely.

Q. -- is thing that poses challenges in a number of areas, including something as simple, perhaps, as providing support to practitioners in the regions?
A. Absolutely. There is a lot of money around that's thrown in to different aspects of the system that I think if we really are serious about what we're facing in the future, with the chronic disease burden, with the ageing population, with palliative care issues, with mental health issues, with post-COVID issues - there's a lot of challenges to our system that are coming in, and if we don't all work together, it's not going to be good.

MR GLOVER: Commissioner, I note the time. I've got about 15 minutes to go. I was going to inquire whether you would be prepared to sit on so Professor Shenouda.

THE COMMISSIONER: I've actually got an online meeting at 1.30, so we'll have to break now.

MR GLOVER: Okay.

THE COMMISSIONER: So we will break now. Just for the purpose of the transcript, and because Mr Chiu and those instructing him won't have got this, this just relates to Ms Hull's evidence, the Agency for Clinical Innovation - you might know this - put out a publication on the Far West Local Health District palliative and end of life model of care in July 2023.

MR CHIU: Thank you.

THE COMMISSIONER: Okay, we will adjourn until 2 o'clock. Thank you.

LUNCHEON ADJOURNMENT

THE COMMISSIONER: Come forward, sir. Have a seat again.

Yes, Mr Glover?

MR GLOVER: Q. Professor Shenouda, just before we return to some issues about training, there are a couple of things I'd like to clarify from your evidence before lunch. Earlier on in your evidence you discussed the program which sees GP practices within Wagga holding a couple of appointment spots open per day so that patients can be referred in to them. Do you remember that passage of your evidence?
A. Yeah.

Q. I think you said that it was an initiative set up largely by the PHN; is that right?
A. It's a combination between the PHNs and the local GPs.

Q. So it's not something with which the local health district has an involvement; is that right?
A. There was an involvement from the local health district.

Q. What was that involvement?
A. On the panel - there was an emergency doctor on the panel that initially discussed this.

Q. The panel that was designing and implementing --
A. Yeah, designing a look to how it would look like to implement in the future.

Q. So for the practices that hold those slots open, how are those slots paid for?
A. They would be paid by the state.

Q. When you say "the state", who do you mean?
A. State health.

Q. NSW Health or the Commonwealth?
A. New South Wales no, not the Commonwealth, the whole program is funded by the state.

Q. By the state?
A. Yeah.

Q. If those appointments are not used, are the GP practices still paid for holding them open?

A. Yes.

Q. And again, to your understanding, is that NSW Health or the Commonwealth who would fund that?
A. The NSW Health. But I would assume that the appointments would always be used.

Q. In that passage of evidence, you referred to urgent care clinics. They're something different to this program, aren't they?
A. There are two urgent care clinics, there's an urgent care clinics run by the state, so the state, both Victoria and New South Wales, have decided they're going to put some funding into the state, to be run by the state, and there is Commonwealth funding also that is running some urgent care clinics around the country. There's two models there funded by two different --

Q. When you refer to the clinic run by the state, are you referring to what is described as "rapid access clinics"?
A. Yeah, that's my - no, it is urgent care clinics, but not the rapid - there's two clinics there too. So there is the rapid access clinics that are done by the - in the hospital. I think we've got the rapid access clinic here that's functioning for the last four or five years. But this is a new funding, different than the rapid access clinic.

Q. In another passage of your evidence you referred to the Commonwealth having a role in training medical students?
A. Yes.

Q. Do you remember that?
A. Yes.

Q. Can you just describe what role the Commonwealth has in relation to the training of medical students?
A. Not medical students, I'm talking about vocational training of doctors for the discipline of general practice. Yes, this is a funded program by the Commonwealth.

Q. Just one step at a time. What's the program that you are referring to?
A. It is the Australian General Practice Training Program.

Q. Who runs that program?
A. So it's funded by the Commonwealth. It used to be run by state-based organisations, and now, from last year, the college of GPs are running this program and they are getting the funding from the Commonwealth, and they are putting the money into general practices.

Q. So the funding from the Commonwealth, what is the funding used for in that training program?
A. For training doctors who choose general practice as a specialty in their vocational training period.

Q. Is that training that supports the trainee doctors or does it go to the practices who are providing the training? How does it work?
A. It goes to the supervisors and it goes to the practices. So it's two components of it: one for the practice that would allow this to happen within the facility, use the rooms for training registrars and look after registrars; but also part of it for the supervisors that deliver the training in the practice.

Q. In your evidence before lunch you used the acronym I-M-G, does that stand for international medical graduate?
A. Yes.

Q. You gave some evidence about some further support that might be needed for international medical graduates to practise in rural and remote areas?
A. Yeah.

Q. Do you have a view on what can be done to attract and support local graduates to rural and remote areas, in particular in relation to general practice?
A. Absolutely. So talking about local graduates, we are missing local graduates for a few issues that - I have mentioned some before but I will go through it again.

Q. Yes.
A. One is the exposure to general practice which we talked about, the PGPPP program. The second one is general practice is becoming a more and more complex job to do.

Q. Why do you say that?
A. Because we're dealing with all the body, we are dealing with mental health, we're dealing with chronic disease, we're dealing with palliative care, we're dealing

with gynaecology, we're dealing with respiratory illness. We're dealing with the whole gamut of things. So that makes the job very complex and to be able to narrow it down to what the problem is, it's more challenging in general practice.

Q. Is that challenge heightened in a rural and remote area?
A. Oh, I think the challenge is all across the borders, it's dealing with more and more complex patients. So younger graduates, when they have the choice between having a more complex job to do, to a rather more simple, as other specialty disciplines, other specialties would concentrate on one organ of the body, whereas we are dealing with the whole body.

So it becomes very - and to be another specialist within the specialists costs - remunerates a lot more than being a GP. So why would you be a young graduate that would choose a more complex, less paid job over an easier, better paid job.

Q. The complexity that you refer to has always been a feature of general practice, has it?
A. Absolutely.

Q. Or has something changed by reason of the demographic of the population to heighten that complexity?
A. I think, yes, we have - the health state we are in now is completely different than it was 15 years ago.

Q. In what way?
A. I can tell you a simple thing. So 15 years - when I started 20 years ago, or 25 years ago, when I started doing general practice, if I have a lady that's 85, I would go to my colleagues and celebrate that she's still alive and kicking and doing well and I'm keeping her alive. Now, I've got 20 of those every day. So definitely we are keeping people living longer and that's, I think - I suppose this is something that we appreciate in general practice, that we've done a lot to keep those people around.

So the scope, when you're dealing with a medication for diabetes, for example, that we have initially two or three medications for diabetes, now there's about 60 medications for diabetes. So we need to know all those

medications, know when they should be prescribed and know the patients that are taking these medications and how these medications would fit that patient.

Q. So the challenges of complexity and viability that you have referred to --
A. Yes.

Q. -- are those things that have been raised with you in your role both training doctors and through the college?
A. Absolutely.

Q. What do you think can be done to lessen the burden of those challenges, to attract people to --
A. Look, I --

Q. -- general practice in regional and remote areas?
A. Sorry, I'm interrupting you.

Q. No, that's okay.
A. I think we need to look at the data. We need to look at the international data, we look at Barbara Starfield in the US, who has done a lot of work into the future of affordability of health in nations, in first country nations, and she's just proven once and again that investing in primary care is the way forward for any nation to survive the issues that we are dealing with.

Q. That's a response perhaps to the health needs of the population. What can be done, in your view, to attract practitioners to general practice and, in particular, in rural and remote areas?
A. Yeah. So there are a few things. I think - I will talk specifically about rural communities, because that's where the shortage is.

Q. Yes.
A. And as I said before, we were involved in the rural generalist pathway and produced a green paper by the Rural Health Commissioner, the first Rural Health Commissioner. It talks about attracting doctors, when they are medical students, so that means --

Q. Let's just step through the pathway.
A. That means - doctors take about 15 to 20 years of training to reach to be vocationally trained, okay? Part of the training is in the university, undergraduates, and

then post-grad they might do a year or two in a hospital and then they move into general practice and it might take them another three or four years to develop that, or another specialty might be longer. So what we found, that we - it's been a trend that we second people from cities to be trained into rural areas for six months or so, and go back to their, you know, place of origin or where they have their network.

We found out that part of that issue is that if you have a training for 15 years, that's where you develop your social network, you develop a spouse or have friendships and people around you within your facility or within that place you are doing that. So if we turn that around and we get people trained rurally from the beginning, so establish medical schools, complete medical schools, in the rural community, and then you take them into hospitals in rural communities, but also into general practice and you get them exposed to the rural communities, they form their own networks in those communities, so by the time they finish their training, they will be embedded in this community and understand the issues with this community and better - and have the passion to deliver care for those communities too.

Q. What you are describing is sometimes described as "grow your own" initiatives, is that --
A. Absolutely.

Q. And do you have a view about their success?
A. I think it would be very successful, if we exposed - like I'm talking about, general practice exposing students to - or medical graduates to general practice, just expose them to the community in that sense, and making them aware of the community, have their ties within the community, definitely would work better.

Q. And does that extend to attracting local students to general practice as well?
A. Absolutely. Look, students love their turns in rural communities. They feel - and young doctors. They feel they learn a lot more than they will do in an urban setting, and the reason for that is in an urban setting, if you're looking at RPA or other big hospitals, the students or the interns are sitting at the end of a big, big, big row that they need to learn something, whereas in rural communities, they are hands-on, they do things, the specialists are in close proximity for them and they can

ask specialists, can ask GPs about what to do next.

Q. Are you familiar with the single employer model that was piloted in this district?
A. Absolutely. I was part of developing it.

Q. And can you just explain for the Commissioner what that model entailed?
A. So that model entailed, in early training of GP training, to get people out of the hospital, to work in general practice, they lose their - they lose their annual leave, they lose all of their payments that they should be paid - they lose it all.

Q. The employment benefits associated with being an employee of NSW Health; is that what you're referring to?
A. That's exactly right. And they also get down in their pay. So again, we found this issue when we did the rural generalist pathway, where we interviewed a lot of younger doctors to explore what their problems are, and one of the problems is that less remuneration they get when they go out into general practice.

Q. So trainee doctors who were employed by the state are now moving to general practice and seeing their remuneration decrease; is that what you are referring to?
A. Especially in the first year. So that was an initiative that we sort of supported into trying to get an employer that would be responsible for paying those doctors not losing their entitlements but also not going down in pay, and the state was happy to do that. But in New South Wales, the state only do it for the rural generalists because they can see the benefit of them working in the hospitals.

I would rather do it for all general practice training, registrars, because the last thing you want in your practice, if you have a rural generalist trainee and a normal trainee, is that they don't have different sort of pays, so we are sort of creating a disparity in pay.

The other aspect of that is that there is a limited place for rural generalists at the end of the day, so we don't want to encourage more doctors to go to do a training that is more long training and might be more expensive, but not practise that specialty that they have trained in, because there is not enough spaces for them to practise

their specialty.

Q. So from that answer, do I understand that you see benefits in expanding the model to general practice in the rural and regional areas more widely?
A. Absolutely.

Q. What benefit would come from that in your view?
A. As I said, there would be more registrars interested in coming to general practice; there would be no disparity between one pay and another pay; there would be, yeah, more doctors taking up general practice as a specialty of their passion.

Q. And I take it --

THE COMMISSIONER: It has been adopted beyond Murrumbidgee, though, hasn't it?

MR GLOVER: It has.

THE COMMISSIONER: In various - all the rural LHDs, or most.

MR GLOVER: Q. I think the distinction you are drawing, Professor Shenouda, is that at the moment it is applied to the rural generalist pathway --
A. Yes.

Q. -- and you would see benefit in it being expanded to include general practice as well; is that right?
A. Yes, that's exactly right.

MR GLOVER: Does that deal with the issue?

THE COMMISSIONER: Understood.

THE WITNESS: But other states have implemented the rural generalists. Queensland have a long time ago, and Tasmania has. So Tasmania has done what I - and Tasmanian health, like state health, have done what I'm talking about, they expanded it to involve all registrars rather than a particular group of registrars.

MR GLOVER: Q. And having observed the model within the district, what benefits do you see - other than the employment benefits, what benefits have you seen to the

medical workforce in the district?
A. I think we haven't seen the benefits yet but we are hoping that there will be benefits for rural communities where there is a hospital attached to the community. So if there is a hospital attached to the community, then, as I said before, the GP would be able to practise in emergency or anaesthetics or gynaecology and obstetrics. The problem we have, too, is in what we call MMM 5 to 7. So this model would work very well --

Q. This is the Monash model of rurality; is that what you are referring to?
A. That's exactly right.

Q. What does 5 to 7 refer to?
A. This the more rural areas that are requiring more doctors. So those areas would require a GP, they don't have a facility of a hospital.

