

**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

1 THE COMMISSIONER: Good morning, everyone.

2

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

11

12 Yes, Mr Muston?

13

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

17

18 THE COMMISSIONER: For health?

19

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

22

23 THE COMMISSIONER: Thank you, Mr Chiu.

24

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

39

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

43

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

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

8
9 As part of our tour we were shown a range of services
10 delivered through smaller facilities, in towns of Batlow,
11 Tumut, Finley and Berrigan, but also had the opportunity to
12 view a range of the services delivered through the recently
13 redeveloped Wagga Wagga Base Hospital.

14
15 We also visited RIVMED, which is an Aboriginal
16 community controlled health organisation based in Wagga
17 Wagga, who provide health care to First Nations communities
18 both in and around Wagga Wagga and interact importantly
19 with the various other entities that deliver health care
20 throughout the region.

21
22 Now, what we discovered is that each of those
23 communities faces a range of unique challenges in the
24 delivery of health care, and each attempts to meet them in
25 their own unique ways.

26
27 Whilst those challenges are unique, underpinning all
28 of them are some of those themes that we identified in
29 opening the Commission late last year.

30
31 Significantly, workforce shortages and maldistribution
32 are a real issue across the LHD. They operate in different
33 ways throughout the LHD, though, in the smaller rural
34 areas, attracting primary healthcare work force and
35 attracting a workforce to the hospitals and medical
36 services settings is a challenge.

37
38 In the larger parts, the regional area within Wagga,
39 the challenges exist not only in that area but also in
40 attracting a specialist workforce, and we will explore some
41 of that throughout the course of the hearing.

42
43 The second theme that has emerged or reoccurred in our
44 discussions and our tour is this divide between the
45 Commonwealth and the state funding of health care and the
46 way in which that has presented two different structures
47 for the delivery of different parts of the health system,

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

3
4 The next theme which underpins all of it is the ageing
5 population, particularly in some of the smaller communities
6 within the LHD, and the increased burden of chronic illness
7 which we have heard a lot about and we've been able to see
8 through our tour of the regions and discussing the
9 day-to-day challenges faced by clinicians, the way in which
10 that really does bite in particularly smaller communities,
11 and also changes in medicine in the way health care is
12 delivered.

13
14 So those issues all combine to manifest themselves in
15 a number of different ways. There are real challenges, we
16 are told, in accessing and maintaining continuity of the
17 delivery of primary and specialist care, particularly in
18 the smaller communities that we visited, and as we've
19 already heard, this has a range of significant knock-on
20 effects within the wider health system.

21
22 The availability of a full range of acute care
23 services in smaller areas is a challenge, and information
24 barriers between the primary care setting and the acute
25 care setting are a particular issue which has been raised
26 with us a number of times, in two particular respects.

27
28 The first is the ability of those working in the two
29 settings to access medical records of the same patients who
30 cross between them, sometimes within a very tight setting,
31 within a small community, presents challenges. In larger
32 communities, but equally in the small communities, there
33 are some real issues that have been raised with us
34 regarding what are described as discharge summaries, which
35 is the communication which occurs between the acute setting
36 and the primary care setting when a patient is released
37 from an acute care episode back to the care of their GP.
38 Real problems, we are told, emerge both in terms of the
39 content and timing of that communication, which has real
40 impacts for the ability of the patient to receive care in a
41 continuous and perhaps seamless way.

42
43 These themes and challenges were also front and centre
44 last Thursday when, over roughly seven hours, the
45 Commission had the benefit of speaking to a wide range of
46 people - clinicians, community members, consumers - who
47 shared with us their various experiences of the health

1 system locally and shared their views on the way in which
2 it might be changed in order to better deliver health care
3 within the region.
4

5 Importantly, what we observed last week, both through
6 our tour of the various locations and the discussions we
7 had with the individuals last Thursday, was that there is
8 no single solution to any of the challenges. Each
9 community is slightly different and will require
10 a different approach. Our task is to consider whether
11 there are systemic changes that might be made which have
12 the capacity to better facilitate this more bespoke
13 process, community by community, to work out within each of
14 them just what the best way of meeting the challenges might
15 be.
16

17 Which brings us to our first witness, Dr Rachel
18 Christmas, who is the president of the Rural Doctors'
19 Association NSW and a rural generalist practising in
20 Temora. I will call Dr Christmas.
21

22 THE COMMISSIONER: There was nothing you wanted to say
23 briefly in opening of these hearings, Mr Chiu?
24

25 MR CHIU: No, thank you.
26

27 <RACHEL CHRISTMAS, affirmed: [10.09am]
28

29 THE COMMISSIONER: Mr Muston will ask you some questions
30 and maybe Mr Chiu will after that.
31

32 <EXAMINATION BY MR MUSTON:
33

34 MR MUSTON: Q. Could I ask you to state your full name
35 for the record?

36 A. I'm Dr Rachel Christmas.
37

38 Q. And you are a rural generalist, as I understand it,
39 who practices out of Temora?

40 A. That's right.
41

42 Q. And also the president of the Rural Doctors'
43 Association?

44 A. Rural Doctors' Association NSW, that's right.
45

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

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

7
8 Q. Could I ask you a little bit about the obstetrics
9 training?

10 A. Mmm-hmm.

11
12 Q. What did that involve from the perspective of a GP?

13 A. So that was a 12-month position in a hospital system
14 part time, so I was doing general practice, finishing off
15 my general practice training and then doing the Diploma of
16 Obstetrics through the Wodonga Hospital at the same time,
17 so sort of doing it half-half, as part of my GP training
18 advanced skill.

19
20 Q. What does that give you the ability to do
21 professionally?

22 A. So professionally I can manage antenatal care and
23 low-risk obstetrics in my hospital. So I don't do
24 operative obstetrics, I haven't got caesar skills. I do
25 assisted caesar skills, but I do low-risk intra partum and
26 post partum care.

27
28 Q. How does that actually work in the context of
29 a delivery within your community?

30 A. So I can manage - our facility is a low-risk facility
31 anyway, so we consult quite freely will Wagga Base
32 Hospital. Any of our higher risk women we automatically
33 confer with Wagga and transfer women as would be
34 appropriate. So I manage women who are considered low
35 risk, if there's such a thing, because there is always
36 a risk with every woman, to deliver in Temora, with the
37 facilities that we have, which are variable. Sometimes we
38 have a caesar team available, so we have a theatre team
39 with the anaesthetist, the GP obstetric surgeon and myself,
40 and then we know that we can manage any situation that
41 arises. But we may not always have that available.

42
43 Q. I might take it back a step. You run a private
44 practice in Temora; is that right?

45 A. That's right. I'm an associate, so that means I own
46 the practice with my two colleagues and we are a training
47 practice as well for GP registrars who are coming through.

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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

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

9
10 Q. Do all of the GPs in town have a role within the
11 delivery of acute care in the hospital?

12 A. Yes, they do. Some to more of an extent than others.
13 So some might only do one on call a month or one or two on
14 calls a month, just as their contribution, at the end of
15 their careers, and others are doing, you know, maybe six or
16 seven on calls in a month.

17
18 Q. In a practical sense, how are decisions made around
19 the extent to which those services are delivered in terms
20 of rostering between you?

21 A. That's a really interesting question, because there is
22 no - because we're contractors to the hospital, we don't
23 have a certain number of hours that we have to do. There's
24 nothing that says that I have to do on call at the
25 hospital, as a GP in the town.

26
27 We, as a town and as a practice, encourage anyone who
28 works with us to work in the hospital because we see that
29 as being important but there's nothing that says someone
30 has to work in the hospital. The advantage of that is that
31 we kind of just manage it amongst ourselves and we fill the
32 roster. The disadvantage of that is there's no impetus
33 from the hospital point of view to watch how many hours
34 we're working, to replace us or to offer us leave or to
35 support us in that way, because we don't actually work with
36 them under a contract that gives us a certain number of
37 hours. So we are VMOs. So what we work, we go in, we do
38 the work and come out. So what that side of the equation
39 doesn't see is what we're doing in general practice. So
40 the two don't talk.

41
42 We have a good relationship with our hospital and our
43 management, but what we're seeing now is we're having to
44 use remote services a lot more often because the demand is
45 just too great and it is just too much.

46
47 Q. Can I ask you to just describe what those remote

1 services involve?

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

7

8 Q. Just pausing there, this is patients who come into
9 emergency?

10 A. Into the hospital, that's right, into emergency,
11 that's right. So if someone comes into emergency, they are
12 assessed by the nurse, they're triaged, what category, and
13 then, instead of calling us as the on-call doctor, the
14 on-call doctor is in a remote location, they take the phone
15 call eventually because they are looking after several
16 hospitals at once, so the time frame could be uncertain,
17 and then the management is negotiated at that level.

18

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

24

25 Q. Is this happening at times when neither you or any
26 other doctor within Temora is able to attend?

27 A. That's right. So this is a way of work - managing our
28 fatigue and managing the stress of our jobs. So we will
29 have someone who is second on call and they will be
30 available. So if it's me, I might have already done an on
31 call on Friday and then on Sunday I will be second on call
32 and we'll have the remote service and I will be available
33 for emergencies, cat 1, cat 2, where there's immediate
34 threat to life. So we will get called in for that, and
35 they're not very common, but at least we are available for
36 those without having to come in for all of the other cat 3s
37 and belows that can be a full-day's work.

38

39 Q. Just for the benefit of those of us who are not within
40 the health system, could you give us a very basic run-down
41 of the difference between cat 1, 2, 3, 4 and 5?

42 A. Of course. So a cat 5 is a "I've cut my finger and
43 I need a band-aid." So that's general practice, low
44 acuity, you've got time to wait before you see someone,
45 there's no danger to your health imminently and so that has
46 a very low priority.

47

1 Then cat 1 is the opposite, and that's someone who has
2 immediate threat to life, cardiac arrest, respiratory
3 arrest, so someone who is very, very unwell. We don't get
4 those very often either. Cat 2 are the ones that could
5 be - go one way or the other, and so we get a few of those.
6 That's chest pains, you know, acute shortness of breath,
7 something that can immediately threaten someone's life.
8

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

12 A. Yes.

13
14 Q. -- on an on-call basis? But when the telehealth
15 service or the remote service is in operation, it picks up
16 the 3, 4, 5?

17 A. That's right. And that's a way of us managing fatigue
18 and our workload.

19
20 Q. That would be a positive aspect of the remote doctor
21 service?

22 A. Yes, but it's not a perfect service, of course,
23 because we know that - well, it's not a cheap service.
24 Actually, GP VMOs are a very cost effective way of running
25 a health - you know, running an ED and running the health
26 service for a town.

27
28 From a hospital perspective, I know from our nursing
29 staff, they find it very stressful because often they can
30 have patients waiting a long time to be reviewed by the
31 remote service. So they might be three hours in the
32 department waiting for a review by someone, so they've got
33 to manage them in the meantime and have them in the
34 department. There might be others waiting.

35
36 Some nurses can cope with that better than others, and
37 I think some of our nursing staff find that very stressful
38 and I don't like seeing my nursing staff stressed, I like
39 to look after them because they do a great job. And the
40 other thing, it can mean we see perhaps more transfers out
41 that might be managed better if we were there doing it
42 ourselves, because we know the patients, we often have
43 knowledge of what their past history has been, discussions
44 before, you know, we bring a lot with us when we see
45 patients in the ED.

46
47 Q. Is that because the patients who you are seeing in the

1 ED tend to be patients who are regular patients of your
2 practice?

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

12
13 Q. While we are on records, I gather from what you've
14 just told us, that's an important part of your ability to
15 deliver good continuity of care to a patient?

16 A. Vital.

17
18 Q. If they don't come from your practice, are you able to
19 get access to their primary health care records in any way?

20 A. No. So the access I have is through the eHealth
21 record, which may give me a health summary if it's
22 available. Often what we - if that has been uploaded. And
23 I know that general practice has been incentivised to make
24 sure they are uploading eHealth records. But if that's not
25 available, sometimes we just get the medications that have
26 been dispensed from a pharmacy, so we know what medications
27 they might be on. That might be all we have to go on.

28
29 Q. What challenges does that present in the context of
30 delivering care to those patients when you are encountering
31 them in the acute or emergency services?

32 A. Oh, understanding what their base line is, especially
33 for blood tests and so on; understanding what their
34 previous presentations have been; understanding the context
35 of their chronic health conditions - have they had
36 investigations, have they seen specialists, what sort of
37 level are we dealing with? Some people are very well
38 informed about their own health conditions and they're able
39 to tell you quite a lot and a lot are not well informed.
40 They don't the medication they are on, they don't know what
41 the specialist said, they don't know where they're at with
42 things, so it depends.

43
44 Q. So how do you deal with that information deficit?
45 What are the consequences of it in terms of the way in
46 which care is delivered?

47 A. Fundamentally, if you are dealing with an acute

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

5
6 The next day often the usual doctor is around, and so
7 you can talk to them about it or hand over the care to the
8 usual doctor, if that is a negotiation that happens.

9
10 Yeah, it just depends on the patient, how acutely
11 unwell they are and what is the priority right there and
12 then. Often, there's time. A lot of the time we're not
13 dealing with life and death; it's just, "Oh, this person is
14 unwell", we treat what we think is going on, we admit them
15 and we get the information the next day.

16
17 Q. You mentioned a moment ago a baseline and test results
18 that you're able to obtain where it is your own patient by
19 looking at their records. Do you, where you don't have
20 access to those records, think that there is perhaps a need
21 to do tests that may have been done in a primary setting
22 earlier that could have been avoided?

23 A. I think we are pretty good at not doubling up on tests
24 too much. We are pretty - I think because we are GPs, and
25 we understand that - you know, we are pretty rational with
26 our ordering of tests, we are used to uncertainty and we're
27 used to having time to wait. We can do certain bedside
28 tests to assess the acuity of the presentation but often
29 we're okay to wait and get something the next day.