THE COMMISSIONER: Q. So 5 to 7 has a population grading, has it?
A. It's actually a combination of factors that they've implemented together.

Q. Seven is the most remote?
A. Absolutely. Absolutely. So the rural generalist model works very well into 3 to 4, like somewhere in Wagga would be very good, or maybe smaller than Wagga, a bit smaller. But when you go more rural, there is not a state facility for this doctor to practise their extended skills, so it becomes they need a GP, rather, okay? So if we expanded that to general practice, that means that we would give those communities an opportunity to have a GP.

MR GLOVER: Q. So this would be a GP employed by the state in those very rural communities?
A. To be honest with you, I don't - I don't care whom they are employed with. What I care is about the patient care in those communities. So in every community, it would be different models of care and different pay for those communities, and this is already practised. In areas like Dubbo, there's some communities where the state health, Commonwealth funding, together with the Commonwealth funding, but also the local government would tip in to make those communities - to have access for those communities for better care. So everyone tips in. Maybe a house there, and that's the model I think would work for the

future, is we get together, think about the problems and really invest in what works, what's more efficient and what's more cost efficient with better outcomes.

Q. Are there any other challenges facing general practices in rural and remote areas that you think require assistance from the system?
A. Oh, look, this is an issue that's very close to my heart. I've talked about the viability of general practice in general and how difficult it is for doctors to maintain and keep the doors open with the funding available at the moment.

Q. That's the funding from the MBS that you have spoken about?
A. Yeah, funding, the Medicare funding or MBS funding. Now, the state, New South Wales state and other states, have decided to implement another tax on general practice called the payroll tax. I'm not sure whether you are aware of it or not, but it's another burden that is going to be put on general practice that will result in more presentation to the emergency department.

Q. That hasn't been implemented yet; correct?
A. Hasn't been implemented in a couple of cases, but there is a lot of negotiation happening now to try to waive these. All general practices pay payroll tax for employed doctors and employed nurses and employed - so. But this is about partners in general practice and that the state is considering those partners are not partners, they are employees by the practice. And that's where their argument is, and I feel like this is going to cost our state more money at the end because there will be more hospital admissions, there will be more hospital presentations, more money spent because general practice would not be afford - to accommodate patients.

Q. Why do you say that?
A. Sorry?

Q. What about the --
A. Because of viability. This is another nail in the coffin of general practice.

Q. What you're raising there is the prospect of general practices having to close?
A. Yes, absolutely --

Q. Is that what you're referring to?
A. -- or pass the charge on patients, and unfortunately, there are patients that can afford and there are patients who cannot afford, vulnerable patients, with chronic burden of disease, because we know the social determinants of health do link to chronic disease. So we are now punishing people who are the most vulnerable, the most sick, that they cannot access care.

MR GLOVER: Nothing further, Commissioner.

THE COMMISSIONER: Thank you. Mr Chiu?

MR CHIU: No questions, Commissioner.

THE COMMISSIONER: Thank you very much, sir. I really appreciate you giving your time. You are excused, thanks.

THE WITNESS: Thank you very much.

<THE WITNESS WITHDREW

THE COMMISSIONER: Who is next?

MR GLOVER: The next witnesses are being called together, Dr McKean and Ms Ewer from the Berrigan Shire Council. They are going to take up positions in the jury box. For those on the live stream, I understand they won't be able to see their faces but they can see them.

THE COMMISSIONER: Okay. The microphones are set up, though, I can see.

MR GLOVER: Yes.

<JULIA MARGARET CORNWELL MCKEAN, affirmed: [2.22pm]

<KARINA DEE EWER, affirmed: [2.22pm]

<EXAMINATION BY MR GLOVER:

MR GLOVER: Dr McKean, could you state your full name for the record, please.

DR CORNWELL McKEAN: Yes. Julia Margaret Cornwell McKean.

MR GLOVER: And Ms Ewer, your full name?

MS EWER: Karina Dee Ewer.

MR GLOVER: Dr McKean, you are the mayor of Berrigan Shire Council; correct?

DR CORNWELL McKEAN: Yes, I am.

MR GLOVER: And when did you assume that role?

DR CORNWELL McKEAN: September of last year.

MR GLOVER: And how long have you been on the council?

DR CORNWELL McKEAN: Since December 2021.

MR GLOVER: And Ms Ewer, you are the chief executive officer of the council; correct?

MS EWER: Yes, I am.

MR GLOVER: How long have you been in that role?

MS EWER: Since June 2020 - is that right? Two and a half years.

MR GLOVER: That's fine. Have you been employed by the council before then --

MS EWER: No.

MR GLOVER: -- or was that your first role?

MS EWER: That was my first role at Berrigan Shire.

THE COMMISSIONER: 2.5 years would be 2021, I think.

MS EWER: 2021. Sorry, they blur together.

MR GLOVER: Dr McKean, can you tell us a little bit about the shire?

DR CORNWELL McKEAN: Berrigan shire, we have a population of around 9,000 people. We have four core towns, Berrigan, Barooga, Tocumwal and Finley. We have an age demographic of approximately 55 years of age. We are one of the last

areas on the Murray River that has not yet been overpopulated, so we are anticipating growth up to 32 per cent across the shire over the next five to 10 years, particularly the town of Tocumwal, we're anticipating a 17 per cent growth.

We have hospitals in Berrigan, Tocumwal and Finley. The town of Barooga, being on the Murray River and in close proximity to Cobram, is predominantly serviced by Victoria and not New South Wales. Having said that, the whole shire is part of Murrumbidgee Local Health District.

MR GLOVER: And you've mentioned some fairly significant growth expectations. What's driving that growth in your shire, to your knowledge.

DR CORNWELL McKEAN: There's a few things and it is that we do have vacant land that's available for development and we're seeing plans being progressively lodged. Our greatest concern actually is that we don't have the infrastructure to support the level of growth and that we will need to manage that.

The Murray River traditionally gets a lot of retirees due to the advantageous weather, 300 days of sunshine in a year, but it was a bit hot last week, let's be honest. But, yes, we definitely do have that sporty - lots of golf courses. It's a good life. It's also cheap. You know, we've been cheap for a long time, and that helps retirees to down-size. Many of them are from Melbourne. We're three hours from Melbourne. We're seven hours from Sydney by vehicle. So it's economical and it's just a great place to live.

MR GLOVER: Are there any particular challenges within the shire in terms of your residents accessing health care?

DR CORNWELL McKEAN: Yes, there are, and particularly during the pandemic we had issues with access to GPs, long queues, particularly not taking new patients. My own personal experience, I moved full-time to the shire - I commuted for many years before that - four years ago. I could not get a GP. My GP is in Melbourne. I have to travel to Melbourne. I'm not the only person who needs to do that. Of course I'm not in the elderly range who needs to see a GP regularly but it is a problem.

It is improving. We have had some new GPs particularly in Cobram, which is on the Vic side, and we have a new one coming to Tocumwal. This should help ease some of that pressure but as we mentioned with that continued growth, I anticipate that will continue to be a problem in terms of that.

In terms of --

THE COMMISSIONER: Do the people in your town, area, that have GPs in Melbourne, do they use technology to have appointments as well as going face to face?

DR CORNWELL McKEAN: It is interesting that during the pandemic a lot of them, particularly those with specialist appointments - so generally, our specialist appointments will be out of Shepparton, Albury or Melbourne, and a lot of them have been utilising technology. But we've also got many who don't know how to use technology, which is a problem, and then we have coverage issues, so it's complex.

Having said that, the hospitals in Berrigan and Tocumwal, who do have - Tocumwal not - their coverage is not the best but they do have IT available for people to come and do telehealth from those facilities.

THE COMMISSIONER: Thank you.

MR GLOVER: Apart from access to general practitioners, are there any other challenges faced by the residents of the shire in accessing health care?

DR CORNWELL McKEAN: Yes. We have been campaigning for nearly 20 years in the shire for an ambulance in Tocumwal and I became involved in that campaign about a year ago. They have a committee, the Tocumwal ambulance committee, and they contacted me and asked if I could assist them. I'm on the board --

MR GLOVER: We'll come back to that.

DR CORNWELL McKEAN: Yes.

MR GLOVER: So lack of access to GPs and ambulance station, any other challenges faced by residents in the shire in terms of accessing health care?

DR CORNWELL McKEAN: Yes. Finley Hospital, there's some funding for an upgrade. There are particular issues around this upgrade not including renal services - people have to travel to Shepparton or Deniliquin - and CT services. There are also issues around access to mental health supports, particularly for younger people in the north of our shire. They need to travel to Deniliquin to access in-person services. They're not so inclined to use telehealth because they don't want to do it at home and they don't want mum to know they have travelled to Deniliquin, and we have, as a council, actually put financial support to the Southern Riverina collaborative, so that we can actually - you know, this is not something that is budgeted. We have to use our ratepayers' funding for something that is not in our remit, just to make sure that young people are being looked after, and that includes work in relation to suicide prevention and things of that nature.

MR GLOVER: Ms Ewer, did you want to add anything to that answer?

MS EWER: I think she has very well covered that - Councillor Cornwell McKean has, yes.

MR GLOVER: Before we go back to perhaps to some of the detail, can I ask you, Ms Ewer, in your role as chief executive of the shire council, what role is the council taking in assisting its residents to overcome some of those challenges?

MS EWER: I think increasingly, councils become - one, start to put their money - have to put up money for assisting things that just don't exist in rural and regional areas, and also lots of advocacy, which doesn't sound like it costs a lot until you realise how far we have to travel sometimes just to get in front of a minister to raise their awareness about what those gaps are.

And there is an increasing expectation, particularly as we see people move from Melbourne, that the services are there, and when they get there and they realise they're not, then the pressure comes to councils to try and access them, somehow make them magically appear. So it can be quite time consuming and it can certainly involve a lot of travel for both of us to make sure that we've got - you

know, we're in front of the right people and advocating for our communities. But primarily, I mean, we've got councils all around us who have bought GP practices, we've got councils who are paying for housing for GPs, that - we're lucky we do have quite a few that we can have access to but not - but we've got Cobram, Victoria, quite close to us. But we see that increasingly across all councils.

MR GLOVER: In terms of council having to fund healthcare services or initiatives, has your council taken any steps in that direction as yet?

MS EWER: As mentioned by Mayor Julia, just before, I'm sure - we don't tend to use our last names very often. As mentioned by Mayor Julia earlier, we are putting about $65,000 a year towards mental health and wellbeing for our youth in Berrigan Shire because they can't access it. To catch a bus, they actually have to go the wrong way, to get to their mental health facilities.

THE COMMISSIONER: What does that money go to specifically?

MS EWER: It goes to the Southern Riverina Wellbeing Collaborative who are delivering the Live4Life and Shine Bright programs into schools, it also goes to mental health first aid training, and a number of seminars that are held in the community so that we can put some supports in, particularly in Finley where we've had quite a high level of suicide rates in our young children.

MR GLOVER: And any other work done by the council in addition to that initiative?

MS EWER: As far as funding goes?

MR GLOVER: Yes.

MS EWER: No, we haven't been directly funding but we have been spending a lot of money making sure that we've got advocacy for the Finley Hospital and the Tocumwal ambulance service in particular.

THE COMMISSIONER: Just before Mr Glover goes on, you also said in one of your answers that you've got councils all around you who have bought GP practices and councils who are paying for housing for GPs. What councils are those

that you're aware of?

MS EWER: I believe - I think Murrumbidgee has a house for the GP and so do Narrandera. I've certainly been in other states where we've had to actually buy a GP practice, so, you know, that is quite normal. One thing Julia has just reminded me of is that we are working on an accommodation - we are actually going to be paying for accommodation so that we've got --

THE COMMISSIONER: For?

MS EWER: For GPs and doctors at the hospital, and nurses and stuff like that, so that we can make sure that we have key worker housing for those people.

THE COMMISSIONER: Are you talking about locums coming and --

MS EWER: Yes. And nurses when they need to, yes.

THE COMMISSIONER: -- agency nurses?

MS EWER: Yeah, that's right

MR GLOVER: When you say the council is going to be paying for accommodation, is this building and then leasing out the accommodation to key workers, is that what you have in mind.

MS EWER: Correct, yes.

MR GLOVER: I take it it hasn't started yet but it's in the planning?

MS EWER: We're just about to go to tender for design and construct.

MR GLOVER: Has that been driven by a need to provide housing for key workers in your region?

MS EWER: Absolutely, yeah. They've definitely told us that they don't - there isn't a lot of housing that is fit for purpose in any of our townships. They're all quite - any of the housing stock does tend to be quite old and therefore very hard to heat or cool and so electricity prices can be quite high and they're also ageing stock. So

we are looking to put in something that's a lot more modular so that we can have our own staff but also Murrumbidgee Local Health District's staff stay in some accommodation, particularly in Finley and Berrigan.

MR GLOVER: You mentioned in an earlier answer some advocacy on issues relevant to your shire, one of them being the ambulance station. Can you just tell us briefly what that issue is and then I will ask you some questions about the process?

THE COMMISSIONER: You might need to identify who you are asking of for the transcript?

MR GLOVER: Yes, I was thinking that as I looked up.

I'll start with Dr McKean and we'll go from there.

DR CORNWELL McKEAN: Sure. So the back story to the ambulance in Tocumwal that we're campaigning for, as I said, there is a committee that have been campaigning for 20 years. They approached me a year ago, I'm on the board of Goulburn Valley Health, I'm someone who ran for council on the back of campaigning for health equity. So I had an interest and I needed to do some research, and I discovered that they had been campaigning with the former Minister for Health, Minister Hazzard, and that a report was commissioned in 2020 in relation to the feasibility of an ambulance station in Tocumwal.

At the time, the committee said that - seemed to consider that that report said a straight-out no, but when I looked more closely into the detail, it actually didn't say that at all; it said that the current first responder model was at its extreme use and that thought would need to be given in the future for a permanent ambulance station in Tocumwal.

MR GLOVER: Just before you go on, you referred there to "the current first responder model".

DR CORNWELL McKEAN: Yes.

MR GLOVER: Can you describe that, please?

DR CORNWELL McKEAN: So New South Wales fire and rescue, when somebody calls 000 from Tocumwal, the first responders

assemble at the station, they get on the truck and then they go to wherever the call-out is.

MS EWER: Fire truck.

DR CORNWELL McKEAN: Fire truck. Then an ambulance will follow some time after that, sometimes a very long time after that.

MR GLOVER: And before I interrupted you to describe that model, you were saying that the report that you examined suggested that it was at its limits; is that right?

DR CORNWELL McKEAN: That is right, and in subsequent documentation that we received by way of GIPAA, it indicates that the statistical use of priority 1 in Tocumwal is 4.1 cases a week and that for first responders the upper limit is 2.

MR GLOVER: So this is the context in which the campaign for an ambulance station in Tocumwal had arisen; correct?

DR CORNWELL McKEAN: Yes.

MR GLOVER: And you became involved?

DR CORNWELL McKEAN: Yes.

MR GLOVER: Can I ask you about how you engaged in that and with whom?

DR CORNWELL McKEAN: Yes. So the former mayor, Matthew Hannan, myself and Ms Ewer, we had attempted to get a meeting with Minister Ryan Park and were successful in doing so after sending some initial correspondence. The initial correspondence we received back from Minister Park referred to statistical area that far exceeds - in fact it didn't refer to the statistical area; it said the relevant area for Tocumwal had a call-out time of priority 1 of eight minutes.

THE COMMISSIONER: What does eight minutes mean? Eight minutes for the ambulance to arrive?

DR CORNWELL McKEAN: For average time, but it's for Upper Murray, which extends from Swan Hill to Albury and has a population of 42,000 people.

THE COMMISSIONER: How many kilometres is that?

DR CORNWELL McKEAN: A long way, yeah. Tocumwal is --

THE COMMISSIONER: You can't drive it in eight minutes?

DR CORNWELL McKEAN: No. It is the average. We're 15 minutes from finally. That's for all call-outs in that population which - and I have said to NSW Ambulance, it's disingenuous, you should not be comparing statistics for that sort of geography as to whether we are getting a reasonable service in Tocumwal. So at the moment we don't actually have concrete numbers about what the average time is in Tocumwal, and they have advised that they are not obliged to give that and that I will need to GIPAA it.

THE COMMISSIONER: Sorry, who has said to you they are not obliged to give it?

DR CORNWELL McKEAN: We had a meeting on Friday just past, actually, with NSW Ambulance, who advised that they are only obligated to give us statistics relating to the SA3 area, which is the Upper Murray, the ABS area, and nothing more specific.

THE COMMISSIONER: Forgetting what they're obligated to give, what's the reason they wouldn't give it to you? It's not --

DR CORNWELL McKEAN: I don't know.

THE COMMISSIONER: It is not national security, is it?

DR CORNWELL McKEAN: I wouldn't have thought so, no. We've already drafted a motion without notice to go before our council on Wednesday for the GIPAA.

MR GLOVER: So you engaged with the minister?

DR CORNWELL McKEAN: Yes.

MR GLOVER: You've referred to a meeting you had last Friday but I assume there were some steps in between.

DR CORNWELL McKEAN: Quite a number of steps in between.

MR GLOVER: Can you just perhaps at a general level describe what they are and then I'll ask you some questions about your view as to the process.

DR CORNWELL McKEAN: Yes. So we met with the minister in August of last year along with two representatives from NSW Ambulance. The minister suggested that maybe a CERT model would be an option. We had not heard of that before.

We subsequently wrote to the minister on two occasions. We didn't get a response. And we also wrote to the premier because we were still waiting for a response. We eventually received a response that indicated that we were eligible for a CERT model but were not a priority.

MR GLOVER: Do you have an understanding now of what a CERT model is?

DR CORNWELL McKEAN: Yes, I do.

MR GLOVER: What is it?

DR CORNWELL McKEAN: It's a community emergency response team. It involves volunteers. The volunteers are rostered on, they have a vehicle, a specific vehicle. They travel in twos. One of the persons who was rostered on has the vehicle with them at all times, so there's no need to actually assemble at a fire station; they can go immediately from wherever they are located. It's fully stocked with the sorts of things that they would need for that first-level response. They have the same training as the first responders.

The big difference is they are volunteers, and I understand for that to work, we would need eight volunteers in the Tocumwal community who would be willing to contribute their time not only to be rostered on but to attend monthly training, as well as deal with the emotional and difficult work that it would be to do that.

MR GLOVER: So after being informed that the region was eligible for this model, what was the next step in the process?

DR CORNWELL McKEAN: We had a town meeting in October, and talked about that.

THE COMMISSIONER: Sorry to interrupt, what do you get if you're part of the CERT model? You get a car given to you, do you?

DR CORNWELL McKEAN: Yeah.

THE COMMISSIONER: And the training is free, I take it?

DR CORNWELL McKEAN: Yes.

THE COMMISSIONER: Provided you've got the time.

DR CORNWELL McKEAN: Yes. But the car gets rotated, so you don't get to keep the car yourself, there are not eight cars. They actually have to hand them over at the end of shift, so there's a bit of mucking about as well, yes.

THE COMMISSIONER: Sure. There's a designated driver that rotates; right.

DR CORNWELL McKEAN: Yes. Sorry, I have lost my train of thought while we are talking.

THE COMMISSIONER: Sorry, that's my fault. We have a transcript for that, a running transcript, that will assist getting us back on track.

MR GLOVER: I will find where we were. There was a town meeting; in October, you had a town meeting?

DR CORNWELL McKEAN: Yes, we did.

MR GLOVER: What was the next engagement with either NSW Health or the ambulance?

DR CORNWELL McKEAN: There was a town meeting, we had the member for Murray, Helen Dalton, attended and over 100 locals.

THE COMMISSIONER: She is a state member of parliament; correct?

DR CORNWELL McKEAN: Yes, that's correct. After that meeting, we had further correspondence, we've been trying to get further meetings with Minister Park. We weren't having any luck. So that's when we went down the GIPAA path to get some more information about the briefings that

have been given to Minister Park. In particular, we drafted our GIPAA so that we were getting - for all the letters we had received back, we were asking for the briefing notes that accompanied those. We were hoping to get the same level of detail that we were successful in getting without a GIPAA, might I add, in relation to the report that was done with Minister Hazzard. So we got --

MR GLOVER: Pausing there, do I take it from that answer that you made a request of the previous minister and received some information, but you hadn't received the same level of detail from the current minister's office; is that right?

DR CORNWELL McKEAN: I was not a councillor at that time. I don't know the precise background. I know that Helen Dalton MP was involved in getting information and Minister Hazzard supplied that report to Helen Dalton without any redaction, in full, which she subsequently passed on to the committee and to members of the community.

THE COMMISSIONER: Sorry, when you say "that report", that report is what?

DR CORNWELL McKEAN: It was a report in 2022 as to whether Tocumwal was eligible for an ambulance. It was quite comprehensive and it indicated in the report that there would be annual reviews, and we, with our GIPAA, wanted to get to the bottom of whether they had, in fact, occurred. We didn't think they had. We kept asking in our letters but no-one answered the question and we have indeed established that they did not occur.

MR GLOVER: You have referred a few times to making GIPAA requests or applications.

DR CORNWELL McKEAN: Yes.

MR GLOVER: What drove you to the view that you needed to make those types of applications?

DR CORNWELL McKEAN: I wanted to get to the bottom of whether the reviews had occurred since 2020. I doubted they had occurred but I wanted to know one way or the other. We also knew that we weren't being provided with the sort of data that was available from 2020, and we were trying to, I suppose, force the hand of the ambulance to

actually go back and look at the figures properly and to take into account the anticipated, and already, we are seeing, population growth in Tocumwal, so we can really understand what was happening.

At that point, we didn't actually know what the upper limit was for the first responders and, in fact, we didn't know what the upper limit - we didn't know what a Cert was. We subsequently found the upper limit for that is 4, when we were actually already at 4.1, and we know that the numbers that --

THE COMMISSIONER: Can you just explain the upper limit to me, what that means precisely?

DR CORNWELL McKEAN: So they have - we discovered through the GIPAA response that there's a table that details various models - the first responder, CERT, Ambulance, there's something called "blended", I've not really got to the bottom of what that means.

For an ambulance full-time station, which they tell me needs to be fully staffed with over 10 paramedics, which doesn't sound realistic, you need to have seven priority 1 cases, at least seven priority 1 cases a week --

THE COMMISSIONER: Right.

DR CORNWELL McKEAN: -- and the CERT. We're in that point that's between the CERT and the --

THE COMMISSIONER: And that. Okay.

MR GLOVER: So a series of requests for a response and information, and then ultimately a meeting last Friday; correct?

DR CORNWELL McKEAN: Yes.

MR GLOVER: I'll just ask you - I take it that your view is there should be an Ambulance station in Tocumwal but leaving aside for a moment for the purposes of my question what I might call the merits or otherwise of that question, I want to ask you about your views as to the process of engaging with NSW Health and NSW Ambulance over this issue at that period of time. Does that make sense?

DR CORNWELL McKEAN: Yes.

MR GLOVER: How have you found the process of engaging with NSW Health and NSW Ambulance on this issue?

DR CORNWELL McKEAN: Disingenuous. When they met us in the foyer in Sydney, two senior officials for NSW Ambulance, Ms Ewer, myself and the former mayor, they said "Geez, you're younger than the last lot." Didn't go that well after that.

MR GLOVER: Other than that introduction, how else would you describe the process of engaging with NSW Health and NSW Ambulance on this issue?

DR CORNWELL McKEAN: I think the minister was the one who suggested the CERT in the course of the meeting.

MR GLOVER: Minister Park?

DR CORNWELL McKEAN: Minister Park, yes. He apologised that he had not flagged that with these two officers prior to the meeting and they were shocked that he had brought that up and tried their best to water the discussion down, but Minister Park asked them to go away and consider options for us.

I found the correspondence we've received - and I was reviewing it in the car on the way here - is repetitive, it continues to use the statistics that I think are highly inappropriate relating to average times for the Upper Murray rather than Tocumwal. I honestly think that they wanted us to just go away, and when we did speak to Bronnie Taylor and Wes Fang, and asked them to please raise these issues at budget estimates --

THE COMMISSIONER: They're politicians?

DR CORNWELL McKEAN: That's correct - which they did, it was the first time we really got any traction.

MR GLOVER: Ms Ewer, do you have anything to add to that from your perspective as CEO?

MS EWER: Yeah, I think they've been - it feels deliberately obstructive.

MR GLOVER: Why do you say that.