30
31 We can always ring the laboratory and get the latest
32 lot of tests if we need to, if that's something that's
33 going to be meaningful right there and then, but often
34 we've got time to chase that up. Because if a patient is
35 really unwell, then often they're not right for our unit
36 anyway, and we send them out somewhere else.

37
38 Q. Is the ability to chase them up a function of the fact
39 that it's a small population of GPs in your town whom you
40 know, so you're confident that the next morning --

41 A. Absolutely.

42
43 Q. -- you'll be able to find out whose patient it is?

44 A. We always - "Yes, I'm a patient of Dr Kurtzer", "I'm
45 a Dr Smith patient", and you say, "Who do you see?" Or
46 they might say, "Oh, we just go to the medical centre", and
47 so you know they don't have a regular GP that they see all

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

4
5 Q. So that's the information one way. Information going
6 the other way, out of the hospital setting back into
7 primary care, as a GP in the town, do you find there are
8 any issues in relation to knowing what may have happened to
9 one of your patients in the hospital setting?

10 A. From within our own hospital, no, because we usually
11 look after them and we see them again the next week and we
12 know what's happened, so the continuity is there and that
13 is really valuable.

14
15 Yes, there can be issues from the larger hospitals,
16 especially outside of our health district, because of the
17 electronic systems that we have within the MLHD, we will
18 get a discharge summary. Some are better than others, but
19 generally I would say that has improved markedly with the
20 eHealth record, and that's something that I think is really
21 good because you often get information that you wouldn't
22 have got before from the junior doctors.

23
24 The issue is the timeliness of it. So I think that
25 can be improved by an actual phone call to the doctor to
26 say, "This person is being discharged. We would like them
27 followed up within a few days, and these are the issues.
28 Are you able to arrange that", rather than a patient coming
29 in and then you haven't got the discharge summary and you
30 don't know what has happened and they don't know what has
31 happened, and that's not easy.

32
33 Q. Within your small community of clinicians do you find
34 that those phone calls happen in a rather organic way?

35 A. Yeah, they don't happen very often at all. I think
36 the GPs aren't communicated with enough, actually, and
37 especially from the point of view of getting information
38 from us when there is a patient admitted. We know our
39 patients really well. We know what medications they have
40 been on, we know what has been tried before. We're
41 a really good resource for the teams in the bigger
42 hospitals, and I think they tend to forget that sometimes.

43
44 Q. So when you're talking about it not happening, maybe
45 if we break it down into two scenarios, first, where the
46 patient has presented at Temora Hospital and it's one of
47 your immediate local colleagues who's potentially dealing

1 with the patient, do you find that the communication
2 happens in that context?
3 A. Yes, it's good.
4
5 Q. Is that because you all know one another so well?
6 A. We know one another and also we do our discharge
7 summaries. We have to. It's part of what we have to do.
8 But I get - you know, I'll come in on Monday or a Tuesday,
9 I check my results and there are some discharge summaries
10 and I read them. "Oh, yeah, so and so has been in
11 hospital", "What has he said? Oh, yeah, doctor has said
12 that I need to follow up on this and this and this", and so
13 you do.
14
15 Q. Your comment about the delay in the discharge
16 summaries and perhaps the failure to pick up the phone at
17 times, when it would be useful, is more directed at
18 occasions when patients of yours have been admitted to,
19 say, Wagga Base Hospital or another hospital?
20 A. Yeah, yeah, that's right. So, you know, they have
21 a high workload, the junior doctors, and so you might not
22 get that discharge summary for a week or so.
23
24 Q. Do you as a VMO working into the system have an
25 ability to access the electronic medical record of your
26 patients within the LHD?
27 A. Yes.
28
29 Q. Wherever they may have been admitted?
30 A. Yes, within the LHD, yes.
31
32 Q. Do you find that that's a useful resource?
33 A. It can be. A bit time consuming, but it can be. So I
34 can access the - from in the hospital system, I can do that
35 very easily. From my practice it's just a bit more of
36 a log-in process which just takes a bit of time, but yes,
37 I can.
38
39 Q. In terms of the time, when you say it's "time
40 consuming", there's the time to go through the actual
41 logging in through your computer; in terms of the ability,
42 your ability to use the information that's there once
43 you've logged in, is that a significant resource?
44 A. It's - well, it's just like opening up the patient's
45 file in front of you. You've got exactly what's happened
46 from the moment they went to the hospital, every nurse
47 review, every doctor, ward round, everything, all the

1 results, everything is there unless they have been in ICU
2 or in surgery. So I can see all of it, just like if I'm in
3 the hospital dealing with the patient.
4

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

11
12 Q. So would I be right in assuming that access to the
13 medical records would not be, in and of itself,
14 a substitute for a good discharge summary?

15 A. Absolutely not.
16

17 Q. But it might actually supplement a discharge summary
18 in a way that could be quite useful?

19 A. It shouldn't have to. But it can. So if I - and
20 I only have that privilege because I'm a VMO. So if I were
21 a GP in Wagga who didn't work in the hospital system,
22 I wouldn't have access to that. I would only have the
23 discharge summary.
24

25 Q. I think you said at the outset that you're also
26 involved in providing training through your practice to
27 future GPs?

28 A. Mmm-hmm.
29

30 Q. What does that actually look like in the context of
31 the way that you run your practice?

32 A. So that involves us being available for our GP
33 registrars 80 per cent of the time. So we have to be
34 around to give advice, to supervise, to answer questions,
35 to sit in with them to supervise consultations, to see how
36 they're going, and generally just being available. If
37 they're at the hospital doing on call, we need to be
38 available if they're not - if they need advice or if they
39 need a second opinion or if something is too much for them
40 to go in and, you know, help out.
41

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

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

9
10 Q. How many trainees would you have at any given time at
11 your practice?

12 A. Never enough. So we have one currently. We have had
13 four.

14
15 Q. The other practice in town, do they train --

16 A. He's not a training practice, no.

17
18 Q. Is that a function of the number of doctors who are
19 working through that other practice?

20 A. No, and that's interesting. I do believe that GP has
21 tried to have trainees come to his practice before and
22 hasn't had them come. He had one that I know of in the
23 time that I've been there, which did not last very long.
24 I'm not sure of the Barriers there. You would have to
25 inquire of him.

26
27 Q. You mentioned a moment ago that the trainees might be
28 on call at the hospital. What is the role that the
29 trainees have within the hospital setting? They're
30 presumably not VMOs?

31 A. They are. So they act as VMOs. They do the same role
32 that I do; it's just that they are under supervision. So
33 functionally it makes no difference. They are on call,
34 like we would be on call, they see everything that comes
35 through, they spend their hours in the middle of the night
36 getting up and going doing it, and coming back to the
37 practice the next day.

38
39 It's quite a stressful job for them and it is very -
40 there's a lot of responsibility, they've gone from being in
41 a big hospital like Wagga, where they're in the emergency
42 department with a load of other doctors and nurses around,
43 to being the only doctor with one nurse. So it is quite
44 a responsibility. So we try to support them as best we can
45 in making sure they understand that we are there, we're
46 happy, we're on the end of the phone and they can ring us.
47 But they are so sensitive to the fact that we are all

1 working very hard as well that sometimes they might be
2 disinclined to call, and that's something that we need to
3 really work on with them, that it is okay.
4

5 Q. So what are the consequences of that disinclination?

6 A. The consequence could be that they're dealing with
7 a situation that they may not be fully equipped to deal
8 with. Having said that, the registrars that I have are
9 a very high calibre and I think are very impressive in what
10 they know and what they can do.
11

12 They can also be very well supported by Wagga. So we
13 have a very good relationship with the district - with the
14 base hospital, the emergency department, through the
15 patient flow system, which is really - makes it very
16 accessible, and I feel very well supported, and I think our
17 registrars do too, that we can ring up and speak to an
18 emergency physician and get an opinion or speak to the
19 physician or speak to a surgeon and get some advice from
20 them, so then we're not needing to use our local resources
21 as much.
22

23 Q. You said a moment ago that there are too few trainees,
24 at least within your area. Do you think that's a recent
25 trend or is it longstanding?

26 A. No, sadly this is a longstanding trend. General
27 practice is undersubscribed nationally, rural general
28 practice is undersubscribed again, the reasons being, well,
29 myriad. I think that's a very complex question. General
30 practice has long been the poor cousin in the medical
31 fraternity. It's not remunerated as well as other
32 specialties, and I think rural general practice is seen as
33 an intimidating, big, hard job to do.
34

35 Q. How has that manifested itself within your community
36 over the time that you've been there? Have you noticed
37 there has been a drop-off in the number of GPs in town or
38 has it been --

39 A. Interestingly, like, for a long time there were three
40 GPs in our town and that was it, and they did on-call for
41 a week at a time each. That is phenomenal. And they work
42 incredibly hard and I wouldn't say they always worked
43 safely, because the hours were just so long, and when
44 I speak to one of our recently retired colleagues, he just
45 says, "Gosh, I don't know how we did it." There were no
46 safe working hours, there was nothing like that. They just
47 worked and worked and worked, and I think, now, we have

1 more trainees coming through, but there is the
2 understanding that that's not acceptable. You can't work
3 people that hard.
4

5 I also think the nature of general practices training,
6 where, what general practice is - the nature of general
7 practice is changing, so what we're expected to do in
8 general practice is increasing, there's more complexity,
9 chronic disease, the more research is done into different
10 health conditions the more we're supposed to manage things
11 so it's getting bigger and bigger. Our days in general
12 practice are more complex, and then we're dealing with
13 people who are living longer, with more complex conditions
14 that we're managing that take longer to sort out. So it's
15 just a snowball.
16

17 Q. Presumably that's not unique to your little corner of
18 New South Wales?

19 A. Absolutely not. Absolutely not. I think also, the
20 idea of moving to a small town, if you're a young,
21 27-year-old, single person, what's going to take you to
22 a small town like mine? Why would you go there unless you
23 had family connections or you had some reason to go there,
24 because it's really hard. How do you meet a partner? Or
25 how does your partner work if they're not a nurse or
26 a teacher or another doctor?
27

28 Q. Do you have a view about what the system might be able
29 to do to better incentivise rural practice and rural
30 generalists in particular?

31 A. Yeah, I think so. One is that people need to
32 understand that if they move somewhere they bring skills
33 with them, that they can actually use those skills, that
34 they have the resources available to use them, that the
35 facility that they're working in supports them. I think
36 they need to be guaranteed leave, because they see people
37 in my role and they see others - these are their role
38 models - working very, very long hours and I don't think
39 they really want to sign up to that.
40

41 I think there needs to be an understanding of these
42 people need guaranteed leave, they need to be supported in
43 taking that leave, because there's the obligation factor
44 that comes in. If I take leave from my practice, my
45 colleagues are working harder, and no-one likes seeing that
46 of their colleagues who are already working hard.
47

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

7
8 Q. Can I ask you about the use of skills and upskilling.
9 What does that actually require of the system in order to
10 enable a practitioner to use their skills and upskill
11 themselves in a way that you say might incentivise more
12 people?

13 A. It's a very good question. So, for example, I'll use
14 my example of being an obstetric person. So I do the
15 low-risk obstetrics. I don't deliver many babies now
16 because if I have anyone who is high risk they go to Wagga.
17 So the women that I have who end up delivering in Temora,
18 I deliver there, but I might be lucky to get 10, 12, 13
19 deliveries a year.

20
21 I don't tend to have women who have had - who are
22 having their first baby deliver in Temora if there's no
23 surgery back-up, because I don't know how they're going to
24 go and they might need an emergency caesar and I don't like
25 sending women out in the middle of labour needing emergency
26 caesar to Wagga.

27
28 Q. When you say "sending" out, you mean sending them to
29 Wagga?

30 A. Sending them to Wagga, that's right, which I have had
31 to do. So what is useful - what is useful for me is being
32 able - because the volume is so low, my confidence starts
33 to drop, the confidence of the nursing staff starts to
34 drop. So if I have a practice that's not - like, within
35 the hospital that is not able to do regular inductions of
36 labour, increase the acuity of what we're dealing with,
37 increase the risk locally and get used to managing more
38 risk, then we tend to think, "Ah, well, we'll just send
39 that away." So we do less and by doing less we get less
40 confidence.

41
42 So what we need is a system where we can say, "Okay,
43 I'm going to be supported to go back to Wagga to do a week
44 in the labour ward, get my skills up again, get talking
45 with people again, see how things are being done ", so then
46 I take that back with me.

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

8
9 Q. I pose the question: how do you think that could be
10 done?

11 A. How do you? So this is where having a good
12 relationship with the local hospital, with the base
13 hospital, is really important; having a good understanding
14 of the peripheral services and then having someone
15 coordinating, saying, "Okay, who have we got out in these
16 communities that need upskilling? So can we offer that
17 person a locum to come into their practice, run the
18 practice, while we get them back in doing their
19 anaesthetics lists for a week?" "Can we get them back into
20 birth suite for a week. How can we do that?" But that
21 needs to be coordinated and it needs to be a priority
22 because if it's not, it won't happen.

23
24 Q. In terms of that coordination, is there value, do you
25 think, in an assessment being made at a more central level,
26 perhaps at an LHD level, of what specialist services might
27 be required and useful in particular settings?

28 A. Absolutely.

29
30 Q. For example, your example of obstetrics, is there
31 a value in saying, "Which communities within our LHD would
32 actually benefit from having a GP with that obstetric
33 specialisation within the town?"

34 A. Absolutely. It's a very complex organism. To do
35 obstetrics properly, you need an anaesthetist. To have an
36 anaesthetist, you need surgical lists, because they don't
37 do anaesthetics just for obstetrics, they need all of those
38 skills. So you need a coordinated approach to make sure
39 all of the services are being carried out in that hospital
40 regularly.