MS EWER: The GIPAA is like reading a KGB document, you've got to kind of - it is so redacted. I felt it was unnecessarily redacted. We have a level of expectation at local government that we make as much information available as is humanly possible, other than people's private - you know, private identifying factors or stuff that is actually commercially in confidence. Why half of those documents are redacted is - even if it is about other areas getting ambulance services, I'm unsure. And, you know, to have some of the stuff that is redacted, I don't understand why it is. So I just find that they don't like to give information and they make it as hard as possible to extract it from them.

THE COMMISSIONER: We are using the term "they", you are referring to specifically --

MS EWER: NSW Ambulance service.

THE COMMISSIONER: Not the government, being non-transparent? We're sticking with ambulance.

MS EWER: No, the department, yeah.

MR GLOVER: Can I ask you some questions about Finley Hospital?

DR CORNWELL McKEAN: Certainly.

MR GLOVER: Dr McKean, I will start with you. In your earlier answer, the consultation around that, what I might call an upgrade, at the moment, can you just describe the consultation process with the council prior to the announcement of that initiative?

DR CORNWELL McKEAN: Consultation prior to me being councillor, I'm obviously not aware of. I imagine there had been consultation with the local health advisory committee and council for some time about Finley needing some level of upgrade. I don't know any specifics about that, until we had a visit a little - well, not the one last year, but the one before, which might have been, I can't remember, six months prior to that, perhaps.

MR GLOVER: In that answer you mentioned the LHAC.

DR CORNWELL McKEAN: Yes.

MR GLOVER: What engagement does the council have with that committee?

DR CORNWELL McKEAN: The Finley LHAC actually has some very committed volunteers and we do have communications and we share information and I regularly speak with Syd Dudley who is the chair of the committee. We are working together, we were working together before, but now that we - we share concerns relating to the concept plan that has been put forward and we've been advocating together.

MR GLOVER: So do I take it from that answer, insofar as Finley is concerned, the LHAC, Finley and the council are working closely together on issues relating to the Finley Hospital upgrade; is that right?

DR CORNWELL McKEAN: Yes.

MR GLOVER: What about in other areas within the shire? Do you have engagement with the LHACs in those other areas?

DR CORNWELL McKEAN: I have never spoken to anyone from the Berrigan LHAC. I think I've spoken to one person from the Tocumwal LHAC. I've never had any formal discussions with the LHACs. We don't have an LHAC in Barooga, though, as I mentioned earlier, it's part of Murrumbidgee Local Health District, I don't know if that's an oversight or deliberate, but that's just where it's at.

MR GLOVER: Ms Ewer, perhaps you're more on an operational side of the council operation, what's your engagement with the LHACs in your shire?

MS EWER: I go to regular 19(2) meetings with Syd Dudley so I'm sort of across where people are moving and what services are being provided and all of those sorts of things.

THE COMMISSIONER: I think I know what a 19(2) meeting is --

MS EWER: I really don't know, it's section 19(2) of the Health Act, I'm guessing.

THE COMMISSIONER: Yes.

MS EWER: Yeah, so they tend to discuss, you know, what pieces of equipment need to be replaced and all those sorts of things.

MR GLOVER: That's in relation to Finley?

MS EWER: Yes, primarily in relation to Finley, yeah. And the others - I do not believe they are as active. I certainly haven't had people contact me to ask for assistance.

MR GLOVER: Has the council sought to engage with those other LHACs within the shire on issues relevant to healthcare services with its population?

MS EWER: Not as often, certainly with Berrigan, MPS a little bit lately because we've had some issues with the GP being able to service out of there, and occasionally with Tocumwal, where I - again the same thing, with the GP not being able to service out of the hospital. So those would be the times I've probably engaged with them.

MR GLOVER: For those LHACs who don't have a president like Syd Dudley, how have you found their engagement with you on those issues?

MS EWER: They're always very good, like, they're always very organised. I find the LHACs actually are very useful to engage with. You know, if there's a problem they will tell us, which is, I think, quite useful for us, but while they're going along quite well generally, yeah, obviously Syd Dudley is probably the most active of all of the LHAC presidents.

MR GLOVER: Do you think that the LHAC process, or construct, if I can put it that way, could be improved to assist you in your work - that is the council in its work - in meeting the health needs of its population?

MS EWER: As far as providing more information, that would be useful for me to know where we might need to assist. Sometimes I think they tend to - the LHAC people tend to feel that they don't want to annoy us because we've got enough on our plate, like most people, and they tend to be more of the elder - older group of people who like to do

stuff themselves. So you don't want to push yourself in because then they feel like you're taking over. So I do tend to wait until they approach us. Yeah. So that's probably --

MR GLOVER: All right. I diverted us to a bit about LHACs from your answer, Dr McKean, about consultation about the Finley upgrade, and you said you had engaged with the Finley LHAC and then I interrupted you, so please continue.

DR CORNWELL McKEAN: So Murrumbidgee Local Health District and Health Infrastructure - and I can't remember the date of this - came to council, it was before I was mayor, and they introduced to us the "How to build a hospital" diagram, and they were consulting on their clinical services plan, which they also call a health services plan. They do have a problem with consistency, which drives me crazy.

They were consulting on that. They took us through how one builds a hospital. They didn't ask - didn't really give us any opportunity to comment. It was a presentation at you, not with you. It wasn't really any level of consultation.

They subsequently put out a press release saying, "Here is our health services plan" - or, "We've approved a final health services plan. We will publish it shortly", but they didn't. We've actually had to subsequently ask for that. We didn't need to GIPAA that one, we did get that. I don't believe it has actually been published but we do have a copy of the final now.

In December, I believe it was 6 December, we had nine representatives from Murrumbidgee Local Health District and Health Infrastructure, and I believe some of them may have been some of their consultants, there were three in person and six online, and they were supposed to be consulting on the concept plan for Finley Hospital, which Syd Dudley and LHAC and the whole community was shocked at. It was not $25 million that we saw in that concept plan, and we had that meeting.

In terms of the process, again, it was not consultation. It was simply telling us what it is that they were going to do. We had that graph come up again, "How to build a hospital." Now we're here. We were there

before. And we challenged them and said, "This isn't $25 million. We would like to see your budget, please." And, "Could you please assure us that your costings have come from a suitably qualified quantity surveyor?" And they started telling us the sorts of things that might be included.

MR GLOVER: We'll come back to that in a moment.

DR CORNWELL McKEAN: Yeah, sure.

MR GLOVER: Other than you - the council that is - and the LHAC, who else was at this meeting?

DR CORNWELL McKEAN: The LHAC wasn't at this meeting, they'd had a meeting earlier in the week but we'd been having discussions among ourselves, "Well, this isn't right. What's missing? What should be there?"

MR GLOVER: So who was at this meeting other than the council and the representatives from Health Infrastructure and the district?

DR CORNWELL McKEAN: Council, council staff.

MR GLOVER: So this was a meeting just between arms of NSW Health on the one hand and the council on the other?

DR CORNWELL McKEAN: Yes. Yes.

MR GLOVER: You said in your answer a moment ago that you didn't think it was consultation.

DR CORNWELL McKEAN: No.

MR GLOVER: Why do you say that?

DR CORNWELL McKEAN: We were not given any opportunity to provide feedback. I actually had to pull up the presentation and say, "Stop now. We've got some things to tell you." And they were a bit taken aback.

One person on the video actually asked if this meeting was about Finley Hospital. They appeared confused.

MR GLOVER: Ms Ewer, were you at that meeting?

MS EWER: Yes.

MR GLOVER: Do you have anything to add to the description given by the mayor?

MS EWER: No, that's very accurate. It was very much a talking down to us, and when we - because I was at a lot of the planning meetings that we'd had with them, because Mayor Julia wasn't on council at that point, but, like, so some of the engagement that we'd had, we asked about, "What happened to all those promises" - that they had said that they would have a CT, that they would have renal care, all of those sorts of things - and they said, "Well, really, we're just providing more assistance for the people who deliver the service". They weren't focused on patient outcomes, and like we said, we've got - and we mentioned to them that we've got an ageing population, that for rehabilitation and things like that, having to travel an hour and a half both ways isn't actually going to assist them in their rehabilitation. They were quite condescending, I think would be the word I would be looking at.

MR GLOVER: In that answer you mentioned some planning meetings that occurred before the mayor's election?

MS EWER: Mmm-hmm, yeah.

MR GLOVER: Can you describe what those meetings were?

MS EWER: They were actually really good, the two I attended, because I helped facilitate them. They were about what services the staff - not the staff, sorry, the community wanted, and the community didn't want, like, extra beds or any of those sorts of things, that is not what they were asking for. They were being very - and even they commented on how considered and practical the Finley community were. They were looking for renal services, rehabilitation services, telehealth with a connection that actually worked, because rurally, once you are outside of Finley, there is no connection, so to be able to come into the hospital and actually have telehealth there, and some mental health space. They weren't asking for the world. So then to receive something that is little more than maintenance has been very upsetting for the community, because they actively engaged in that whole process.

THE COMMISSIONER: Just stopping there, the meetings Mr Glover asked you about, which he called planning meetings --

MS EWER: Mmm-hmm.

THE COMMISSIONER: -- which occurred before the mayor's election --

MS EWER: Yes.

THE COMMISSIONER: -- these are before the government, which would be the previous state government, announced there would be a $25 million redevelopment of Finley Hospital?

MS EWER: Just after. Just after the $25 million announcement.

THE COMMISSIONER: Okay, so that's been announced?

MS EWER: Mmm-hmm.

THE COMMISSIONER: And then these meetings are to discuss the form of that redevelopment?

MS EWER: That's correct. And to develop the clinical services plan. That was the whole point of it.

THE COMMISSIONER: And chronologically, the other meetings you were talking about or the meeting you were talking about, then, when Mr Glover asked Dr McKean about consultation, was at a later time?

MS EWER: Correct, yeah.

THE COMMISSIONER: Had the plans of the redevelopment already been released at that stage, and the nature of the health services that would be provided?

DR CORNWELL McKEAN: For the second meeting in December? Yes. The earlier one must have been around the same time as the clinical services plan was being developed.

THE COMMISSIONER: Are we talking December 2022 or 2023?

DR CORNWELL McKEAN: 2023.

THE COMMISSIONER: So just a few months ago?

DR CORNWELL McKEAN: Just recently, yes.

THE COMMISSIONER: Thank you. Sorry.

MR GLOVER: So going back to the earlier meetings that you were at, from a consultation perspective, are they more in the nature of the consultation that you would expect to have occurred?

MS EWER: Yes, the original meetings were much more a consultative platform where people actually got to engage and talk about - and they wanted to hear the stories of the community, what it's like to have a baby out there that needs special care and you need to drive backwards and forwards with it. So they were very genuinely engaged at that point. After that, that's when it's definitely --

MR GLOVER: Do I understand the concern, at the time that it came to be presented what was occurring, was there was a disconnect between what had been discussed at the what you describe as planning meetings or whatever label they had and what was presented to you - that is the council - at the meeting which the mayor has referred to; is that right?

MS EWER: Correct. It's very much like, "The decision has been made. Now you just have to deal with it."

MR GLOVER: Do you have anything to add to that, Dr McKean?

DR CORNWELL McKEAN: One of the points that was made at that meeting in December was that the health services plan is about services and that the concept plan is about infrastructure - and this is when we challenged the lack of CT and renal services being included in the so-called upgrade - and, therefore, they don't need to deliver on the health services plan because that's service, not infrastructure. So I don't quite understand how that can be part of the same diagram and there'd be a disconnect.

The other point that we did make at that meeting is that the emergency department at Finley Hospital had a refurb in 2019, and we couldn't understand why it needed

another one now, and there was a lot of talk about clinicians' requirements and that the clinicians had seen this and they had seen that, and what-have-you. And there were two things I asked them. The first one is, "Surely, without building anything, you can consider what operational efficiencies you can put in place?" And I am on the board of Goulburn Valley Health and I know that they have done exactly that. They have had a look - make sure the trolleys are closer, IT is closer, just little basic things to save minutes. "Why aren't you doing that?" Didn't get a straight answer at all.

When they kept talking about clinicians and clinicians, I actually got a little bit upset and I said, "I really don't like your vernacular. You're not talking about patients or patient outcomes or service delivery for patients. You're talking about making life easier for the clinician." Of course, that's important, but it's not number 1. The patients need to be number 1. And that I really found quite troubling.

MR GLOVER: After the meeting that you have described, was there any more engagement or attempts at engagement by the council with NSW Health about the Finley upgrade?

DR CORNWELL McKEAN: Yes. So they - we received a response, a joint response from NSW Health and Health Infrastructure in - I think it was 18 December, following the meeting. In the meantime, we had written to Minister Park to tell him how appalled we were by that meeting.