41
42 Now, what is the motivator for the LHD to do that? If
43 we're not measuring that and if we're not making LHDs
44 accountable for those services being done in those
45 peripheral hospitals, then there's no motivation to
46 actually see it through and make sure those services are
47 actually provided. Part of that is funding. So we've got

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

10
11 If they're not accountable - if we're not saying you
12 need to run these service, we have KPIs around how many
13 people are being operated on in those peripheral
14 hospitals - then there's no impetus to make it happen. And
15 that's what I see. I see that we have people willing to do
16 the job, we have GP anaesthetists who want to do it, we
17 have who are nurses trained up and wanting to do it. We
18 have specialists who want to come and do it, but for some
19 reason it's not happening. Why is that? Where's that
20 block?

21
22 Q. So other than an ability to enable practitioners
23 within that community to maintain their specialist skills,
24 are there other benefits to continuing to provide those
25 services within the smaller hospital settings?

26 A. The benefit is that at the moment, there is a big push
27 from the Commonwealth and from state levels to increase the
28 number of rural generalists, so if we - and that's
29 trainees, that's GPs who train up with extra skills in lots
30 of different areas.

31
32 If we're not pushing for those services to be
33 maintained or encouraged or improved in smaller areas,
34 we're not going to get the doctors moving to those places
35 with their skills. So there is an impetus, there is
36 a motivation to improve that so we can get new people
37 coming through with their skills and somewhere to practise
38 them.

39
40 Q. So one of the incentives to get rural generalists to
41 come to more remote and smaller hospitals and communities
42 is to expand the scope of what they can do when they are
43 there?

44 A. Absolutely.

45
46 Q. Are there others? Other incentives?

47 A. I think that's probably more around general practice

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

12
13 Q. Let's look at that. To what extent do you see
14 challenges in the delivery of primary health care within
15 smaller communities like yours?

16 A. Workforce. Absolutely workforce. So if we don't have
17 enough GPs we can't see the people we need to see, waiting
18 lists blow out, people don't have their health conditions
19 treated appropriately. We've got nursing homes we need to
20 look after: are they being cared for adequately in the
21 nursing homes? It just has flow-on effects. People don't
22 go to the doctor because they can't get an appointment. So
23 things just - and that flows off into the hospital system,
24 so then we're dealing with people in the hospitals who have
25 conditions that aren't being treated well and these
26 presentations could have been prevented if they'd had their
27 conditions dealt with better in general practice.

28
29 So the other thing in general practice that I think
30 is an area for improvement is the upskilling of our nurses
31 in general practice and paying them, allowing them to
32 actually bill for some of the things they do in general
33 practice, which is not the case currently.

34
35 Q. When you say "allowing them to bill", is that
36 through --

37 A. Through the MBS. Yes.

38
39 Q. Do you have any views about how to better incentivise
40 people to come into general practice within the rural
41 setting?

42 A. That's a really difficult one. It's a complex area.
43 I am vexed between - I'm vexed when it comes to communities
44 providing support - so I think councils feel a lot of
45 pressure to attract people and they provide housing, they
46 do all these wonderful things to try to improve the
47 situation for people coming to their towns, and I don't

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

3
4 The Albanese government introduced the bulk billing
5 incentive for rural areas, which is tiered for how rural
6 you are. That actually has been a significant improvement
7 because it does mean that general practice is better
8 reimbursed for bulk billing their population. Bulk billing
9 is important. A lot of people do not prioritise paying for
10 their general practice things, consultations, and some
11 can't afford to. But I do know, having run a practice
12 myself, that general practice is expensive and it's
13 becoming more and more marginal. So if you can't make
14 a good living in general practice, doing what you do, with
15 the value that you are adding to a community and the
16 responsibility of that, then why would you do it?

17
18 So to incentivise coming to rural areas to practise,
19 I think people need to feel well supported, they need to be
20 well remunerated and they need to be socially supported.
21 The social support one is really difficult. Simple things,
22 such as if you are an overseas trained doctor, having to
23 pay for your children to go to school in the primary - in
24 the local primary school, is one barrier. Adequate jobs
25 for spouses is another one, because professionals usually
26 marry professionals and they bring their partners with them
27 and they need work.

28
29 Q. How, systemically, can that problem realistically be
30 solved?

31 A. Yeah, I don't know. That's a question that many
32 people have looked at, and I don't know and I don't know
33 where the responsibility lies for that, but it's certainly
34 part of the picture.

35
36 Q. Is part of it, perhaps, being more selective about
37 recruitment and identifying that as an almost unsolvable
38 problem in the case of some potential recruits and making
39 clear to them that that's an issue and potentially, on that
40 basis, not recruiting those people?

41 A. I tell you what, we're so desperate for recruiting
42 people - this is the trouble. You don't want to put anyone
43 off coming because we want anyone to come. I guess that's
44 the question that an individual has to ask themselves, is
45 this for them for all those different reasons, but, yes,
46 look, I think that is a really big question and I don't
47 have the answer for it.

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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?

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

11
12 Q. Let's sort of break it down into the pros and cons.
13 In terms of the benefits of that sort of system - that is,
14 state-based delivery of primary health care in a
15 community - what would you see some of the potential
16 benefits of that?

17 A. Getting primary health care. So you're getting
18 someone out there. So you're seeing people - if that sets
19 up a regular pattern and especially if you're a similar -
20 you know, you've got a team of practitioners who are coming
21 that may then enable there to be some continuity, then
22 that's a benefit.

23
24 If you're getting people's blood pressures down and if
25 you're getting their AF managed and you're getting all of
26 those things done that you need to do, their diabetes well
27 controlled, it doesn't really matter how you do it as long
28 as you're doing it. That's one of the benefits.

29
30 The disadvantage is continuity --

31
32 Q. Can I ask you a little bit, a question about
33 a potential benefit first and tell me if it is or isn't.
34 Do you see that there are any benefits in terms of
35 recruitment to rural generalism through a state-based
36 primary health care system --

37 A. Yes.

38
39 Q. -- of the type we're talking about?

40 A. Yes. So the advantage of that is for the person doing
41 it, if that were me, I would think, "Okay, I don't have
42 practice costs, I don't have to worry about paying my staff
43 I just go, do the job, I get paid, I come home."

44
45 Q. You mentioned earlier that one of the important
46 things is --

47

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

3
4 MR MUSTON: Potentially the cost and continuity.

5
6 THE WITNESS: Yes, so --

7
8 MR MUSTON: That is a question better directed to the
9 witness.

10
11 THE WITNESS: That's right. So a locum is someone who
12 would come in to do a job for a certain period of time and
13 do a job and go again. Whereas an employment situation, if
14 you're in an arrangement that that's the contract you have,
15 you would be going back on a regular basis and being paid
16 as an employee of the service. That's slightly different,
17 I think.

18
19 The difficulty is when you're looking at it being
20 a hospital system, again primary care versus emergency and
21 inpatient care, and that's where there's sort of a blur.
22 So it will depend on the type of employment arrangement and
23 what you're - what the contract is.

24
25 MR MUSTON: Q. So that's some potential pros. You said
26 you wouldn't like to see it happen in your town. What do
27 you see as some of the cons?

28 A. The cons is that loss of the relationship. So the
29 advantage of being a GP in a rural town is I know my
30 population, I know the people, I know their context, they
31 know me. The ease of communication and the understanding
32 of what is happening with the people in my town just means
33 that caring for them is so much easier.

34
35 So it's just one of those privileges of general
36 practice, I think, having that understanding of the
37 patients that you see and knowing the challenges that they
38 have and understanding them. It's as simple and as
39 difficult as that.

40
41 Q. Do you see any potential cons to that state-based
42 system insofar as - well, from the perspective of someone
43 running a GP, a viable GP business within a town?

44 A. If you have both systems running in a town - so
45 a private general practice and a hospital one - I think
46 there could be the potential for conflict.

47

1 Q. What's that conflict?

2 A. I think it would depend on whether the general
3 practice side of the public funded one is doing hospital
4 care or not, whether they're just doing general practice
5 based care. It would depend on the patient experience of
6 what they are getting. And then I think there is the
7 potential for devaluing what the GPs in place are doing.

8

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

11 A. Mmm.

12

13 Q. Can you just expand on that a little bit?

14 A. Yes. So as a GP now I do my general practice patient
15 care, so just in my rooms, doing what I do, I see them in
16 the nursing homes, and I'm going to the hospital and doing
17 my work there. So that's a big lot I'm taking care of.

18

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

27

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

35

36 Q. And why would that be, to your mind, more like the
37 locum situation?

38 A. Oh, because that's what locums often do. So if we
39 employ locums at my practice, we have a locum who's
40 employed on the understanding that they work in general
41 practice as well as in the hospital, just like I do.

42

43 Q. So in the context of a state-based system, why would
44 it be problematic if the individual employed within that
45 state-based system was delivering care through both the
46 hospital setting and --

47 A. If they were, then that's good, but they might not be

1 under that kind of system because I imagine that would be
2 a come out, do your general practice primary care and then
3 go again.
4

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

8 A. Mmm.

9
10 Q. That is, that wholesale service --

11 A. Wholesale service.

12
13 Q. -- hospital, aged care, primary care to patients
14 within the community?

15 A. That's right. Because that's what GP - rural general
16 practice is about. Mmm.

17
18 Q. If that sort of system were considered, do you have
19 a view about the features of a community that might make it
20 appropriate for that sort of service other than no doctors,
21 as the starting point that you told us?

22 A. Mmm, mmm.

23
24 Q. That is, the community - a small community that might
25 have a small rural hospital, no in-town GP, may well
26 benefit from a system like that?

27 A. Absolutely. I think so.

28
29 Q. As you move away from that --

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

36
37 As all things, as you mentioned, every country town is
38 different and what they need is different. So I think it
39 would depend on what is identified by the town as an issue
40 and as a priority and then working within that to work out
41 how to address that priority. Flexibility is really
42 important. So I don't have a specific answer for that
43 question, because I think you have to look at every case
44 very individually in a community, because they're all
45 different. I think there is room for some flexibility and
46 some creativity when it comes to providing services in
47 rural areas, and funding models don't always allow for

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

3
4 Q. Could I ask you about the Rural Doctors' Settlement
5 Package?

6 A. Yes, you can.

7
8 Q. Can you explain to us what that is?

9 A. So that was a contract that was developed back in the
10 '80s for rural doctors so they could be paid for the work
11 that they were providing in the hospitals. Rural GPs, like
12 me, going into the hospitals, were not really paid for the
13 work they were doing at that time. And so there was a big
14 strike and they came up with the Rural Doctors' Settlement
15 Package and now there are a certain number of hospitals
16 around the state, 130 or something hospitals around the
17 state, that - whose doctors work under this contract, which
18 is the way by which they are paid for the services that
19 they render, and it's a fee for service contract.

20
21 So I get to see - I see a patient and I get paid
22 depending on the time of day, what else I might do at that
23 presentation, whether I, you know, do a certain procedure
24 at the time, and then I bill those item numbers and I'm
25 paid according to that.

26
27 Q. Do you see that as working as an incentive to draw
28 people in to rural generalism?

29 A. It has its benefits. It pays quite well. It's a good
30 model for the work that I do. It works well for me because
31 the more you see, the more you get paid, so there's no
32 ceiling, really, to how much you get paid, depending on
33 what you see. So there is that, you know, getting up in
34 the middle of the night, "Well, at least I'm getting paid
35 for going out and doing this." But it doesn't pay you well
36 for other aspects, and it's swings and roundabouts, and
37 most of us who know it and use it realise that, "Okay, I'm
38 not going to get paid so well for that, but if see three
39 kids with a cold and I can see them pretty quickly in the
40 ED then, I get paid nicely for those, you know, because it
41 doesn't distinguish between complexity.

42
43 The issue is where we have situations where there
44 might be low acuity, not many patients being seen, but
45 you're still on call for 24 hours providing a service, and
46 so you might only see three people in the emergency
47 department, but you're still in that town, you're there,

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

11
12 Q. That's working at, in essence, the financial push and
13 pull factors?

14 A. Mmm.

15
16 Q. Do you see any opportunities through training or
17 changes in the way doctors are trained which might
18 encourage more people into rural generalism?

19 A. Yes. I think the more exposure junior doctors have to
20 rural areas, the more likely we are to put that in the
21 front of their minds about choosing a career. What we know
22 is that general practice - exposure to general practice in
23 a rural or an urban setting ceases pretty much after they
24 join the hospital system.

25
26 We know that there is a lot of negative talk about
27 general practice within the hospital system, so those
28 juniors who go from being medical students into the
29 hospital system, where they're being exposed to a
30 cardiology term, a surgery term, all the fun that goes
31 with, "Come with me. Let's go and look at this", "This is
32 fun. Let's go and do that", and you say "I'm interested in
33 general practice," "Oh, why would you do that, you can do
34 anything you want". That's the kind of attitude that we
35 hear.

36
37 We know that if junior doctors are exposed to a good
38 general practice term where they see - where they actually
39 can meaningfully contribute to that general practice, not
40 just sitting in as a med student watching and learning but
41 actually sitting in, making decisions, assessing people,
42 coming up with diagnoses, following them through and, in
43 rural areas, doing some of the hospital work as well and
44 working in with the GPs and seeing the work we do and
45 taking responsibility for that, that suddenly, their
46 experiences change and they start thinking, "Oh, this might
47 be a career for me." It's not going to be for everyone.

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

4
5 Q. Can you see there being a sweet spot, in your
6 observation, in terms of how long you need to be in that
7 setting for that to start to gel?

8 A. Yeah, look, I think you need to be there for three to
9 six months. You need to get over your initial - you need
10 to have the initial kind of novelty, then you get to that
11 kind of six to 12 weeks where the novelty is wearing off
12 and you're in the middle of the finding it hard.

13
14 Q. Missing my friends?

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

22
23 Q. Before I finish, can I ask you to put your president
24 of the Rural Doctors' Association hat on. Is there
25 anything that we have not covered that you think is an
26 important issue that the Commission should be thinking
27 about in terms of the way in which we go about dealing with
28 some of these challenges, particularly in the rural
29 setting?

30 A. I think we need to actually look at measurable
31 outcomes. If we are really serious about improving health
32 care delivery in rural areas, we need to actually be
33 measuring things and we need to be accountable for the
34 services that we provide. So, how many women, Aboriginal
35 women, are birthing on country, how many women are birthing
36 in the smaller hospitals, so then we're actually
37 accountable for the outcomes in those areas and then
38 they're not just pushed to the side. Looking at funding
39 that can encourage services to be provided in those smaller
40 hospitals, as I've talked about.

41
42 Other things is training positions for specialty
43 training. That's not my big area of knowledge, but I do
44 know that we have difficulty with getting specialists,
45 non-GP specialist training positions in rural hospitals.
46 There is funding provided, that's devolved from federal to
47 state to the hospital level. Making sure that those funds

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

5
6 Q. What's the blockage in terms of the training, the
7 specialist training, so far as you are aware?

8 A. I don't know.

9
10 MR MUSTON: I have no further questions for this witness,
11 Commissioner.

12
13 THE COMMISSIONER: Q. Can I just ask before Mr Chiu
14 does, Mr Muston finished with some questions for you about
15 with your president of the Rural Doctors' Association hat
16 on. The submission this Inquiry received was signed by
17 your predecessor.

18 A. It was.

19
20 Q. No doubt, it's a submission that's statewide rather
21 than specific to Murrumbidgee LHD. A large part of it
22 talked about feedback to the association from GP VMOs not
23 feeling that they were valued by hospitals and, in
24 particular, issues regarding payments for seeing patients
25 being rejected and/or delays in getting paid?

26 A. Mmm.

27
28 Q. Is that something you can speak to from your own
29 experience?

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

39
40 Q. Communication with whom, so between the VMO and --

41 A. Between the VMO and the manager who is responsible
42 for signing off on things. I think --

43
44 Q. The manager in the hospital?

45 A. Well, it's different in different places.

46
47 Q. Or the LHD - yes.

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

6
7 I don't have any issues in my hospital. We're very
8 good, we have great communication within my local hospital.
9 But I do know of other hospitals where that's not the case
10 and so --

11
12 Q. In this LHD?
13 A. In this LHD.

14
15 Q. And from your members that are talking about other
16 LHDs as well?
17 A. And from my members across the state. And that does
18 cause a degree of stress. GP VMOs are overworked, they are
19 tired and they don't want fuss. They just want to get paid
20 for the job they do and they want to be appreciated for the
21 work they do.

22
23 Q. Is it common that the - let's just call it payment
24 dispute - is it common that they are ultimately resolved
25 but it just takes a while or --
26 A. I think there are probably lots of little ones that
27 happen and get resolved without us being aware of them.
28 Usually by the time we hear of them it's a litany of woes.
29 So it's not just one thing. It's a repeated - repeated
30 rejections of item numbers or being very picky about detail
31 or - there is other things feeding into it.
32 Dissatisfaction --

33
34 Q. When you say picky about detail, that means?
35 A. So someone, for example, a surgeon getting called in
36 to do a list of the middle of the night, the registrar
37 writes their notes and does all that, the surgeon was
38 there, but because they haven't written a note in the file,
39 they are not getting paid.

40
41 Q. Right. They ultimately no doubt do get paid but there
42 is time spent convincing someone that's meant to be
43 arranging the payment that "I was actually - I am the
44 surgeon and I was actually there even if I didn't write the
45 notes"?

46 A. "I was there"; that's right.
47

1 Q. That's what you mean by communication problems, I
2 suppose?

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

7
8 Q. In relation to those issues that your members are
9 having, what would make the system work better?

10 A. Training on both sides and communication - improvement
11 in the way we communicate. I think there are big barriers
12 to good communication within LHDs and that's very dependent
13 on individuals. That's a hard one, because certain
14 managers have --

15
16 Q. Managers should be trained, though, shouldn't they?

17 A. One would think so. I'm not a manager so I don't know
18 what training they have. But that doesn't always flow down
19 to the experience of those who are communicating with them.

20
21 Q. And the real problem with this is that it's - don't
22 let me put words in your mouth, you can tell me whether you
23 agree, disagree or say anything else you like, but the
24 problem I think, coming from the submission, is that these
25 issues are causing a disincentive for GPs to actually want
26 to be VMOs in the remote rural hospitals?

27 A. Yes, they can. Probably more - it's providing a good
28 excuse or reason for people to withdraw their services.

29
30 Q. It's not worth it?

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

35
36 Q. Yes.

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

39
40 Q. It's very frustrating.

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

43

44 THE COMMISSIONER: Thank you.

45

46 Did anything arise out of that?

47

1 MR MUSTON: No.

2

3 THE COMMISSIONER: Yes, Mr Chiu.

4

5 <EXAMINATION BY MR CHIU:

6

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

10 A. Mmm.

11

12 Q. Besides delivering babies, what other kinds of
13 procedures did you have in mind?

14 A. So more surgical procedures. So we have a surgeon who
15 comes once a month to provide basic surgical services,
16 low-risk, low-acuity, things that just need to get done,
17 skin cancers and so on. They come once a month at the
18 moment. There is capacity within the hospital from the
19 nursing staff point of view to do more lists, and I know
20 there are surgeons who want to do more lists, and I know
21 the anaesthetists would be happy to do the anaesthetics for
22 those lists, but they're not happening.

23

24 Q. I see. So there is a demand from the community for
25 more of these types of procedures to be done locally;
26 that's correct?

27 A. I'm not thinking so much from the community point of
28 view. The community does love having things done locally,
29 and we get people from other towns coming, so not just from
30 Temora, but sometimes people from the Wagga lists who may
31 see, well, if you go and get it done in Temora or Young or
32 Cootamundra, you might get it done sooner than if you're on
33 the list at Wagga Base. So there is a demand for it,
34 because these lists take away pressure from the base
35 hospital.

36

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

41 A. Mmm.

42

43 Q. -- despite dwindling numbers, there is still a role
44 in these small hospitals for providing the acute procedural
45 type care?

46 A. Absolutely. I think so.

47

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

5
6 Q. And is that in itself potentially an incentive for
7 some GPs with additional skills such as yourself, and such
8 as the GM anaesthetist, to move into a place because
9 they're not just dealing with primary care; they're also
10 dealing with hospital care?

11 A. Yes. And that's the hope, by training up more rural
12 generalists, that we'll have more GP anaesthetics, we'll
13 have more GP, hopefully, surgery and obstetrics, and to
14 incentivise people to come or to give them a job to look -
15 you know, to have at the end of it, you need to have
16 somewhere for them to do it, so yes.

17
18 Q. The other issue I think you raised earlier was the
19 problem with the RDSP being that there is - the clinicians
20 are not reimbursed sufficiently for what they provide to
21 the hospitals; is that correct?

22 A. It can be. So generally, the RDSP is not a one size
23 fits all, it's now 40 years old nearly, so it is having
24 to - as the nature of the work we do changes and the work
25 pressures are different in different centres, we're having
26 to look at different models by which we pay our VMOs. So
27 I don't think it's outdated, as such, but it does need
28 updating in certain areas and we do need other options.

29
30 Q. One of the other options that you were asked about was
31 actually the LHD employing general practitioners. That in
32 some ways is the other extreme?

33 A. That's a different extreme entirely - that's a totally
34 different model and a totally different question because
35 then you're not talking about VMOs; you're talking about an
36 employee model.

37
38 Q. What I'd like to explore with you is whether there's
39 something in between whereby the VMOs or GPs cede some of
40 their autonomy as sole practitioners running their own
41 businesses but in exchange get more certainty from the
42 hospital as to: these particular days I'm going to be
43 working at the hospital and I'll get paid a fixed amount
44 for that. I don't have to deal with billing?

45 A. Yes.

46
47 Q. Has that been something you have considered or looked

1 into?

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

7 So --

8

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

11

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

14

15 MR CHIU: So the general practitioner is still
16 self-employed, so has a practice in town, but the general
17 practitioner signs an agreement with the LHD that says
18 three days a week, and it's always going to be these three
19 days, I'm going to be working at the hospital for these
20 hours and I know that and I know what I'm going to be paid
21 for that, so I don't need to worry about balancing my
22 lists, et cetera, I can organise my life, and I know that
23 three times a year, I'm going to have to go to Wagga for
24 this additional training. Is that a model that has been
25 developed --

26 A. That sounds fabulous. It's a model that I think can
27 work in some places. The trouble is, you may not have
28 a full day's work at the hospital.

29

30 Q. Sure. But the hospital takes the risk of that, if --

31 A. Yes, but then what happens is you're taking a GP out
32 of the town, who is being underemployed in the hospital and
33 not seeing people in the community.

34

35 Q. So there may need to be more flexibility built into
36 that?

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

47

1 Q. Dare I ask is there anything stopping GPs and
2 hospitals negotiating that sort of flexible model?
3 A. Probably will, understanding that that can happen,
4 having the conversation. Current contract models. I don't
5 believe there's a reason not to be able to do that. I can
6 think of a hospital off the top of my head where that would
7 be ideal, that situation.
8
9 THE COMMISSIONER: Q. It might require some
10 experimentation as to --
11 A. Yeah, and I think that's where - when I was talking
12 before about having creative solutions to problems, that's
13 exactly one of them: What is our town facing? What do we
14 need right now and how can we do that in a way that
15 actually values the service and gives the GP that
16 certainty, I suppose. Certainty of hours, which is nice;
17 certainty of income, that's nice; and then that further
18 support for upskilling, fantastic.
19
20 MR CHIU: I have no more questions.
21
22 THE COMMISSIONER: Thank you. Nothing arising?
23
24 MR MUSTON: No.
25
26 THE COMMISSIONER: Dr Christmas, thank you very much for
27 your time it is greatly appreciated.
28
29 THE WITNESS: You're welcome.
30
31 THE COMMISSIONER: You are excused. Thank you.
32
33 THE WITNESS: Thank you.
34
35 <THE WITNESS WITHDREW
36
37 THE COMMISSIONER: Shall we start with Ms Hull --
38
39 MR MUSTON: Yes.
40
41 THE COMMISSIONER: -- before taking the break?
42
43 MR MUSTON: I think so.
44
45 THE COMMISSIONER: We will take the break at 11.30 but
46 we'll give it a start now.
47

1 MR MUSTON: Yes.

2

3 THE COMMISSIONER: Come forward, Ms Hull.

4

5 <KAY ELIZABETH HULL, sworn: [11.17am]

6

7 <EXAMINATION BY MR MUSTON:

8

9 MR MUSTON: Q. Just give us your full name for the
10 benefit of the record, please?

11 A. Kay Elizabeth Hull.

12

13 Q. Could you tell us a little bit about your background
14 within the Murrumbidgee region?

15 A. I've been the - I've been a Wagga Wagga city
16 councillor, 1991 to 1998, and deputy mayor in that time.
17 Then I became the federal member for Riverina in 1998 and
18 retired, voluntarily retired, in 2010. I have worked
19 significantly in the health sector with constituents right
20 across the Riverina region, and I continue to do so on
21 the - I sit on the oversight council, the UNSW medical
22 school oversight council, and my main focus has been on GPs
23 and access to GPs, and their benefits and their
24 recognition.

25

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

33

34 Q. Before we come to the Palliative Care Enhancement
35 Council, can I just ask you in terms of work you have been
36 doing to try and encourage greater access to GPs, what does
37 that actually involve?

38 A. Well, we started with, in 1996, we had 49 per cent of
39 our graduates across Australia were entering into GP
40 practice, okay? So I was very active in Wagga Wagga City
41 Council at the time and we were relying specifically on
42 OTDs for many of our regions, but particularly here in
43 Wagga Wagga as well, and I became really interested in the
44 fact that we were losing that connection to GPs, and
45 perhaps we were losing that respect for GPs. We were
46 bringing in a lot of specialists but our GPs seemed to be
47 diminishing and, of course, you need a GP to refer to

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

7
8 So we - I worked with them whilst I was the deputy
9 mayor and then, of course, as soon as I was elected into
10 the federal parliament, it became my number one objective.

11
12 Michael Wooldridge, John Anderson, at the time, who
13 was the Deputy Prime Minister, undertook a regional tour
14 and came back, and we determined that we would implement
15 clinical schools - and I listened to the former speaker
16 here, presenter - and the clinical schools were designed to
17 train generally country kids in country locations. We felt
18 that if you trained them in the country - they live in,
19 come from the country, you train them in the country -
20 they'll stay in the country, right, in the rural and
21 regional areas.

22
23 We implemented 11 clinical schools, and ours was the
24 first one, UNSW clinical school, under the stewardship of
25 Professor Mohamed Khadra. Our intention was - we went with
26 UNSW at the time simply because they had a medical degree
27 and we needed somebody - we needed to roll out very
28 quickly. Charles Sturt University wanted to do that but
29 they didn't have a medical degree so it would take some
30 time to get that.

31
32 So basically, we started this practice of trying to
33 educate and involve our students in rural and regional
34 communities, but unfortunately all their training wasn't
35 done in, say, the Wagga Wagga one or the Bathurst one or
36 wherever, it was done - two to three years were done in the
37 city, and that's where you lost them, because they
38 generally were told that, you know, "GP practice or being
39 in the country, you won't progress." So generally it's
40 a tutorial, it's the professors that have a very different
41 view of what their students should be doing, and
42 sometimes - and mostly, we lost them.