In the first letter from health and infrastructure, they indicated that they weren't going to give us the budget; it was commercial in confidence. In the letter that subsequently came from Minister Park, which curiously had the same language throughout, we were also advised that the budget was commercial in confidence.

MR GLOVER: Can I perhaps try to draw the two examples together? You tell me if I've got it right or wrong.

DR CORNWELL McKEAN: Mmm.

MR GLOVER: In both examples you've given some evidence about it being the ambulance issue in Tocumwal and the upgrade in Finley. The concerns you're raising are a lack

of information flow from NSW Ambulance or NSW Health to you as the council in relation to those two issues; is that right?

DR CORNWELL McKEAN: Yes.

MR GLOVER: And a lack of responsiveness to your requests to information; is that right?

DR CORNWELL McKEAN: Yes.

MR GLOVER: And a feature of that latter concerned the need for the council to resort to processes like GIPAA to access information the council feels it needs to meet the needs of its residents; is that right?

DR CORNWELL McKEAN: Absolutely.

MR GLOVER: For the benefit of the transcript, you have been nodding, but do you have anything to add to those answers given by the mayor?

MS EWER: Sorry. Yeah, the - I mean, the Finley GIPAA, the Finley Hospital GIPAA that we've had, has been delayed considerably. They haven't provided the normal process that you normally go through where they would write a letter say that they've accepted it, this is when it's due. I've actually had to follow them up on a number of occasions and it's now not due back to us until 29 March, even though we put it in in January, and they've charged us $1,500 for the pleasure of getting budgets which should not be - I do not believe - will not take them 38 hours to find where their budget is.

THE COMMISSIONER: When you say "budgets", we know $25 million has been committed for the redevelopment of Finley Hospital, this is, what, for a break-down as to how that is going to be spent?

MS EWER: We want to understand how what the concept plan looks like - how that is $25 million. Where has that money been spent, if it's no longer there?

THE COMMISSIONER: Or is going to be spent?

MS EWER: Yes.

THE COMMISSIONER: Okay. And the commercially confidential bit of that is what?

MS EWER: We're not sure why a budget would be commercial in confidence. We have to publish ours every day.

THE COMMISSIONER: Okay. We went to Finley Hospital last week, the Inquiry team and also people from NSW Health, and there were clearly - some of the rooms there were from the 19 - you know, post war, 1950s.

MS EWER: Absolutely.

THE COMMISSIONER: As I understand it, those rooms are going to be upgraded to modern hospital rooms. Do you know what else is being done at the hospital, by way of redevelopment?

MS EWER: Very little. It really looks much more like maintenance. I think Julia in her position on GV Health is probably better able to answer.

THE COMMISSIONER: Is that why you are using the term "so-called upgrade"?

MS EWER: Yes.

DR CORNWELL McKEAN: Yes. We actually think they might have spent a good amount of that money already with all those consultants who are turning up at meaningless meetings.

THE COMMISSIONER: Okay, all right.

MR GLOVER: In an earlier answer, Dr McKean, you mentioned that one of the features of the shire is its proximity to the Victorian border. Does that pose any complexity in the delivery of health care services to the residents of the shire?

DR CORNWELL McKEAN: It does, though I don't think it should.

MR GLOVER: In what way does it, firstly?

DR CORNWELL McKEAN: Well, for example, there have been times when the Victorian government, for example, have said

that particular services, JEV vaccine, are only available to residents of Victoria, and that means, for example, a Barooga resident, technically, would not be allowed to attend Cobram and get one of those vaccines.

Arrangements were made during the pandemic in relation to COVID vaccines and testing, so that worked okay.

In terms of advocacy in the shire, you know, we've met with Murrumbidgee Local Health District with the area person. That role seems to change quite often. I don't think the person we met with is currently in that role. They told me about the towns we have in Berrigan Shire being Berrigan, Tocumwal and Finley, and I said, "I think you forgot Barooga." And the fact is basically Murrumbidgee Local Health District does not advocate for Barooga. They do not provide anything to Barooga. We did have one bus come for COVID testing during the pandemic.

The complexity I find with this is the Victorians - and nor should they - are not going to advocate for the people of Barooga, but neither is Murrumbidgee Local Health District. So we're stuck with really no representation, and that actually was the reason why I applied to get on the board of Goulburn Valley Health, because I know that's where we will go and get our health services and we would at least have one person on our side.

MR GLOVER: Can I just break that answer up a little bit?

DR CORNWELL McKEAN: Sure.

MR GLOVER: You referred there to a vaccine only being available to residents of Victoria. To your understanding, was that because the delivery of that vaccine was being funded by VicHealth?

DR CORNWELL McKEAN: I believe it was a directive from the Department of Health but I don't believe it was actually complied with.

MR GLOVER: Then you raised some particular issues about Barooga. One of them was a lack of engagement from the health district about the needs of that town.

DR CORNWELL McKEAN: Yes.

MR GLOVER: What steps has the council taken to engage the district in relation to the needs of the residents of that town and its surrounds?

DR CORNWELL McKEAN: I'm president of the Barooga Advancement Group and when you have an opportunity you take an opportunity, so in August last year when we were meeting Minister Park, I delivered him a letter from the community outlining our concerns about the lack of advocacy from Murrumbidgee Local Health District.

MR GLOVER: When you say "lack of advocacy", what do you mean?

DR CORNWELL McKEAN: Well, those issues, for example, where there were holes in Victoria, where they weren't - you know, if we needed particular things, when we had the issues with the mosquitoes and Japanese encephalitis, we were hearing a lot in terms of advocacy for other towns of Berrigan Shire but not for Barooga because no services were actually actively being delivered.

It's more about - when I talk about advocacy for Barooga, it's about availability of services, service delivery, making sure we've got access to GPs, patient transport, all the things, but nobody actually has taken responsibility to say that town needs someone to speak up for them.

MR GLOVER: When you say "nobody", are you speaking of nobody within the LHD?

DR CORNWELL McKEAN: Health district. Yes, they did actually come to a meeting with the Barooga Advancement Group. It was very cordial, but we talked at length about the fact that Victoria services us, and they did say there was maybe potential for services in the future - transport, for example, if you had been in hospital in Shepparton and you needed transport to and from the hospital; in-home care. But the short story from those in attendance was "Well, the hospital sorted that out for us anyway and the Victorians are supplying and you didn't check."

MR GLOVER: Are there any other features of the proximity to the Victorian border that give rise to complexities in the residents accessing the healthcare services that they need?

DR CORNWELL McKEAN: There is also the issue of the incentivisation for students to study in nursing and other medical courses. So Victoria offers an incentive, but if you take up that incentive, you need to work in Victoria. New South Wales has a similar incentive scheme. The difficulty is that a lot, 60 per cent, in fact, of students - this is high school and primary school, I imagine it extends actually higher - in Berrigan Shire actually study in Victoria, but they may actually want to come and work at Finley Hospital, for example. So it's actually become a disincentive. They don't want to be forced to work in Victoria or they don't want to be forced to work in New South Wales.

MR GLOVER: What you're describing are incentives given by the Victorian government to study nursing?

DR CORNWELL McKEAN: Yes.

MR GLOVER: But that is tied to employment within the Victorian health system; is that what you are saying?

DR CORNWELL McKEAN: That's correct, and the same applies with New South Wales. There's no cross-border arrangement to - yes.

MR GLOVER: To your knowledge, is there a difference between the incentives offered between Victoria and New South Wales?

DR CORNWELL McKEAN: I believe both are HECS payments being waived. I don't know if there's anything additional. I don't think there is a financial but I wouldn't swear by that. But I do know there is a requirement to work in the respective state.

MR GLOVER: The issue you're raising is that a large number of students from within your shire actually end up studying in Victoria and then may be lost to the New South Wales system by those incentives; is that the issue you are referring to?

DR CORNWELL McKEAN: They could be lost but instead they don't study nursing or any of those particular courses that might have the subsidies at all.

MR GLOVER: Ms Ewer, did you have anything to add to those answers - that is, around the features of the proximity of the shire to the Victorian/New South Wales border?

MS EWER: We do have some evidence where people in Cobram, because the emergency room in Cobram is actually a paid emergency room, it is a private venue, will get themselves to Finley in an emergency so that they go through the free system and go back to Shepparton. So we're aware that that puts more pressure on the Finley emergency room, and that's - yeah, and then that's also the other reason, with the education, while we're trying to get a country university centre in Finley so that we can support getting more nurses and doctors and things like that, so they can train at home.

MR GLOVER: One of the threads that has run through the evidence you've both given today is the engagement between the council and NSW Health, NSW Ambulance and the district.

Ms Ewer, if I can start with you, what would you like to see done differently so that the council may better engage with each arm of the New South Wales health system?

MS EWER: I'd like them to be honest. We're not trying to catch them out in anything. We're just trying to advocate for our community. So making it as hard as possible doesn't lend us to trust that what they're, saying is, in fact anything to do with our community.

MR GLOVER: More open lines of communication; is that what you have in mind?

MS EWER: That would be very nice.

MR GLOVER: And more free-flowing exchange of information?

MS EWER: Yes. I think to the level that local government is expected. I don't understand why it has to be so difficult to get information from a state government agency.

MR GLOVER: I take it - is it the case that if there was truly confidential information, the council wouldn't have any difficulty in maintaining that confidentiality; is that right?

MS EWER: They have a code of conduct that requires that none of us can divulge confidential information. There are penalties for doing so.

MR GLOVER: Dr McKean, do you have anything to add to that answer?

DR CORNWELL McKEAN: I think Ms Ewer is a hundred per cent correct. I think that we just want genuine engagement. Look, frankly, sometimes I feel we get treated like we're country hicks. They don't expect us to actually be educated people who want to represent our community. They don't buy into - and I'm going get technical here, into the quintuple aims of health care. It's so important that health equity is available to regional areas and every day of the week, we will make sure that we represent our community in relation to health equity and making sure that we are making inroads to achieve it. So I think they need to be accountable and genuine and know that we mean business.

MR GLOVER: In that answer you referred to "the quintuple aims of health care". So we're all on the same page, can you tell us what you have in mind?

THE COMMISSIONER: Equity sounds like one.

DR CORNWELL McKEAN: I always saved this earlier because I thought I always miss one. So the quintuple aims, it's a focus on health equity; clinician wellbeing; the pursuit of better health; improved outcomes; and lower costs.

So it looks at the economics of preventative medicine as well as making sure that people who are unwell have improved outcomes, and that health equity piece. The two newest pieces are health equity and clinician wellbeing. Previously it was the triple aims.

MR GLOVER: Those are some areas for improvement. In the current climate, does the current way in which any of the arms of NSW Health engage with the council - I'll start with you, Ms Ewer - affect the ability of the council to meet the needs of its residents?

MS EWER: I don't believe that they are aiming for health equity. I believe that it is all about the cost.

MR GLOVER: Dr McKean?

DR CORNWELL McKEAN: I agree. They are going through the motions, that's it.

MR GLOVER: Thank you, Commissioner. That's all I have.

THE COMMISSIONER: Mr Chiu?

<EXAMINATION BY MR CHIU:

MR CHIU: I might just start with the issue about the Finley Hospital $25 million upgrade, as it were.

Ms Ewer, you referred to an earlier process after, I think, from late 2022 onwards, where there was consultation.

MS EWER: Mmm-hmm.

MR CHIU: Is that correct?

MS EWER: Yes.

MR CHIU: As I understand it, there were about four sessions or four meetings involving the local council?

MS EWER: Yes.

MR CHIU: And were you aware that besides those four meetings, there were also a number of other meetings with other interest groups in the community as well?

MS EWER: Certainly. I attended quite a few of those meetings.

MR CHIU: Yes.

MS EWER: And you thought that those planning meetings, as it were, were actually quite constructive in terms of discussion about what was needed?

MS EWER: They were.

MR CHIU: And the meeting which you were not so enthusiastic about was the recent meeting in late last year; is that correct?

MS EWER: The last two meetings.

MR CHIU: The last two meetings

MS EWER: Yes.

MR CHIU: Is that around the time that an early design was released, in November 2023?

MS EWER: Yes.

MR CHIU: And as you understand it, that early design, I understand your complaint is, or your concern, if I might put it that way, is that the earlier design didn't seem to reflect a spending of $25 million?

MS EWER: Correct, but it --

MR CHIU: That was one concern?

MS EWER: Yes, but it also did not address the clinical service consultation that we had had.

MR CHIU: Indeed. And were you also aware that, as part of release of this early design, the local health district invited stakeholders like yourself to provide written responses?

MS EWER: I did not know they asked for written responses, no. I would have certainly put in a submission.