43
44 We're now doing that, we're now being converted to
45 a full medical school where your whole practice is done,
46 your whole degree is done here in Wagga Wagga, except for
47 one year where you can go and do what you really want;

1 like, you can do sort of an elective and choose to do that.
2 So it's been fairly intensive ongoing work just trying to
3 get an understanding and a respect for GPs and the services
4 that they provide, particularly rural and regional remote
5 Australia.
6

7 Q. Going back to something you said a moment ago,
8 I gather, based on your observations within Wagga Wagga and
9 through your role with UNSW, that a strike rate of keeping
10 these rural students who were being trained at least
11 partially rurally has not been great?

12 A. No. We've gone - as I said, we had 49 per cent
13 Australia-wide in 1996, we have 13 per cent now, going into
14 GP practice. That is - I was worried about 49 per cent.
15 I said, "That cannot service rural and regional remote
16 Australia." We're 13 per cent. Something is wrong.
17

18 Q. Within a community like Wagga, do you think there is
19 something that could be done differently to better
20 incentivise students who train here to stay within the
21 region and practice as rural generalists within the region?

22 A. I think for a beginning, you know, the students get
23 great tutoring here in Wagga Wagga. Honestly, the
24 specialists here are dedicated and the GPs who present to
25 our students are dedicated, and I think we can capture
26 them. And particularly if they meet a partner here, that's
27 a big plus, because they - you know, they sort of have
28 somebody with a base here, that makes a big difference.
29

30 But the cost to the student is fairly significant, as
31 well, to do their - you know, travel out into the regional
32 communities, to stay there, you know, to be allocated to
33 a GP. We try and pick up that, a lot of those areas, in
34 housing and things, but lots of them have got part-time
35 jobs and, you know, casual jobs to pay for their degree, so
36 if they've got a job in Wagga Wagga and - like, say
37 a hotel/motel type job in Wagga Wagga, after their studies,
38 and then they have to leave and do, say, six weeks in
39 Temora, they've got to come back from Temora back to Wagga
40 to do their job to pay for their degree and, you know - so
41 it's a bit of a dilemma, the cost to the student is
42 significant. So I think it becomes a little bit more
43 difficult for them to get that feel that that's not always
44 going to be the case for them. They are not always going
45 to struggle like this.
46

47 I think the incentive that I would say is to ensure

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

7
8 And I think there's also this - you know, this
9 hierarchy of GP/specialists thing, and I think there has to
10 be more respect for the GP. I'd like to call them primary
11 health care specialists. I think "general practitioner"
12 seems to think that they are less than - you know, less
13 than a specialist when, in fact, they are a specialist.
14 They're a specialist right across the board, and we need
15 respect for that and I think that's one of my biggest
16 problems with the health system.

17
18 Q. Can I take you to the Palliative Care Enhancement
19 Council?

20 A. Mmm.

21
22 Q. What are the origins of that body?

23 A. We had intended - we had put in to have a hospice. We
24 don't have access to a hospice.

25
26 Q. When you say "we"?

27 A. That's combined - probably, we were developing with
28 the former member for Wagga Wagga, Darryl Maguire, and
29 myself years ago, and then the new member - or not new
30 now - member for Riverina, Michael McCormack, and we were -
31 everyone was involved in looking at a new base hospital.
32 Wagga Wagga City Council, the state government, everybody
33 was involved.

34
35 But when you've sort of been engaged in this health
36 journey for a long time, you kind of get dragged in to all
37 of this. You might think you're retired but all of
38 a sudden you're dragged back in, and we were looking at
39 a hospice unit at the Wagga Wagga Base Hospital, new build,
40 and then it disappeared and so we - it was a bit of a, you
41 know, sort of a bit of a difficulty for the region again,
42 and thus, we formed a - well, Professor Gerard Carroll AM,
43 who is a cardiologist here, started advocating with Calvary
44 Hospital to deliver a palliative unit at the Calvary
45 Hospital site.

46
47 Eventually, he won. We both actually went in to that

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

15
16 So we are in - you know, so when that was delivered,
17 the Calvary Palliative Care Enhancement Council, which
18 I chair, and I'm the inaugural chair of that, we decided
19 that we would raise funds to enhance end of life experience
20 for patient and family.

21
22 Q. So that's enhancing outside of the context of the
23 eight-bed unit at the Calvary?

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

34
35 We've put in sort of things like, you know, benefits
36 to - like, big TVs, sorry, very big TVs, because the
37 general TV is only this big, so we've put in massively big
38 TVs in there. So we've put a lot of enhancement into the
39 unit and beds into the unit for family members to enable
40 them to experience a warm, comfortable, respectful,
41 dignified end of life process or journey toward it.

42
43 MR MUSTON: I note the time, Commissioner. We might take
44 the break at this time.

45
46 THE COMMISSIONER: Certainly, yes. We'll have a break
47 until 10 to 12.

1
2 **SHORT ADJOURNMENT**
3

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

8 A. Yes.
9

10 Q. What is that role?

11 A. Our role is that we provide a public forum and we
12 produce booklets on palliative care, understanding it, all
13 the services that are required, and that you can access,
14 because people don't know this. It's a very difficult
15 time.
16

17 So we run a public forum and we have, each year - it's
18 a free public forum, we have a whole range of various
19 aspects of palliative expertise on the stage. They give
20 a presentation, whether that be emergency department or
21 night-time palliative specialists, oncologist, Dr Jane
22 Hill, David Palmieri, oncologist, as well, and we do - we
23 have a whole host of various specialists and they give
24 presentations, and then the --
25

26 Q. In terms of the public forum, so it runs like
27 a conference; is that right?

28 A. It runs - we have a presentation, so it's just - it's
29 always in the evening, about 6.30. We have a presentation
30 on the stage of various aspects of palliative and capacity
31 for, you know, getting access to services, et cetera. And
32 then we have a Q&A from the audience, and we get about 200
33 people, different people, every time.
34

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

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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 in 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

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

5
6 What I do with the Palliative Care Enhancement Council
7 is just another arm of ensuring that we can get better
8 access to our GPs, funding for our GPs, funding for
9 specialists for face to face or, where not possible to have
10 face to face, have, you know, online access, so that people
11 are able to know that they have explored and been given the
12 respect and dignity.

13
14 So what is the answer to the question? All that we
15 do, we're a small group of people, there are three or
16 four - four doctors on there and just some - a couple of
17 volunteers, an accountant, so that we can give best advice
18 to, you know, people in our publications; and a lawyer, so
19 we can also understand the issues and give that best advice
20 as best as we can to people, because many people don't have
21 access to all of these services.

22
23 I've done six at home and they've all been very
24 different. I have access to great support, and I think how
25 it was so hard, when I have intimate access to great
26 support for at-home palliative care: how does the general
27 person do it? It is an extraordinary honour, but it's just
28 also draining as well, for everybody, and so I think what
29 we - our task is to get as much information to as many
30 people through these publications, in doctors' surgeries,
31 in accountants', in lawyers', to get them all to understand
32 that there is a need for better information for palliative
33 care but, most of all, there's a need for better access to
34 a palliative care specialist for a GP and funding for
35 online, for palliative specialists.

36
37 Q. Eight palliative care beds at Calvary, relative to the
38 wider population of the district, seems like a small
39 number. What other palliative care services are available?

40 A. We've got our palliative cares that run out of our
41 nurses, our support services that run out of Murrumbidgee
42 Local Health District, and they cover an enormous region.
43 So if you have a look at the geographic coverage of the
44 MLHD, which is quite significant - and they do an amazing
45 job. They are incredibly - I think, I would imagine they
46 are incredibly busy and they do a lot of travel, you know,
47 in order to service. But as far as inpatient, across our

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

10
11 Q. The experience of palliating as an inpatient, both for
12 the individual and their wider family, would be different,
13 I assume, in a very small --

14 A. Yes.

15
16 Q. -- regional MPS as opposed to, say, Wagga Base
17 Hospital?

18 A. Oh, absolutely, but then you've got to have that
19 24-hour funding for palliative. Palliative is a 24-hour
20 process. So, you know, your areas, centres, will have -
21 maybe they might close at 8, you know, close at even 6, but
22 you've got to have - they've got to be funded for - when
23 required, for a palliative patient to have that 24-hour
24 care when they're in their local community.

25
26 Q. In a practical sense, what is it that you think is
27 required in addition to what is already available?

28 A. We would advocate that, in smaller regional
29 communities, funding be provided, should it be required,
30 for a palliative patient to have your facility open, to
31 have somebody with that patient 24/7, not just ship them
32 into Wagga Wagga, right, from - I heard some of the
33 discussion before - Temora.

34
35 So instead of just shipping them into Wagga Wagga Base
36 Hospital because they've got 24, that you would have a pool
37 of funding available, that was an additional pool of
38 funding, to the local health district, to be able to have
39 that facility open longer, to be able to have the local GP,
40 if there is one, able to come in and be funded and be able
41 to deliver that service, but also for that GP to have
42 access to a specialist, a palliative specialist, that they
43 can contact and that specialist is funded as well.

44
45 So I would say that would be a great start. But the
46 next big thing we want is for funding for face-to-face
47 palliative specialists, to be able to travel into the

1 regions, do face to face, and work with the GPs and the
2 other oncologists and specialists in other areas and be
3 funded appropriately for it, for that --
4

5 Q. Are you aware of any GPs within the area who have
6 specialist palliative care training?

7 A. No, I'm not aware of - I'm not aware of those who -
8 no, who have specialist - there is, they can do it, but if
9 they go in, they do - they're a GP palliative specialist,
10 they go into hospital, they will be rebated by Medicare as
11 a GP, right? So they'll do the additional, but their
12 rebate will be as a GP, not as a palliative specialist,
13 right? So there's not a lot of incentive.
14

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

19 A. Yes, as a GP.
20

21 Q. As a GP, through the MBS. The same individual who
22 might be providing treatment as a VMO through the hospital
23 is not being remunerated by Medicare, are they?

24 A. I'm unsure - yes, they would be if they've got - if
25 they've got VMO, yeah, at the hospital, they will get that
26 baseline remuneration, right? But if they're a palliative
27 specialist, I don't believe that they will be remunerated
28 as a palliative specialist; they will be remunerated under
29 the GP VMO.
30

31 Q. Are there any other additional services that you think
32 rural communities would benefit from in terms of the
33 provision of palliative care support?

34 A. Far more localised palliative nurses, but we have
35 a nurse shortage as well. So it's very difficult, you
36 know.
37

38 Q. Pausing there, more palliative nurses, is that to
39 assist people palliating in their home?

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

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

10
11 But I was able to get him at midnight into Calvary
12 because I had support that I could call on. But that's not
13 every - that's very rare for the general public. So what
14 I'm sort of saying is that you literally have an experience
15 at home and you would prefer to be there, but if you have
16 this - if you have ability for a patient to be managed and
17 get back on track again, it's a win/win for everybody.
18 It's a less costly situation.

19
20 Q. To the extent that you're aware, based on your
21 discussions with people involved in either experiencing or
22 delivering palliative care within the region, do you have
23 a sense of the extent to which the existing specialist
24 nursing team is sufficient to meet the --

25 A. No, it's not sufficient.

26
27 Q. What leads you to that?

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

39
40 Q. To the extent that it's delivering information, is
41 there opportunity to use virtual or remote services to
42 deliver that information?

43 A. Well, there is in some cases, but you have to have
44 affordable access to technology, which is outside some of
45 our boundaries and areas, you know? We are getting better
46 access, but it's still certainly very patchy in many areas,
47 and yes, it is an option, but my fear is that, you know,

1 there was a recommendation from an upper house inquiry
2 that - I think recommendation 24 - the Far West model be
3 rolled out, and it's very online and very important.
4

5 Q. Could you just describe for us what the Far West model
6 involved?

7 A. Well, it's very hard for us to get access to
8 understand that, but I understand that the palliative care
9 system works online with exactly what I'm talking about,
10 like, with specialists and others to work with a patient
11 and the family member. I don't have the detail of that,
12 but I just read in the recommendation that there was
13 a recommendation that that could be rolled out.
14

15 My worry with that being rolled out is that you roll
16 out all this online, on palliative, and you think you've
17 done your job. You think, "Okay, everyone's got this
18 online access now." But that's the fallback if you can't
19 have face to face. The best option for the GP and the
20 palliative patient is to have access to a specialist,
21 a palliative specialist, that can give clear understanding
22 of options that may be available. And I think that's the
23 most important thing at the moment. If you want to just -
24 yes, there is - to answer your question, yes, there is
25 a place for it, but it shouldn't be the only place. And
26 VAD, the introduction of that in November, has left us in a
27 very significantly different, difficult place.
28

29 Q. "VAD" - I take it that's the voluntary assisted dying?

30 A. Yes, the introduction of voluntary assisted dying.
31 You know, if you live in the city and you have access to a
32 hospice, your GP has access to a specialist, et cetera, for
33 you, and you have, you know, voluntary assisted dying to
34 consider, you have a choice, you actually have a choice.
35 But when you live in rural, regional or remote New South
36 Wales - or Australia, really, but we're talking New South
37 Wales at the moment - you have very little choice, and if
38 you are not going - if we're not going to think of end of
39 life as a health issue that needs funding and needs support
40 and needs access to specialty, you know, services, then,
41 you know, we're not doing our job in that we're not giving
42 those rural and regional and remote New South Wales
43 residents a choice.
44

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

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

3
4 THE COMMISSIONER: Q. Sorry, we flipped to voluntary
5 assisted dying from online palliative care. When you said
6 "There is a place for it but it shouldn't be the only
7 place", were you referring to the Far West New South Wales
8 palliative care model or something else?