MR CHIU: That, in fact, right now, they're in the process of collating responses to that early design?

MS EWER: No, they didn't let us know that in the meeting, certainly.

MR CHIU: Are you aware that there's going to be, after - well, that there's going to be --

THE COMMISSIONER: When is the deadline for submissions?

MR CHIU: It's imminent, Commissioner, I believe.

THE COMMISSIONER: Imminent?

MR CHIU: Yes. I might have to seek some further instructions about that.

THE COMMISSIONER: Can you put in a submission online? I'm asking you too much detail.

MR CHIU: I don't know the answer to that.

THE COMMISSIONER: Don't worry.

MR CHIU: I'm really on the run with this.

THE COMMISSIONER: Yes, that's all right. We're still getting submissions for this Inquiry.

MR CHIU: I'm still getting instructions as we speak.

As part of that process, the plan is that there would be a further design to be provided to be released to community later in 2024; were you aware of that?

MS EWER: No.

DR CORNWELL McKEAN: I did know it was a concept plan and it wasn't a final plan, so I was aware that we would receive something further.

MS EWER: But we're not aware of the - they didn't make us aware of those matters in those meetings that we've had with them and I haven't received any - normally you would receive an information in your email system that says - you know, to invite you to put submissions in, so I get them from lots of other places, so no.

MR CHIU: I will certainly follow that up. Was there any discussion as to the reasons why the budget, as in the break-down of the money being spent, might be commercially in confidence, such as, for example, it hadn't gone out to tender yet?

DR CORNWELL McKEAN: There's a reference in both of the letters of something about - I can't remember exactly - that some line items might be too detailed. I can't remember exactly. But it was in both of the correspondence from Minister Park and from the health service.

MR CHIU: So you specifically requested the budgetary

information from Minister Park and that was declined --

DR CORNWELL McKEAN: Yes.

MR CHIU: -- from the minister?

DR CORNWELL McKEAN: Yes, and we've subsequently done a GIPAA for it, yes.

MR CHIU: And that GIPAA hasn't come back yet?

DR CORNWELL McKEAN: No.

MR CHIU: I take it you intend to continue to be engaged in this process, despite your disappointment at the present time?

DR CORNWELL McKEAN: I think it's important.

THE COMMISSIONER: I just found this online. There's a survey for the community which was open until 6 December last year. Is that what you are referring to?

MR CHIU: I don't believe that's what I'm referring to.

THE COMMISSIONER: A different thing, okay.

MR CHIU: Commissioner, because I'm dealing with this somewhat on the run --

THE COMMISSIONER: No, and I'm completely sympathetic about that, don't worry about that.

MR CHIU: I'm hoping to put what's necessary to the witnesses but then obtain some further evidence.

THE COMMISSIONER: Of course, yes. No drama at all.

The document I'm looking at actually anticipates construction starting this year, which, if that's the case, would anticipate planning approval fairly soon, I would imagine.

MR CHIU: As I understand it, there's no planning approval as yet.

THE COMMISSIONER: There's not?

MR CHIU: There's not. And by "construction this year", I don't know whether that means --

THE COMMISSIONER: Local councils must move - oh, I suppose - well, I don't know who --

MR CHIU: That could mean December.

THE COMMISSIONER: Who is the consent authority, the council or the --

MR CHIU: It would be the local council.

THE COMMISSIONER: Anyway, sorry to distract you. I was just seeing if I could help. I probably just made it worse.

MR CHIU: Thank you, Commissioner.

If I could just ask you both now the other topic about engagement with NSW Ambulance. Again, I'm just trying to clarify the history of the engagement. In July 2020 the minister met a delegation from Tocumwal to hear the request for an ambulance station.

DR CORNWELL McKEAN: I don't know if it was July. It was 2020. It was the pandemic - I understand that a representative actually came to Tocumwal that year and there was a subsequent meeting with the ambulance committee. But I don't know the precise date.

MR CHIU: I think we might be talking about separate events. There was an ambulance delegate that came to Tocumwal.

DR CORNWELL McKEAN: Yes.

MR CHIU: And separately there was a delegation that went to the minister.

DR CORNWELL McKEAN: That's correct.

MR CHIU: Ms Ewer, you were around then and --

MS EWER: No, well, I wasn't. I was 2021. I have rightly been told I started in 2021, in June. No, they did

definitely have a delegation to the minister. We know that because of the lovely comment that was made to us as we came up the stairs.

DR CORNWELL McKEAN: And I met with the committee just last week and we were talking about the dates and trying to work out what month it was. So it definitely occurred about the time of that minister's report.

MR CHIU: I don't think it's critical.

DR CORNWELL McKEAN: No.

MR CHIU: Do you recall - I think this might be directed at you, Ms Ewer, because you were around at the time - that one of the reasons given at the time for not providing that ambulance station in Tocumwal was that NSW Ambulance had done a service planning process to determine need? Do you recall that, first of all?

MS EWER: That's what the report said, yes.

MR CHIU: And then did the report also explain that they look at gaps in current demand coverage, including data on the number of 000 calls?

MS EWER: Yes.

MR CHIU: And what they found was that, on average, 450 calls originate from the Tocumwal area each year. Do you recall that, the 450 calls?

MS EWER: I've heard that in the budget estimates recently. I had not heard that previous to then.

MR CHIU: Okay. And that only about half of those required a lights and sirens response. Again, that's not something you have specific recollection of.

MS EWER: We didn't actually receive the report - council did not receive the Minister Hazzard report until a year after it was published.

MR CHIU: That was one of the things --

DR CORNWELL McKEAN: I am familiar with all those statistics, and the regrettable thing is the data gets

mixed up by financial year and calendar year so nothing quite matches, but I've heard all of - you know, of various numbers around that.

MR CHIU: So as part of the consultation process, one thing that could potentially be improved is the presentation of the data to assist you understand it?

DR CORNWELL McKEAN: Definitely.

MS EWER: Absolutely.

MR CHIU: And again, this might be directed at Ms Ewer because it's 2020: in the meeting, or at least one meeting, maybe more meetings at the time, was there a discussion about how they reached that decision, prioritisation of different ambulance stations?

MS EWER: I wasn't at the 2020 meetings.

DR CORNWELL McKEAN: We did have a meeting last Friday where this was discussed and we were told that Tocumwal was about 20th on the list. We were taken through a whole range of different demographics on these matters.

MR CHIU: I take it you don't know one way or the other whether that same discussion had occurred previously to last Friday?

DR CORNWELL McKEAN: Various words around that were in that report and correspondence, and the subsequent GIPAA.

MR CHIU: If I were to suggest to you that between January 2023 and last Friday, there had been, in fact, four meetings where this issue was discussed, does that sound correct to you?

MS EWER: Not between December and January.

MR CHIU: Four meetings since 2020?

MS EWER: Since 2020? Three of those would be with us - two of those, three of those? I don't know.

DR CORNWELL McKEAN: Two with us. I don't know about anything else.

MR CHIU: Last Friday when you had this meeting and the CERT was raised, was one of the issues that you need to find quite a large number of volunteers to be able to provide that?

THE COMMISSIONER: I think you said eight.

DR CORNWELL McKEAN: Eight, yes.

MR CHIU: It's eight volunteers. Is that something that the community in Tocumwal would be able to provide?

DR CORNWELL McKEAN: I expressed serious doubts.

MR CHIU: In terms of the outcome of the meeting last Friday, first of all, you received some information; is that correct?

DR CORNWELL McKEAN: Yes.

MR CHIU: You were not happy with the information you received in terms of whether it was adequate?

DR CORNWELL McKEAN: The meeting was most cordial. It was the most cordial meeting that we've had in relation to any health issues in recent times. It was very polite conversation. I asked for the statistics on - we were given some rough numbers, because the person who was there, who was the numbers person, had had a look and said something like, "Maybe 17 minutes" - it was all a bit vague. And then I said, "Can you give me that data", and then he said, "Oh, I'm only obliged to give you SA3", and I said, "Don't worry about it, I'll GIPAA it".

MR CHIU: Did you also say at the conclusion of the meeting that regardless of the data, this is something that you and your community believe they will need and will continue to push for?

DR CORNWELL McKEAN: Yes.

MR CHIU: No further questions.

THE COMMISSIONER: Thank you. Did anything arise out of that?

MR GLOVER: No, Commissioner.

THE COMMISSIONER: This is for you, Mr Glover, I think at first. There has been a series of answers that have raised whether the questions included information like the report provided by Minister Hazzard, correspondence redactions - I take it none of that material is in the tender bundle yet?

MR GLOVER: Not at the moment.

THE COMMISSIONER: What will we do about that?

MR GLOVER: There's a list, as I understand it, being compiled, and we will acquire it, to the extent relevant, through an appropriate process.

THE COMMISSIONER: It's being followed up?

MR GLOVER: Yes.

MR CHIU: Commissioner, I could perhaps assist. A statement is being prepared from NSW Ambulance which will contain all of this material and the entire background and I will speak with my learned friend about that.

THE COMMISSIONER: Very good. Thank you for that.

MR GLOVER: If my friend takes it on, all the better.

THE COMMISSIONER: Thank you very much both for your time. We are grateful and you are excused.

<THE WITNESSES WITHDREW

THE COMMISSIONER: For the next witness, first of all, how long do you anticipate they will be?

MR GLOVER: Mr Muston is taking them.

MR MUSTON: I think --

THE COMMISSIONER: I won't hold you to it.

MR MUSTON: No, I think a higher authority might hold us to it because I'm told that we can't sit on.

THE COMMISSIONER: We can't?

MR MUSTON: That's what I'm told.

THE COMMISSIONER: I just saw that, so - a few minutes, all right. I'll just check with the people who are assisting us from Epiq. Is everyone all right without a break? (The court responded in the affirmative). Well, we'll just do what we can in the time left today.

MR MUSTON: I can guarantee to those who are recording it that I won't try to fit it in by making sure that we speak fast.

I call Adrian Lindner.

<ADRIAN KEITH LINDNER, sworn: [3.31pm]

<EXAMINATION BY MR MUSTON:

MR MUSTON: Q. Could you state your full name for the benefit of the record?
A. Adrian Keith Lindner.

Q. You are the interim chair of the Murrumbidgee LHD board?
A. Correct.

Q. How long have you held that role?
A. Currently it's probably two months. Previously I did a six-month term and then I was deputy chair for a period before then.

Q. How long have you been on the board of the LHD?
A. This is my eighth year.

Q. Cutting right to it, what do you see as being the key functions of the board? Putting to one side what the Act says and the like, in a practical sense, what do you see as the functions of the board?
A. I believe it is effective corporate and clinical governance. That's probably the two key areas.

Q. And how does the board - or do you as its chair - go about pursuing that objective?
A. Okay, we have a number of subcommittees that specialise certain areas.

Q. What are those subcommittees?
A. There's health care safety quality committee, planning resource and performance, audit and risk committee, there's Aboriginal health and wellbeing committee. We have a working group, it's a committee with the PHN, that's a new one that we have started.

Q. Do you, as chair, sit on any of those committees?
A. We've just had a revamp of our membership. We're trying to get more specialised membership of those committees. So I'm on the planning resource and performance committee and the PHN working party group. There is also the Murrumbidgee Health and Knowledge Precinct. I'm - actually, that's another one, that's a new one that I'm on. I'm not a formal member of the health care safety quality committee now, but I will be attending as chair.

Q. So going through each of those committees, could you just give us a brief description of what each of those subcommittees feed in to the board?
A. Okay. The healthcare safety quality committee is the clinical governance key one, and a lot of our work that we do is looking at metrics that come to the board. We're looking at --

Q. Just pausing there, where do those metrics come from?
A. From - management give us reports and we have certain reports during the year and then there's always a monthly or, sorry, every two months, this committee meets, so bi-monthly there's set data, every time it could --

Q. Just dealing with that, the healthcare safety and quality subcommittee, what do the metrics relate to?
A. Well, every meeting, there's always healthcare acquired complications, so, for instance, it could be infections in health, in health care; it could be falls; it could be delirium. We also look at sentinel events or harms to patients while in care. And then every few months we might have a particular focus on an area of our health services - it could be cancer services, it could be renal, it could be aged care.

Q. And what does the subcommittee do with the information once it has collected those metrics?
A. Okay, we look at the data and when - we'll look at, like, trends, it could be that could indicate particular

facilities might be experiencing an issue that is abnormal and we might raise that with management and ask questions about, you know, what's happening, for instance. There might be a higher incidence of falls at one facility and they'll --

Q. Just to be clear, having had one of those irregularities, if I can call it that, drawn to the subcommittee and the board's attention, do you see it as the board's function to come up with a solution to it or is it more you then look to management of the LHD to explain what they see as the cause of the problem?
A. Exactly.