9 A. No, I was actually referring - there is definitely
10 a place for the Far West model but it shouldn't be the only
11 option, you know.

12
13 Q. Do you know what that model is exactly, though?

14 A. Well, it's - I've got it on my - I didn't bring it
15 with me. I've got it on my computer. It's hard to
16 understand, but it is certainly accessible.

17
18 Q. Whatever information you've got on it, I would be
19 grateful if you supplied it, because --

20 A. I will.

21
22 Q. This isn't a criticism, but if you read the
23 legislative council report with that recommendation 24 you
24 spoke of, it doesn't really give an explanation --

25 A. It doesn't.

26
27 Q. -- about what this model of care is. It gives
28 a reference to a submission that was made by the Western
29 New South Wales PHN, but - and again I don't mean this
30 disrespectfully - that, when I read it, didn't really set
31 out what the model of care is either. So I'm curious to
32 learn what it is we're actually talking about in a specific
33 sense. No doubt it's some form of online palliative care,
34 to the extent that you can do that, for very remote towns,
35 but the details - it might be my fault but I haven't seen
36 how it actually works in practice.

37 A. And we're the same. I've been trying to access it as
38 well, but I do have a little bit more information I can
39 provide.

40
41 Q. That would be great, thank you.

42 A. And the link to it. And we are on the same - but I'm
43 clear about the detail is that the local palliative nurse
44 works online with specialists.

45
46 Q. With a doctor?

47 A. With a doctor.

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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.

- 1
2 As I understand it, back in 2004, you were part of the
3 Palliative Care Enhancement Council; is that correct?
4 A. In? No, I have been - we've only been since 2016,
5 I think, for the Palliative Care Enhancement Council.
6
7 Q. Were you part of a group that recommended --
8 A. Yes. Yes, we were a doctors group.
9
10 Q. A doctors group in 2004?
11 A. Yes, I was, sorry, yes. Absolutely. We had been
12 working on a whole host of medical issues. I've always
13 been a part of the doctors group here.
14
15 Q. Back in 2004, that group recommended a four- to
16 five-bed hospice at Wagga Wagga hospital --
17 A. They did.
18
19 Q. -- for the redevelopment?
20 A. They did.
21
22 Q. What happened there was that when the clinical
23 services plan for that development came out a couple of
24 years later, they didn't adopt that recommendation?
25 A. No.
26
27 Q. And was it the case that that clinical services plan
28 recommended that palliative care be community-based
29 instead, with physicians, nurses and GPs, and access to
30 inpatient hospital beds as required?
31 A. That was the idea of - that was the reasoning behind
32 it. However, that's not realistic.
33
34 Q. No, okay. But you did give some evidence earlier that
35 most people do prefer to palliate at home, if they can?
36 A. If they can and we have a great model at home,
37 although, our model here in Wagga Wagga - I now know that
38 we don't have a palliative - our palliative care nurses are
39 not able to go out at night because of safety, of course.
40 They are prevented from going out at night. So you then go
41 to ED and that's --
42
43 Q. In an ideal world -- sorry to interrupt you. In an
44 ideal world, you would have the workforce and the capacity
45 for people to be seen at home?
46 A. Yes.
47

1 Q. Rather than hospices and EDs?

2 A. Yes.

3

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

7 A. There is, yes.

8

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

12 A. Mmm.

13

14 Q. -- is that right?

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

25

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

33

34 Q. All the options are open?

35 A. Yes.

36

37 Q. Because the alliance means that every facility is
38 available for it?

39 A. Yes, yes.

40

41 MR CHIU: No further questions, Commissioner.

42

43 THE COMMISSIONER: Thank you.

44

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

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

6
7 THE WITNESS: Thank you.

8
9 THE WITNESS: You are excused. Thank you so much for
10 coming in. It is greatly appreciated.

11
12 THE WITNESS: Okay, thank you.

13
14 <THE WITNESS WITHDREW

15
16 MR MUSTON: I think the next witness is Associate
17 Professor Ayman Shenouda. Mr Glover is going to be taking
18 this witness.

19
20 <AYMAN SHENOUDA, sworn: [12.21pm]

21
22 <EXAMINATION BY MR GLOVER:

23
24 MR GLOVER: Q. State your full name for the record,
25 please.

26 A. Ayman Shenouda.

27
28 Q. You are a general practitioner?

29 A. Yes.

30
31 Q. You practise here in Wagga Wagga?

32 A. Yes.

33
34 Q. You're a fellow of the Royal Australian College of
35 General Practitioners; correct?

36 A. That's right.

37
38 Q. And you're a past president of that college?

39 A. Yes.

40
41 Q. When were you president of that college?

42 A. I was president and - I was vice president of that
43 college at the end of - Harry Nespolon was the president
44 and Harry unfortunately passed away, so I had to take over
45 presidency for about six months when he passed away.

46
47 Q. When was that?

- 1 A. 2019.
2
- 3 Q. And you're the chair of the rural faculty of the
4 college; is that right?
- 5 A. I was ex - I'm the immediate past chair of the chair
6 of the faculty, yes.
7
- 8 Q. You held that role for about six years?
9 A. Yes, exactly.
10
- 11 Q. When did you cease in that role?
12 A. The same time, 2020, yes.
13
- 14 Q. Can you just in general terms describe the function of
15 the rural faculty of the college?
- 16 A. Well, the rural faculty represents rural GPs, which is
17 about 95 per cent of rural GPs, and it represents them,
18 advocates for them, enables them and gives them education,
19 if needed, and among other things.
20
- 21 Q. Can you just tell us a little bit about your practice
22 here in Wagga? How many doctors are in practice with you?
- 23 A. I've got about eight to 10 doctors, variably, so eight
24 doctors at the moment, and I've got all allied health
25 professionals under the same practice, so we've got a
26 dietician, we've got a diabetic educator, we've got an
27 exercise physiologist, a psychologist, and a pharmacist
28 sometimes, too, so all - majority - podiatrist, too, sorry.
29
- 30 Q. In providing care to your patients, I take it that you
31 have cause to interact from time to time with the acute
32 care setting; is that right?
- 33 A. Absolutely.
34
- 35 Q. And are there any particular challenges you find in
36 interacting with the acute care setting in the management
37 of your patients?
- 38 A. Yeah, there's a lot of - there's some issues about the
39 acute care setting. I can tell you a story, maybe that
40 would make it easier.
41
- 42 Q. That's easier.
43 A. Three of my patients have been through the system.
44
- 45 Q. First of all, perhaps just if you wouldn't mind
46 identifying some particular challenges, and then by all
47 means with some examples, it would be very helpful.

- 1 A. Yes, so challenges with the - in terms of handing over
2 patients. So in the health system at the moment, they
3 call - the handover is the discharge summary, which we are
4 in principle against the idea of a discharge, because --
5
- 6 Q. Just before you go on, this is a summary that comes
7 from the hospital back to you as the general practitioner?
8 A. That's exactly right.
9
- 10 Q. When one of your patients might have been admitted or
11 presented to hospital?
12 A. That's exactly right.
13
- 14 Q. What is the particular difficulty with the discharge
15 summary?
16 A. There's two things about discharge summaries, they are
17 very delayed, so we don't get them when the patients
18 present back to us.
19
- 20 Q. When you say "very delayed", what sort of in your
21 experience, just --
22 A. Some times --
23
- 24 Q. These two ladies here are taking down everything we
25 say, and if we speak over it each other it makes their --
26 A. I'm sorry.
27
- 28 Q. No, I'll be guilty of it as well but we'll both have
29 to try hard to let one of us speak at a time. So what is
30 the particular difficulty that you have experienced with
31 discharge summaries?
32 A. Delay in having the discharge summaries, and that can
33 be up to a week or two, sometimes.
34
- 35 Q. And what challenge does that pose to you as a general
36 practitioner in the management of your patients?
37 A. That I would need to know what has happened to the
38 patient during the stay in the hospital, so I can
39 appropriately continue managing their disease or their
40 illness.
41
- 42 THE COMMISSIONER: Q. Do you know why it takes a week or
43 two to get a discharge summary?
44 A. I --
45
- 46 Q. Are you given any reasons, for example?
47 A. I think that the hospital relies on the interns to do

1 that job. They are the most junior doctors and they have
2 a lot of other things that they need to do, and that's
3 another dimension of how a problem is, that you get
4 a discharge from a junior doctor that doesn't necessarily
5 have all the context that you want to have as a GP.
6

7 Q. They're reading from notes and they may not have seen
8 the patient themselves; is that right?

9 A. Sometimes it's like that, but other times, their
10 understanding of the complexity of the patient is very,
11 very low. So their discharge summary is based on their
12 understanding rather than based on what the issues are.
13

14 THE COMMISSIONER: I see, thank you.
15

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

19 A. Yes.
20

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

23 A. Correct.
24

25 Q. And two is content; is that right?

26 A. That's exactly right.
27

28 Q. Any others?

29 A. Again, naming it "discharge summary", for me, is
30 a difficulty, because I'm used to "handover of care", and
31 handover of care is a doctor calling a doctor. So I'll
32 give you the other way around.
33

34 Q. Yes.

35 A. If I want to send the patient to the hospital, which
36 I think they are seriously ill, then I would call the
37 emergency department, talk to the admitting doctor, say,
38 "I've got this patient, this is the issues, this is the
39 situation I'm facing. I need this and this and this to be
40 done, and I think that's how, and if you please inform me
41 about the outcome of what happened to this patient." This
42 is specifically in seriously ill patients. So there are
43 ill patients that not require me calling and I might write
44 a letter to the emergency department. But in seriously ill
45 patients, I would definitely call the admitting officer and
46 let them know what's going on.
47

1 Q. And do I understand you correctly, that the challenge
2 with the discharge summary that comes back to you from the
3 hospital is that you don't see it as a handover of care; is
4 that right?

5 A. Yes. I see it like we've finished with the care of
6 this patient, where there's still some responsibility to -
7 the doctor who is delivering the care is to hand over this
8 care rather than discharge the care from there.

9
10 Q. Is this an issue that has been taken up by the
11 college, to your knowledge, with --

12 A. Yes, absolutely.

13
14 Q. In what forum?

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

18
19 Q. And has it been raised with, for example, where we are
20 here, with the Murrumbidgee Local Health District?

21 A. I believe it did, because we have the faculties. So
22 the rural faculty represent, and national faculty more of,
23 but we've got the New South Wales faculty, we've got the
24 Queensland faculty, and with all of those faculties, their
25 job is to liaise with their acute setting, whether it's
26 Queensland Health or NSW Health or Western Australian
27 Health.

28
29 Q. What changes, if any, could improve the process from
30 your perspective?

31 A. There is a couple of things that I would mention
32 there. The patient understanding of what happened to them
33 in the hospital is very, very limited, and I think I rely
34 on the patients, and quite often I will tell the patients,
35 "What happened in the hospital? What sort of things
36 happened?" And they say, "Look, they were very good to me.
37 They dealt with me in a very good way", and I say, "Do you
38 understand which medication they started you on, what is
39 the effect of this medication on you?" No understanding
40 whatsoever about their illness, the challenges they are
41 facing and how they're going to continue on their care.

42
43 So part of it, for me as a doctor, is a document that
44 will give me an idea, a good idea, of what happened in the
45 hospital. Maybe, if it is a serious-enough condition,
46 I would need the specialist or a senior doctor within the
47 hospital to give me a call to say, "Are you aware of this

1 patient coming out today? Can you please see them within
2 24 hours?"

3
4 And the third one is, the third dimension is, the
5 patient's understanding about what happened and their
6 illness within the hospital system. We talk a lot about
7 patient-centred care but we are still so disease focused.
8

9 Q. Just explain that last concept to me a little bit
10 more. When you say that there is a lot of reference to
11 "patient-centred care but we are disease focused", who is
12 the "we"?

13 A. I think in the hospital system mainly. I think
14 general practice is so, you know, patient centric. We
15 discuss issues with patients about their health, we educate
16 them about their health. They understand what their
17 options are and they have the choice of where to go
18 further.
19

20 Q. Do I take it that some discharge summaries might be
21 better than others, that you receive?

22 A. Absolutely. You will have some discharge summaries
23 that are better than others.
24

25 Q. Are there any other challenges that you face in your
26 caring for your patients in terms of interaction with the
27 acute care setting, other than discharge summaries?

28 A. Yeah, I find that acute care setting, again, is
29 disease focused. So I can give you some examples, as
30 I said before.
31

32 Q. Yes, please do.

33 A. I had a Miss Grace, she was 80 --
34

35 Q. Well, don't mention --

36 A. No, not mentioning any specifics.
37

38 Q. Yes, just anonymise them. No names.

39 A. Yeah. She was now a 90-year-old lady. She has been
40 my patient for 20 years. A few years ago she presented to
41 the practice and she had shortness of breath. I wasn't
42 there at the moment because I was on leave and the locum
43 was there. The locum had assessed her and, given her
44 acuity, he said he thought the best thing is to refer her
45 to the hospital.
46

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

1 admitted under a respiratory physician. They did some
2 scans for her and some respiratory tests that they do,
3 respiratory function tests, and they couldn't find any
4 reason for her shortness of breath so they got the
5 cardiologist involved. The cardiologist came in and
6 they've done an echocardiogram, they've done some other
7 tests and tried again to find out the reason for the
8 problem and they couldn't find the problem.
9

10 The first day I'm back, she was in my rooms, waiting
11 for me. She booked the first appointment. She was very
12 frustrated and very anxious about what happened to her
13 during this period, and I didn't have a discharge summary,
14 so I heard the story from her, and I noticed that in her
15 body language she's a bit anxious. I know the patient, so
16 I had longitudinal care for her for a long time, and I felt
17 that she was stressed more than anything else. So I put my
18 hands on her hands and said, "Are you okay?" And she went
19 into tears and crying about her abusive ex-husband that is
20 dying in the hospital and her priest is telling her that
21 she needs to visit her ex-husband before he dies and she
22 didn't feel very well. As a matter, she had some very bad
23 experiences with her husband and all those experiences were
24 brought on with the priest's intervention.
25

26 At the end of the day, this lady suffered from
27 anxiety, and no-one would have picked on that because
28 no-one has asked her what her story is. For me, it was
29 this, counselling, a couple of sessions after that, and she
30 was okay. There was no shortness of breath anymore.
31

32 Q. But do I take it you were able to identify those
33 circumstances because, as you say, you had the longitudinal
34 care of the patient?

35 A. Absolutely, and I ask the patients, too. I'm not only
36 focused on the shortness of breath; I'm focused on the
37 personal issues. I tell the registrars and the young
38 doctors to learn how to treat - not to treat disease in
39 patients but to treat patients with disease.
40

41 Q. Is that perhaps a function of the difference between
42 the role of a general practitioner and the role of the
43 acute care setting?

44 A. Oh, look, I understand the acute care setting has got
45 its own challenges, but that doesn't mean that we don't get
46 the patient involved in their care and understanding their
47 care.

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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

1 all the GPs together with the help of the PHNs and we
2 designed a care that's based on all GPs in town we'll make
3 two appointments available every day for this urgent care.
4

5 Q. Is this something different to the urgent care clinics
6 that you've just mentioned?

7 A. Yes. So this is a new model that hasn't been done
8 before in any part of the country. So the model that was
9 supposed to happen is to create new clinics that would --

10

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

15 A. Yes.

16

17 Q. What was good about it?

18 A. That was good that the funding - the state funding is
19 spent into general practice --

20

21 Q. I see.

22 A. -- and delivers a good quality at the end of the day
23 that would reduce patient admission at the end of the day,
24 so --

25

26 Q. And how does it do that, from your perspective?

27 A. So as I said, the state was happy - or we're still in
28 the - we haven't started delivering the care yet, but the
29 state was happy to pay money to general practice to be able
30 to do this care for those patients.

31

32 Q. New South Wales?

33 A. Yes.

34

35 Q. And this is a new --

36 A. Initiative, yes.

37

38 Q. Hasn't started yet?

39 A. Hasn't started yet.

40

41 Q. This is different to other clinics that have been
42 rolled out in other places; is that right?

43 A. That's exactly right.

44

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

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

11
12 Q. So under this program, you said that the GP practices
13 will hold two appointment slots; is that right?

14 A. Yeah.

15
16 Q. And how does the patient come to be referred into one
17 of those appointment slots?

18 A. I think Healthdirect would be involved in that and the
19 patients would call Healthdirect. And then we are now
20 negotiating with Healthdirect to what are the questions,
21 what are the things that would need to be in place, and
22 give the priority to the patient's own practice before they
23 get into another practice.

24
25 Q. And these might be patients who either have no regular
26 GP; correct?

27 A. Yes, they might have no regular GP or have a regular
28 GP, so we would rather them see their regular GP rather
29 than --

30
31 Q. Yes, but they may not be able to, for various reasons?

32 A. Yes, absolutely.

33
34 Q. And this is an example where collaboration between the
35 district and general practice has worked well, from your
36 perspective?

37 A. I think so. I think there's a lot of cases. In my
38 view, for the patient to be assessed in the hospital, it
39 costs the hospital system about \$450 for an assessment of
40 a patient. It costs the taxpayer money \$38 to see a GP.
41 So if this money is spent into general practice and we
42 avoid hospital admissions and avoid the cost that we will
43 assess a patient in the hospital, it will be a better
44 outcome.

45
46 Q. So through Healthdirect it is diverting patients who
47 might otherwise present to ED into a general practice, into

1 one of these spots; correct?

2 A. Exactly right.

3

4 Q. Are there any examples where community healthcare
5 initiatives have been delivered where you consider that the
6 collaboration or communication from be it the ministry or
7 the district and general practice has been lacking?

8 A. Not a lot of those. I have to say, there is not an
9 intent - just it's understood by the state health that
10 general practice is Commonwealth funding, we should not
11 spend - this is a Commonwealth problem, we should not -
12 instead of thinking about it as a patient problem, an
13 access problem and quality of care problem.

14

15 Q. Could I ask you about training of general
16 practitioners. You have an affiliation with the University
17 of Notre Dame; correct?

18 A. That's exactly right.

19

20 Q. What is your role with that institution?

21 A. I'm an associate professor with Notre Dame, adjunct
22 associate professor, and I train young doctors or young
23 potential doctors, students, in my practice.

24

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

26 A. Yes.

27

28 Q. Before we come to some specifics, are you aware
29 through your work of the college of the trends of people
30 training to become general practitioners across the state
31 and the nation?

32 A. Yeah, unfortunately we have a very declined amount of
33 doctors choosing general practice as a specialty at the
34 moment. So we went - 10 years ago it was 50 per cent of
35 our graduates that would choose general practice as
36 a specialty, or a vocational training, now it's down to
37 17 per cent.

38

39 Q. And has the college been able to identify, to your
40 knowledge, any reasons for that decline?

41 A. Yeah. One of the big reasons is that the doctors, the
42 young doctors, are not exposed to general practice during
43 their training at all, and one of the very, very successful
44 programs that happened beforehand was a program called the
45 PGPPP.

46

47 Q. What's that?

1 A. Prevocational General Practice Placements Program.

2

3 Q. When was this program in place?

4 A. I cannot - it's a few years ago. It would be 15 years
5 at least, maybe. And that meant that young doctors, while
6 in their younger - in their RMO years, they can be located,
7 three months into general practice, to have experience of
8 general practice. I was able to attract 16 doctors of
9 those in my period when I did the training for them, and
10 12 of them have chosen general practice after they
11 finished.

12

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

22

23 Q. These are general practitioners?

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

33

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

37

38

39 Q. -- is that something you have read that is an
40 Australian-wide statistic?

41

42

43

44

45

46

47

Q. You can tell us later.

A. Yeah, yeah, I can give you the statistics, it's very

1 clear, yes.

2

3 THE COMMISSIONER: Thank you.

4

5 MR GLOVER: Q. In that last answer you said the state
6 should be investing in general practice, do you mean
7 New South Wales?

8 A. I think New South Wales, in my opinion, and there are
9 other states that have already started doing that in some
10 areas.

11

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

15 A. It is a nationwide problem.

16

17 Q. When you say the states should be investing in general
18 practice, what did you have in mind?

19 A. A lot of things. One of this is funding another PGPPP
20 program where they expose the young doctors to have the
21 experience of general practice as a rotation, so as you
22 might know, in the first year of training we have mandatory
23 terms for our young doctors to have to do, like,
24 paediatrics, it's actually emergency and medicine and
25 surgery and others. So I want --

26

27 Q. So at the moment general practice is not included in
28 that?

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

40

41 Q. What do you mean by that?

42 A. I feel like they feel like general practice, maybe -
43 like Kay Hull said, is not a specialty of its own.

44

45 Q. When you say "state health" have that view --

46 A. Because they don't have --

47

1 Q. -- what do you mean?
2 A. They don't have interactions with GPs as much.
3
4 Q. Who's "they"?
5 A. The state.
6
7 Q. The ministry?
8
9 THE COMMISSIONER: Q. Do you mean NSW Health --
10 A. NSW Health.
11
12 Q. -- the ministry or --
13 A. The hospitals, maybe the districts.
14
15 Q. -- the LHDs?
16 A. The LHDs themselves.
17
18 MR GLOVER: Q. And when you say "they don't trust
19 general practice", what do you mean by that?
20 A. I don't - I don't - I'm not certain whether they trust
21 or don't trust, but what I know is when they create - when
22 they create a program into the community, they don't
23 consult with general practice. They create a program under
24 their own specialists to be delivered in to the community
25 without consulting or collaborating with general practice.
26
27 Q. Is there an example that comes to mind?
28 A. There is a lot of examples. So there is a cardiac
29 rehab program for patients who finish cardiac surgery.
30 That's totally run by the hospital without involving
31 general practice. There is a respiratory program, again,
32 same thing, it's just run by the state department --
33
34 Q. These are programs delivered into the community?
35 A. Yes.
36
37 Q. Is the point that you're raising that when they were
38 developed and implemented, from your perspective, there's
39 a lack of consultation with general practice --
40 A. Absolutely.
41
42 Q. -- in that area?
43
44 THE COMMISSIONER: Q. With the example you gave, how
45 would it have helped if - I assume when you are saying "the
46 state", you're talking about the LHD?
47 A. Yes.

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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.

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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.

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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?

1 A. Absolutely.

2

3 Q. What did you have in mind?

4 A. Oh, look, education support, support - social support,
5 financial support, support to navigate the system. So for
6 me as a GP, to employ an IMG to get them from overseas, to
7 get them into Australia, they are qualified doctors
8 overseas, they have their pathways that they have to go
9 through, but it will take me about three years to get - and
10 \$30,000 to pay to get a doctor in here, and then I will
11 start looking after them and training.

12

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

17

18 Q. That's within your practice?

19 A. Yeah, within my practice.

20

21 Q. A cost to your practice, and a training burden you
22 take on?

23 A. Yes, exactly right. Yeah. So I put an extra bit to
24 support. So I want this bit not to come from an individual
25 that aspires to do - I want this to be, you know, regulated
26 in a way that there is other GPs who would do that, they
27 would be paid for the training, they would support the IMGs
28 adequately so when they go on their own, they can go on
29 their own and be confident in delivering quality, safe
30 care.

31

32 Q. Where, in your view, should that support be coming
33 from? Is it the Commonwealth, the state, the college?

34 A. I think health issues are health of the nation and we
35 need to start thinking about addressing issues in a
36 different way than we've been doing it for years and years.

37

38 Q. When you say " a different way", you're referring
39 to --

40 A. Divided between the Commonwealth and the state, we
41 need to collaborate, we need to think about the problem and
42 sit together and try to come up with solutions and make it
43 happen.

44

45 Q. As a one system rather than a Commonwealth and a state
46 system; is that what you mean?

47 A. I think the one system - Kevin Rudd had a go on that

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

7
8 Q. Is what you're referring to that the fragmentation in
9 the system --

10 A. Absolutely.

11
12 Q. -- is thing that poses challenges in a number of
13 areas, including something as simple, perhaps, as providing
14 support to practitioners in the regions?

15 A. Absolutely. There is a lot of money around that's
16 thrown in to different aspects of the system that I think
17 if we really are serious about what we're facing in the
18 future, with the chronic disease burden, with the ageing
19 population, with palliative care issues, with mental health
20 issues, with post-COVID issues - there's a lot of
21 challenges to our system that are coming in, and if we
22 don't all work together, it's not going to be good.

23
24 MR GLOVER: Commissioner, I note the time. I've got about
25 15 minutes to go. I was going to inquire whether you would
26 be prepared to sit on so Professor Shenouda.

27
28 THE COMMISSIONER: I've actually got an online meeting at
29 1.30, so we'll have to break now.

30
31 MR GLOVER: Okay.

32
33 THE COMMISSIONER: So we will break now. Just for the
34 purpose of the transcript, and because Mr Chiu and those
35 instructing him won't have got this, this just relates to
36 Ms Hull's evidence, the Agency for Clinical Innovation -
37 you might know this - put out a publication on the Far West
38 Local Health District palliative and end of life model of
39 care in July 2023.

40
41 MR CHIU: Thank you.

42
43 THE COMMISSIONER: Okay, we will adjourn until 2 o'clock.
44 Thank you.

45
46 **LUNCHEON ADJOURNMENT**

47

1 THE COMMISSIONER: Come forward, sir. Have a seat again.
2
3 Yes, Mr Glover?
4
5 MR GLOVER: Q. Professor Shenouda, just before we return
6 to some issues about training, there are a couple of things
7 I'd like to clarify from your evidence before lunch.
8 Earlier on in your evidence you discussed the program which
9 sees GP practices within Wagga holding a couple of
10 appointment spots open per day so that patients can be
11 referred in to them. Do you remember that passage of your
12 evidence?
13 A. Yeah.
14
15 Q. I think you said that it was an initiative set up
16 largely by the PHN; is that right?
17 A. It's a combination between the PHNs and the local GPs.
18
19 Q. So it's not something with which the local health
20 district has an involvement; is that right?
21 A. There was an involvement from the local health
22 district.
23
24 Q. What was that involvement?
25 A. On the panel - there was an emergency doctor on the
26 panel that initially discussed this.
27
28 Q. The panel that was designing and implementing --
29 A. Yeah, designing a look to how it would look like to
30 implement in the future.
31
32 Q. So for the practices that hold those slots open, how
33 are those slots paid for?
34 A. They would be paid by the state.
35
36 Q. When you say "the state", who do you mean?
37 A. State health.
38
39 Q. NSW Health or the Commonwealth?
40 A. New South Wales no, not the Commonwealth, the whole
41 program is funded by the state.
42
43 Q. By the state?
44 A. Yeah.
45
46 Q. If those appointments are not used, are the GP
47 practices still paid for holding them open?

1 A. Yes.

2

3 Q. And again, to your understanding, is that NSW Health
4 or the Commonwealth who would fund that?

5 A. The NSW Health. But I would assume that the
6 appointments would always be used.

7

8 Q. In that passage of evidence, you referred to urgent
9 care clinics. They're something different to this program,
10 aren't they?

11 A. There are two urgent care clinics, there's an urgent
12 care clinics run by the state, so the state, both Victoria
13 and New South Wales, have decided they're going to put some
14 funding into the state, to be run by the state, and there
15 is Commonwealth funding also that is running some urgent
16 care clinics around the country. There's two models there
17 funded by two different --

18

19 Q. When you refer to the clinic run by the state, are you
20 referring to what is described as "rapid access clinics"?