Q. And what they're doing about it?
A. Yeah. No, we don't come up with the solution. We basically highlight this as a problem and we ask management for an explanation and they might - they're probably already aware, because they're providing the data into the report anyway, and so it triggers an alarm for them as well, and so then when it does come to the board often they're prepared with an answer, you know, with a good explanation. Sometimes, if we're --

Q. Just pausing there, is there a follow-up, then, on whether or not the answer they've given you in future reporting periods has provided effective solution?
A. Yeah, correct, yeah. If we're not satisfied with the answer they have given, we'll ask for what we might call a "deep dive", where they have to come back to a future meeting and there's an action item, so that it's followed up, and they come back with a more detailed explanation, and then we will track that metric in future statistics.

Q. I think we can infer what the audit and risk subcommittee does. Moving to the next one, I think that you listed, the planning, resources and performance subcommittee --
A. Correct.

Q. -- what's the function of that subcommittee?
A. Yeah, it's - looking at all the finances of the district is probably a key area there, and then the performance. And by "performance", we're talking about volume of activity, so we often have targets that we have to meet through inpatient activity or mental health admissions.

Q. When you talk about activity there, is it activity which is recognisable for the purposes of activity-based funding or is it - are you using "activity" in a more general sense?
A. In a more general sense for this, yes.

Q. So what is it that that committee is looking to measure through that information?
A. Well - yeah, well, it might look at, for instance, emergency departments. There's been quite a spike in recent time with the number of people presenting in our ED departments, and again, we might look at the facility by facility and obviously, you know, Wagga Base Hospital is our biggest hospital, and that will - has often been, you know, a high one, but we've noticed in recent times in the more remote areas, the smaller hospitals, that ED presentations have increased as well. And part of that is because of the - I think the breakdown of the GP primary care service. So people are finding they can't get in to see a GP or there's no GP in the town, and so they're presenting to ED for that primary care.

Q. Do you see the board as having a role in trying to find solutions to that problem within the primary care setting?
A. Yes.

Q. What is that role?
A. Well, I think it has sort of been mentioned, about the employer-led GP training, which we sort of pioneered in this district and now it's been rolled out around the state, because we saw that there was a need out there. Like, we need GPs as VMOs in our health facilities, but also the communities need the GP to service their primary care, and we're just finding there's - you know, there are too many gaps and there are retirements or departures that aren't being filled, and I guess one of the other initiatives that we've been doing - and it was in my statement - is collaboration with the primary health network, which has primary responsibility for primary care, being federally funded, and us being state funded - you know, the two silos need to come together, to work together.

Q. I think you mentioned earlier that there's a new subcommittee which has been formed as part of the board --

A. Correct.

Q. -- which is aimed at collaborating with the PHN?
A. Yes.

Q. While we're on that, how does that collaboration operate in a practical sense?
A. Yes. Well, it started in 2022 and the two boards got together with executive staff and we realised, you know, as a health system we are one. You know, public, they don't differentiate between what's state funded, what's federally funded, this primary versus hospital care, you know, they just want a seamless service.

So we looked at ways we could collaborate and we've signed a new agreement last year, and so collaborative commissioning - you've probably heard that mentioned a few times - that's one of the areas, and that could include things like a diabetic strategy, for instance - you know, the patients will come in to us, but if we can go upstream and say we need better screening, we need better services in the primary care setting to educate people to - well, it could be to do with cardiac issues, if people are screened, and if the primary care is done better, then it takes pressure off our hospital system.

Q. So one of the other subcommittees, I think, is a medical and dental appointments advisory committee?
A. Yes.

Q. What's the function of that subcommittee?
A. Appointment and review. I don't have a lot to do with it. The board doesn't have representation on that. We have appointed our director of clinical governance and director of medical services on that committee.

Q. So what does that appointee feedback in to the board from their involvement?
A. We do get an annual report from them.

Q. What does that report tell you in general terms?
A. Just - well, it's overall more governance and it's really just, you know, the comings and goings, any issues during the last year.

Q. Comings and goings and issues with what?
A. Oh, with any of the credentials of any of the medical

appointments, if there was any that, you know, had to leave for certain reasons.

Q. We're at cross purpose. My understanding of "appointments" was a different one to that. So we're not talking about appointments that you make and attend; we're talking about appointments, as in an appointed clinician?
A. Correct, yes.

Q. And I think the last one you referred to was the Aboriginal health and wellness subcommittee?
A. That's right. That's a new one.

Q. What do you see as the function of that subcommittee?
A. Well, particularly as, you know, there is a strong focus that the Ministry of Health has to improve the health outcomes for Aboriginal people, "Closing the Gap". We feel that, as a committee, just solely focused on the Aboriginal health and wellbeing, and we have two of our board directors who are Indigenous, which is a very high proportion of our - percentage-wise, of our eight, only two, so we're very pleased to have strong representation there, so they will be on that committee, I will be attending, and another board member.

We're only just starting that committee, so I can't really speak too much about it at this stage.

Q. So what is it that you hope that that subcommittee will feed in to the board in terms of information and direction?
A. It will look at how our strategies are going, the "Closing the Gap", and just, you know, are we getting the traction that we should be in Aboriginal services.

Q. How is that subcommittee going to go about assessing that performance against objective?
A. By, yeah, reviewing reports and looking at the metrics. At the moment, the board gets a number of metrics, which I think will be going to this committee in future. For instance, one of the items that we see regularly is the unplanned discharge of people from their health care. Indigenous people have a high proportion of unplanned discharge, and it's chiefly around the renal area, and so we're looking at how --

Q. When you say "unplanned discharge", do you mean

self-discharge?
A. Correct, yeah. For instance, say if a renal patient came in and they should be in the renal clinic for a certain period of time - could be hours - sometimes, you know, they will cut that short and they will leave, and particularly it's a sensitive issue with Aboriginal people. We need to have the right atmosphere and just explain the reasons of why you need to be there for the full course of that treatment, but it's an ongoing process, that sort of explanation and training.

Q. To what extent does the board interact with or engage with the Aboriginal community controlled health organisations in relation to the particular issues we're talking about now - that is, the advancement of First Nations health?
A. We have a director of Aboriginal health that reports directly to our chief executive, and that's only probably in the last 12 months it's been elevated to that level. It was previously a manager level, but it was something the secretary of the ministry was very passionate about and it was advocating that Aboriginal leadership needs to be elevated in the executive of our districts, and so that role will certainly have a lot more leadership and gravitas, I guess, to do more connections with our - the rest of our services.

Q. So do you know the extent to which that individual engages with the ACCHOS?
A. Sorry with the?

Q. Aboriginal community controlled health organisations like RIVMED?
A. That I don't know. I'm not sure. Like, you mean the Aboriginal medical centres in the --

Q. Yes.
A. That I'm not sure.

Q. So coming back to my question, are you aware of any direct engagement between the board and the Aboriginal medical centres?
A. We don't have any direct relationship with them. We get a report through the director of Aboriginal health services, which will detail the scope of our services and whether we're reaching our KPIs. So that's probably - what you're talking about is probably more the operational level

between our Aboriginal health team and the medical centres.

Q. You're aware that a substantial amount of the health care which is delivered to First Nations people is delivered through organisations like the Aboriginal medical services across the LHD?
A. Mmm - yeah.

Q. Are you aware of that?
A. Yeah, but we - we don't get any reporting or any metrics from those individual medical centres.

Q. Do you think it would be useful from the point of the board's objectives for there to be some more direct level of engagement between the board and those entities?
A. Yeah, I believe so, and I think this new governance wellbeing committee that we're starting, that is probably one area that we can certainly, you know, bring in to that committee.

Q. Do you think that a slightly closer engagement with those Aboriginal medical services might assist you - you, the board - in developing an understanding of the particular needs of that community within the wider LHD?
A. Oh, yeah, I agree.

Q. Putting that to one side, how else do you, as chair, go about familiarising yourself with the wider LHD and the needs of - health needs of the community that exist within it?
A. One of the roles I do is with our chief executive, we visit every single facility during the year, and we will visit the facility, I guess, view it, its infrastructure, its services, but importantly meet the staff, meet some of the patients and get a bit of a feel, you know, for the vibe of the place.

We'll also then sit down with the LHAC representatives, often the chairman and a few others, whoever wants to come. Then we also invite along the local mayor or general manager or their delegates, and it's really a two-way discussion. We will talk about the services we're providing and elaborate on what we plan to do for that community. But in return, they will feed in to us and talk about their concerns or their issues, and probably one of the big ones - and I think you've been hearing it in this hearing - is the workforce issue.

We see working with LHACs and the councils as a great way of partnering with our local communities to address that workforce issue. For instance, you were talking earlier about Finley. One of the things that Syd Dudley does, the chair of LHAC, is every new staff member who arrives at work, he will turn up on their first day and he will give them a briefing, you know, about the town, the services, what to do, what not to do in the town, and just really give a warm welcome to them. And we've sort of taken that to our other LHACs to say, well, let's develop a welcome package for new staff, you know, because we're very much wanting to retain them.

The other thing at Finley is that we have spoken to council about critical worker accommodation and they've proceeded to get accommodation that we can use for, say, nurses on short-term basis. Rental accommodation is very hard to find in a lot of our small communities, it is either expensive or just not possible. So by us engaging with councils at our visits, we often find we can get their support to establish things like this, you know, critical worker accommodation.

Q. In relation to the recruitment of workers in some of these particularly more remote hospitals, can you just explain, at least insofar as you're aware of it, who is responsible for the actual day-to-day task of advertising, interviewing and hiring a new recruit, say a nurse, you know, in the hospital, for example?
A. Yeah. We have a people and culture department within MLHD and they will sort of moderate the recruitment process. We have actually gone overseas just recently to try and recruit more nurses. We've found, you know, with COVID and the closure of the borders, that sort of dried up a lot of that immigration of nurses that we used to get, and then the actual recruitment will be done at the local level for those nurses.

Q. When you say the "recruitment", we're talking about, for example, dealing with getting visas for them and accommodation?
A. Well, our people and culture will assist in all that, yes.

Q. So which part of it is done by the LHD and which bits of it are done by, say, the director of the facility down

in Finley, as an example?
A. Well, it'd be a nurse unit manager. It's chiefly done through the people and culture department, and then obviously the nurse unit manager would be part of the interview process and, you know, screening of applicants and helping them.

Q. Do you know what sort of efforts are made to determine whether or not a town will be a good fit for the potential recruit, as opposed to the extent to which the recruit might seem to be a good fit for the job, if you understand what I mean by that rather convoluted question?
A. Well, I think I do. Probably the example - I mentioned about the overseas recruitment. That was to England and Ireland. We did secure I think it was close to 100 in that recruitment drive, but they all chose, you know, the Waggas, the Griffiths, I think maybe some went to Deniliquin. So we were really trying to get some of the small facilities but, you know, none came there. So in future we're going to tweak that recruitment plan to be more, you know, targeted at a smaller centres, you know, the benefits of a small centre, rather than just an open chequebook, so to speak.

Q. You told us a little while ago about the importance of the LHACs and your engagement with the LHACs in the tour you take around the LHD.
A. Mmm-hmm.

Q. Just correct me if I've misunderstood this, but your tour is to each of the facilities which are located in some of the towns, but not all of the towns, around the LHD?
A. Yes.

Q. The LHACs tend to be built around those facilities?
A. They are, yes.

Q. So, for example, the LHAC for Finley would ordinarily be made up of people from Finley?
A. True.

Q. And similarly, a facility at Tumut would have an LHAC populated by people from Tumut?
A. Yes.

Q. Do you see the LHD as having a responsibility to deliver the health needs of the community across the entire

LHD - that is, the LHD board, I should say, has a responsibility to deliver for the needs of the entire LHD not just those --
A. I didn't understand your point there. What was --

Q. So hospitals are located in some of the little towns. LHACs tend to be populated by people from those little towns that are associated with those hospitals. Those hospitals and the wider network of hospitals within the LHD actually serve a much wider population than that which exists in those towns.
A. Right. So you think, like Wagga, for instance, has a huge catchment because it's a referral hospital bringing in from right across the district?

Q. Or even an example, you may have been sitting here while your predecessors were giving their evidence, the town of Barooga, for example, doesn't have a facility?
A. That's right, yes.

Q. It doesn't have an LHAC. Nevertheless, it has a population?
A. Yeah.

Q. Do you see the LHD board as having an obligation to deliver for the health needs of the people of, say, in that case, Barooga?
A. Mmm.

Q. Yes or no?
A. It's historically tended to be per facility - per facility, as your introductory comment made. We haven't sort of gone to the next stage of saying, you know, what about all the little communities that don't have a facility but could be, you know, represented. For instance, for Barooga, could Barooga people join the Finley LHAC? They could, and then contribute to those services.

Q. I suppose the first question is: do you see the LHD board as having a responsibility for delivering for the health needs of the people in all of those small communities within the LHD, including, for example, Barooga?
A. Yeah, yes.

Q. And the next question is to what extent, recognising that they tend not to be part of any LHACs, is the board

seeking to assess the needs of and engage feedback from individuals within those smaller communities as part of its wider planning remit?
A. Mmm.

Q. The answer might be not at all, but my question to you is, to what extent does it currently happen?
A. Yeah, it doesn't currently happen.

Q. Do you think it should happen, or it would be an improvement to the system if it did?
A. I think it would be an improvement to have representation from those communities. But there is nothing to say Barooga people can't now join the Finley LHAC. I guess we haven't been active, knocking on doors in Barooga, saying, you know, "Please join Finley LHAC to improve services".

Q. While we're dealing with Finley, were you involved in any of the planning around the upgrade to Finley Hospital?
A. Not directly. I know that the - well, I first used the facility probably five years ago, and obviously could see, you know, it was in need of an upgrade.

The previous government made the commitment of the $25 million in November 2021, and that would have been based on the client service plan - the clinical service plan, rather. And I understand it was probably quite dated by then, so, you know, it is using old figures.

Q. As in the clinical services plan was quite dated?
A. Oh, well, the costings for getting to that $25 million, because we recently finished Tumut and it was something like $60 million, and then, when it was announced that Finley was going to get $25 million, most of us were surprised about how small it was, you know, in comparison. And I remember when I did visit Finley I was talking to Syd Dudley - this was about the time of the changeover of government - I said to him, you know, "Just hope you keep your $25 million because the new government may find there is no money and it may disappear, you know, because under the new government it is a whole new ball game." But the new government did stick with the $25 million.

I think most of us realise that it is not enough. It will end up just being a refurbishment, unfortunately, not a big, brand new hospital, which they would all love to

have.

Q. So there are two components to that. There is the clinical services planning?
A. Mmm-hmm.

Q. That process is identifying the needs of the community which ought be delivered through a facility like Finley?
A. Yeah.

Q. To what extent do you see the board as having a role in that clinical services planning process?
A. Yep, we received that clinical services plan, it would have been a few years ago, and we signed off on it. You know, we have to endorse it, and that was based on, in the best case scenario, you know, all these new services or improved services.

Q. So in terms of the sign-off or endorsement process, what information do you, as the board, gather in order to determine whether what is set out in the clinical services plan that you have been presented with actually reflects the clinical needs of the community that that facility is intended to serve?
A. When those clinical service plans are prepared, they do go through a consultation process with the communities, and whether it is local LH --

Q. Is the board involved in that consultation?
A. Not at that stage. It's done - it's all delivered to us after that due process is done, you know, the consultation is done, and it's basically presented as a "This is a final" - "this is a recommendation to proceed for clinical services for this site."

Q. Do you as a board - or, insofar as you are aware, does the board make any independent assessment of whether or not what has been presented to you as a recommendation is the appropriate recommendation to adopt?
A. Well, we would look at the health needs of that community. When you get a clinical services plan, it will have the population health data for that population, you know, what are the health needs, and so we're guided by that in making that determination.

Q. Do you know where that information, that populates that part of the report, comes from?

A. I think it's BHI, the health information bureau. Yeah. But just in relation to Finley, I think my understanding of what happened was the clinical services plan was the ideal; then when the money came, it wasn't - it's not going to be enough, and so, you know, it is a matter of now doing the conceptual, leading to master planning, on a, you know, prioritised basis. You know, if you can't spread the Vegemite thick enough, you know, how thin do you do it and so what are the priorities for delivering services?

Q. So do you see the board as having a role in deciding how to spread the Vegemite, to use your nice phrase?
A. It's often driven by Health Infrastructure, you know, they have - and then our executive team will be working with them, and I think from the discussions that we heard from the previous two witnesses, it's a matter of going back to the community and going through, "Well, these are the concepts now, based on the reality of the dollars", and then we will be informed as a board.

Q. So when you say you will be informed, you will be informed of what? Of what is going to happen?
A. We will get an update on the planning once it goes through this next consultation phase, yes.

Q. Do you see the board as having a role in deciding, for example, whether renal beds should be prioritised over, say, some other service, assuming that the dollars won't stretch to both?
A. We can have a comment about that and ask the questions, you know, based on, again, the data we might have about number of renal patients and needs.

Q. To what extent, as part of that process, do you, as a board, seek to independently engage with the community either through the LHACs or other means?
A. It's the - well, we have the visits I was talking about; we do have the twice a year LHAC forums, but those sorts of forums are more general, where we might talk about overall strategies, you know, we might have a new strategic plan, and we will do a few presentations on a particular focus that we're looking to do - could be workforce recruitment; it could - you know, "grow your own", you've heard that phrase quite a bit. That's something that we've really been pushing hard. So we will do more those, I guess, global initiatives at the LHAC forums but we

won't, you know, at that forum, be sitting down with say Finley or Tumut and going through, you know, their individual health needs at that point.

Q. Is there any process whereby the board makes an independent assessment, through engagement with LHACs or otherwise, of those needs?
A. Well, each month we get a report from each of the LHAC meetings and it's a summary of the issues that they have raised and it's basically from their minutes, and it could be particular concerns and it might have then an action item that the executive have addressed. They might send one of the executive team out to explain to them about the new services that are coming or what has changed, or sometimes it might escalate to us and ask us for a bit of advice or just, you know, to do more, I guess, activation of a problem.

Q. So who is seeking advice from you in that context?
A. Well, that's in the LHAC report we get - we get this every month and it's summarised for each LHAC, and so it might come to us with a comment, you know, that there needs to be more work around - could be, say, renal services at Finley, you know, and so we will then ask the questions, "Well, what are we doing to address that?"

Q. So those questions you are asking of management of the LHD?
A. Correct, yep. But it's fed through from the LHAC meetings through this report to the board and then we, I guess, query management as to, you know, "What are we doing to address that?"

Q. And in terms of the querying of management, do you see the board as having a role in directing what should be done in relation to that or is it more just making sure that management hasn't overlooked it or not thought about it?
A. It's probably a bit of both, I would expect.

Q. In the case of the --

THE COMMISSIONER: I'm sorry, I don't want to stop you and make the witness come back if you are nearly finished, but I just need to check, first of all, is it okay for us to keep going for a little longer?

THE WITNESS: Yes, I'm happy.

THE COMMISSIONER: Okay. How long will you be?

MR MUSTON: I can be quite quick. I will endeavour to be, I think, seven minutes, which is what I have been told I should be.

THE COMMISSIONER: Let's go ahead.

MR MUSTON: Q. In the case of the former, where you see the board as having some role in providing direction as to what should be done to meet these needs, how do you go about doing that as a board?
A. In the forum are you talking about?

Q. No, in terms of - sorry, I got distracted. You've got the report?
A. Oh, the monthly report.

Q. The report said, "Something should be done about this." That is, the LHACs will say, "Here is an issue that we have that doesn't seem to be being addressed."
A. Mmm-hmm.

Q. You then have a process where you engage with management in relation to that. I asked you whether you saw the board's role as being to direct what management does about that issue or, rather, just to direct - just to make an assessment of whether it's something that has been thought of by management. You said a little bit of both. In the case of the former - that is to say where the board has a role in directing what is to be done about it - what is that role and how is it --
A. Well, it's probably more of a recommendation to, you know, "How can we help this community with these services?" And it could well be a shared service with a neighbouring facility, for instance - you know, there is a bit of a discussion going around about, you know, more renal chairs, well, we're talking about renal, but having them so that they become like a bit of a hub and spoke, so that Deniliquin is a bit of a hub at the moment for renal, with those chairs there, but if we were to put more renal chairs in another facility, well, then, that would draw in the neighbouring facilities. We can't have renal clinics in every facility, is what I'm pointing to.

Q. So in terms of the engagement with the LHACs, that's

a way in which they provide information. That information from them filters up to the board.
A. Mmm.

Q. Is there a mechanism whereby information filters from the board back down to the LHACs?
A. Well, that's with the twice a year forum where the chair and other board members attend that forum, and I will address them and talk about, I guess, what's on my heart as far as, you know, the current state of the district and where we're heading and what issues are on our plate.

Q. So through those forums - I think you indicated earlier that they operate at a slightly higher level than the particular needs of say Finley or Tumut hospitals?
A. Correct.

Q. Is there a way in which the board engages with - that is to say information is passed from the board to the LHACs about those more particular needs of their facilities and decisions that are made about the particular needs of their facilities?
A. Yeah.

Q. What is that process?
A. Well, that would be more informal, like, at the LHAC forum, if one of the LHAC groups, you know, took us aside and said, "Look, we are concerned about this", and then I guess I would take it on to talk with management about that concern that they have, but we really rely on the more regular monthly report that we get as far as the LHAC meetings.

Q. Do you think there would be utility in that monthly provision of information going both ways - that is to say, do you think there would be utility in having the board communicating with the individual LHACs about the issues that they might raise with you?
A. Yes, there probably would be, but often it's - it could be a general - a generic sort of response as to, you know, the services we're providing or our plans.

Q. Do you see the LHACs as having a role to communicate information about the facility and decisions made around the facility to their communities?
A. Not so much about the facilities. Like, it's only an advisory committee. So, you know, I would put the onus on

them to have to front the community and say, you know, "We've only got $25 million for this building", and explain - you know, that's our responsibility as the district, to go to our communities. So the LHACs are - you know, for them, it's - they might go to the community and talk about, you know, more health services rather than the infrastructure, and then their communities will feed to them, you know, their concerns, whether - you know, for instance, suicide, youth suicide is an issue in rural New South Wales, so they might pick that up from things like the men's shed or just, you know, talking around the PCYC and that sort of thing, and then the LHAC can bring that information back to their group and then it feeds in to management and the board.

Q. But you don't see the LHACs as having a role to play in, while perhaps not fronting public meetings and saying "We're not going to give you a renal chair", for example --
A. Yes.

Q. -- do you not see them as potentially having a role to play in communicating and engaging with their own community in a way that at least explains decisions that have been made in parallel with the explanation that has been given by you and the executive?
A. Yeah, just - yeah, to some extent, that's right, yep, particularly with the health services that are provided; they can be an advocate for our decision-making.

Q. Would that role be better facilitated by a clearer provision of information to the LHACs about decisions that are made around those issues that are important in their communities?
A. Yes, I think that probably would help.

Q. Can I ask you, an issue that we've heard a great deal about is patient record systems and the fact that both within - between primary health care and the acute care setting, they don't talk to one another. Do you recognise that as being a significant issue within your LHD?
A. I don't sort of see it as - you know, from the board, I don't hear that, you know. I hear more about, you know, the interstate lack of integration between health records.

Q. What is the particular issue?
A. Well, because we have a long border with Victoria, for instance, and a lot of our patients will go to referral

facilities into Victoria, and so there is no integration of data; and likewise with the ACT, you know, when we talk about Boorowa, Young, going into Canberra hospitals, it's the same. You know, we might have our EMR, eMeds, discharge summaries all electronically, but there is no talking between the states. That's what I see, you know, at a board level, the bigger issue. I'm not really familiar with the primary care issue you were talking about.

Q. So the issue that you at board level hear more about is the fact that the Victorian patient record systems - system or systems - such as they might be on the other side of the river do not communicate with the equivalent systems in New South Wales --
A. Correct.

Q. -- in the regular particular patient flow?
A. And I understand Victorian hospitals, each have their own, like, EMR as well, so often they don't talk between themselves.

MR MUSTON: I note the time, Commissioner. I think I don't have any further questions for this witness.

MR CHIU: I have nothing.

THE COMMISSIONER: Thank you very much for coming in, sir, we are very grateful for your time. You are excused.

<THE WITNESS WITHDREW

THE COMMISSIONER: All right. There is no reason to start at any time other than 10 tomorrow?

MR MUSTON: No.

THE COMMISSIONER: All right. We will adjourn until 10 o'clock tomorrow. Thank you.

AT 4.15PM THE COMMISSION OF INQUIRY WAS ADJOURNED TO TUESDAY, 19 MARCH 2024 AT 10AM

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