21 A. Yeah, that's my - no, it is urgent care clinics, but
22 not the rapid - there's two clinics there too. So there is
23 the rapid access clinics that are done by the - in the
24 hospital. I think we've got the rapid access clinic here
25 that's functioning for the last four or five years. But
26 this is a new funding, different than the rapid access
27 clinic.

28

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

32 A. Yes.

33

34 Q. Do you remember that?

35 A. Yes.

36

37 Q. Can you just describe what role the Commonwealth has
38 in relation to the training of medical students?

39 A. Not medical students, I'm talking about vocational
40 training of doctors for the discipline of general practice.
41 Yes, this is a funded program by the Commonwealth.

42

43 Q. Just one step at a time. What's the program that you
44 are referring to?

45 A. It is the Australian General Practice Training
46 Program.

47

1 Q. Who runs that program?

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

7

8 Q. So the funding from the Commonwealth, what is the
9 funding used for in that training program?

10 A. For training doctors who choose general practice as
11 a specialty in their vocational training period.

12

13 Q. Is that training that supports the trainee doctors or
14 does it go to the practices who are providing the training?
15 How does it work?

16 A. It goes to the supervisors and it goes to the
17 practices. So it's two components of it: one for the
18 practice that would allow this to happen within the
19 facility, use the rooms for training registrars and look
20 after registrars; but also part of it for the supervisors
21 that deliver the training in the practice.

22

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

25 A. Yes.

26

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

30 A. Yeah.

31

32 Q. Do you have a view on what can be done to attract and
33 support local graduates to rural and remote areas, in
34 particular in relation to general practice?

35 A. Absolutely. So talking about local graduates, we are
36 missing local graduates for a few issues that - I have
37 mentioned some before but I will go through it again.

38

39 Q. Yes.

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

43

44 Q. Why do you say that?

45 A. Because we're dealing with all the body, we are
46 dealing with mental health, we're dealing with chronic
47 disease, we're dealing with palliative care, we're dealing

1 with gynaecology, we're dealing with respiratory illness.
2 We're dealing with the whole gamut of things. So that
3 makes the job very complex and to be able to narrow it down
4 to what the problem is, it's more challenging in general
5 practice.
6

7 Q. Is that challenge heightened in a rural and remote
8 area?

9 A. Oh, I think the challenge is all across the borders,
10 it's dealing with more and more complex patients. So
11 younger graduates, when they have the choice between having
12 a more complex job to do, to a rather more simple, as other
13 specialty disciplines, other specialties would concentrate
14 on one organ of the body, whereas we are dealing with the
15 whole body.
16

17 So it becomes very - and to be another specialist
18 within the specialists costs - remunerates a lot more than
19 being a GP. So why would you be a young graduate that
20 would choose a more complex, less paid job over an easier,
21 better paid job.
22

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

25 A. Absolutely.
26

27 Q. Or has something changed by reason of the demographic
28 of the population to heighten that complexity?

29 A. I think, yes, we have - the health state we are in now
30 is completely different than it was 15 years ago.
31

32 Q. In what way?

33 A. I can tell you a simple thing. So 15 years - when
34 I started 20 years ago, or 25 years ago, when I started
35 doing general practice, if I have a lady that's 85, I would
36 go to my colleagues and celebrate that she's still alive
37 and kicking and doing well and I'm keeping her alive. Now,
38 I've got 20 of those every day. So definitely we are
39 keeping people living longer and that's, I think -
40 I suppose this is something that we appreciate in general
41 practice, that we've done a lot to keep those people
42 around.
43

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

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

4

5 Q. So the challenges of complexity and viability that you
6 have referred to --

7 A. Yes.

8

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

11 A. Absolutely.

12

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

15 A. Look, I --

16

17 Q. -- general practice in regional and remote areas?

18 A. Sorry, I'm interrupting you.

19

20 Q. No, that's okay.

21 A. I think we need to look at the data. We need to look
22 at the international data, we look at Barbara Starfield in
23 the US, who has done a lot of work into the future of
24 affordability of health in nations, in first country
25 nations, and she's just proven once and again that
26 investing in primary care is the way forward for any nation
27 to survive the issues that we are dealing with.

28

29 Q. That's a response perhaps to the health needs of the
30 population. What can be done, in your view, to attract
31 practitioners to general practice and, in particular, in
32 rural and remote areas?

33 A. Yeah. So there are a few things. I think - I will
34 talk specifically about rural communities, because that's
35 where the shortage is.

36

37 Q. Yes.

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

43

44 Q. Let's just step through the pathway.

45 A. That means - doctors take about 15 to 20 years of
46 training to reach to be vocationally trained, okay? Part
47 of the training is in the university, undergraduates, and

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

9
10 We found out that part of that issue is that if you
11 have a training for 15 years, that's where you develop your
12 social network, you develop a spouse or have friendships
13 and people around you within your facility or within that
14 place you are doing that. So if we turn that around and we
15 get people trained rurally from the beginning, so establish
16 medical schools, complete medical schools, in the rural
17 community, and then you take them into hospitals in rural
18 communities, but also into general practice and you get
19 them exposed to the rural communities, they form their own
20 networks in those communities, so by the time they finish
21 their training, they will be embedded in this community and
22 understand the issues with this community and better - and
23 have the passion to deliver care for those communities too.

24
25 Q. What you are describing is sometimes described as
26 "grow your own" initiatives, is that --

27 A. Absolutely.

28
29 Q. And do you have a view about their success?

30 A. I think it would be very successful, if we exposed -
31 like I'm talking about, general practice exposing students
32 to - or medical graduates to general practice, just expose
33 them to the community in that sense, and making them aware
34 of the community, have their ties within the community,
35 definitely would work better.

36
37 Q. And does that extend to attracting local students to
38 general practice as well?

39 A. Absolutely. Look, students love their turns in rural
40 communities. They feel - and young doctors. They feel
41 they learn a lot more than they will do in an urban
42 setting, and the reason for that is in an urban setting, if
43 you're looking at RPA or other big hospitals, the students
44 or the interns are sitting at the end of a big, big, big
45 row that they need to learn something, whereas in rural
46 communities, they are hands-on, they do things, the
47 specialists are in close proximity for them and they can

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

2

3 Q. Are you familiar with the single employer model that
4 was piloted in this district?

5 A. Absolutely. I was part of developing it.

6

7 Q. And can you just explain for the Commissioner what
8 that model entailed?

9 A. So that model entailed, in early training of GP
10 training, to get people out of the hospital, to work in
11 general practice, they lose their - they lose their annual
12 leave, they lose all of their payments that they should be
13 paid - they lose it all.

14

15 Q. The employment benefits associated with being an
16 employee of NSW Health; is that what you're referring to?

17 A. That's exactly right. And they also get down in their
18 pay. So again, we found this issue when we did the rural
19 generalist pathway, where we interviewed a lot of younger
20 doctors to explore what their problems are, and one of the
21 problems is that less remuneration they get when they go
22 out into general practice.

23

24 Q. So trainee doctors who were employed by the state are
25 now moving to general practice and seeing their
26 remuneration decrease; is that what you are referring to?

27 A. Especially in the first year. So that was an
28 initiative that we sort of supported into trying to get an
29 employer that would be responsible for paying those doctors
30 not losing their entitlements but also not going down in
31 pay, and the state was happy to do that. But in New South
32 Wales, the state only do it for the rural generalists
33 because they can see the benefit of them working in the
34 hospitals.

35

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

41

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

1 their specialty.

2

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

6 A. Absolutely.

7

8 Q. What benefit would come from that in your view?

9 A. As I said, there would be more registrars interested
10 in coming to general practice; there would be no disparity
11 between one pay and another pay; there would be, yeah, more
12 doctors taking up general practice as a specialty of their
13 passion.

14

15 Q. And I take it --

16

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

19

20 MR GLOVER: It has.

21

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

24

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

28 A. Yes.

29

30 Q. -- and you would see benefit in it being expanded to
31 include general practice as well; is that right?

32 A. Yes, that's exactly right.

33

34 MR GLOVER: Does that deal with the issue?

35

36 THE COMMISSIONER: Understood.

37

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

44

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

1 medical workforce in the district?

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

10
11 Q. This is the Monash model of rurality; is that what you
12 are referring to?

13 A. That's exactly right.

14
15 Q. What does 5 to 7 refer to?

16 A. This the more rural areas that are requiring more
17 doctors. So those areas would require a GP, they don't
18 have a facility of a hospital.

19
20 THE COMMISSIONER: Q. So 5 to 7 has a population
21 grading, has it?

22 A. It's actually a combination of factors that they've
23 implemented together.

24
25 Q. Seven is the most remote?

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

34
35 MR GLOVER: Q. So this would be a GP employed by the
36 state in those very rural communities?

37 A. To be honest with you, I don't - I don't care whom
38 they are employed with. What I care is about the patient
39 care in those communities. So in every community, it would
40 be different models of care and different pay for those
41 communities, and this is already practised. In areas like
42 Dubbo, there's some communities where the state health,
43 Commonwealth funding, together with the Commonwealth
44 funding, but also the local government would tip in to make
45 those communities - to have access for those communities
46 for better care. So everyone tips in. Maybe a house
47 there, and that's the model I think would work for the

1 future, is we get together, think about the problems and
2 really invest in what works, what's more efficient and
3 what's more cost efficient with better outcomes.
4

5 Q. Are there any other challenges facing general
6 practices in rural and remote areas that you think require
7 assistance from the system?

8 A. Oh, look, this is an issue that's very close to my
9 heart. I've talked about the viability of general practice
10 in general and how difficult it is for doctors to maintain
11 and keep the doors open with the funding available at the
12 moment.
13

14 Q. That's the funding from the MBS that you have spoken
15 about?

16 A. Yeah, funding, the Medicare funding or MBS funding.
17 Now, the state, New South Wales state and other states,
18 have decided to implement another tax on general practice
19 called the payroll tax. I'm not sure whether you are aware
20 of it or not, but it's another burden that is going to be
21 put on general practice that will result in more
22 presentation to the emergency department.
23

24 Q. That hasn't been implemented yet; correct?

25 A. Hasn't been implemented in a couple of cases, but
26 there is a lot of negotiation happening now to try to waive
27 these. All general practices pay payroll tax for employed
28 doctors and employed nurses and employed - so. But this
29 is about partners in general practice and that the state is
30 considering those partners are not partners, they are
31 employees by the practice. And that's where their argument
32 is, and I feel like this is going to cost our state more
33 money at the end because there will be more hospital
34 admissions, there will be more hospital presentations, more
35 money spent because general practice would not be afford -
36 to accommodate patients.
37

38 Q. Why do you say that?

39 A. Sorry?
40

41 Q. What about the --

42 A. Because of viability. This is another nail in the
43 coffin of general practice.
44

45 Q. What you're raising there is the prospect of general
46 practices having to close?

47 A. Yes, absolutely --

1
2 Q. Is that what you're referring to?
3 A. -- or pass the charge on patients, and unfortunately,
4 there are patients that can afford and there are patients
5 who cannot afford, vulnerable patients, with chronic burden
6 of disease, because we know the social determinants of
7 health do link to chronic disease. So we are now punishing
8 people who are the most vulnerable, the most sick, that
9 they cannot access care.
10
11 MR GLOVER: Nothing further, Commissioner.
12
13 THE COMMISSIONER: Thank you. Mr Chiu?
14
15 MR CHIU: No questions, Commissioner.
16
17 THE COMMISSIONER: Thank you very much, sir. I really
18 appreciate you giving your time. You are excused, thanks.
19
20 THE WITNESS: Thank you very much.
21
22 **<THE WITNESS WITHDREW**
23
24 THE COMMISSIONER: Who is next?
25
26 MR GLOVER: The next witnesses are being called together,
27 Dr McKean and Ms Ewer from the Berrigan Shire Council.
28 They are going to take up positions in the jury box. For
29 those on the live stream, I understand they won't be able
30 to see their faces but they can see them.
31
32 THE COMMISSIONER: Okay. The microphones are set up,
33 though, I can see.
34
35 MR GLOVER: Yes.
36
37 **<JULIA MARGARET CORNWELL MCKEAN, affirmed: [2.22pm]**
38
39 **<KARINA DEE EWER, affirmed: [2.22pm]**
40
41 **<EXAMINATION BY MR GLOVER:**
42
43 MR GLOVER: Dr McKean, could you state your full name for
44 the record, please.
45
46 DR CORNWELL MCKEAN: Yes. Julia Margaret Cornwall McKean.
47

1 MR GLOVER: And Ms Ewer, your full name?
2
3 MS EWER: Karina Dee Ewer.
4
5 MR GLOVER: Dr McKean, you are the mayor of Berrigan Shire
6 Council; correct?
7
8 DR CORNWELL McKEAN: Yes, I am.
9
10 MR GLOVER: And when did you assume that role?
11
12 DR CORNWELL McKEAN: September of last year.
13
14 MR GLOVER: And how long have you been on the council?
15
16 DR CORNWELL McKEAN: Since December 2021.
17
18 MR GLOVER: And Ms Ewer, you are the chief executive
19 officer of the council; correct?
20
21 MS EWER: Yes, I am.
22
23 MR GLOVER: How long have you been in that role?
24
25 MS EWER: Since June 2020 - is that right? Two and a half
26 years.
27
28 MR GLOVER: That's fine. Have you been employed by the
29 council before then --
30
31 MS EWER: No.
32
33 MR GLOVER: -- or was that your first role?
34
35 MS EWER: That was my first role at Berrigan Shire.
36
37 THE COMMISSIONER: 2.5 years would be 2021, I think.
38
39 MS EWER: 2021. Sorry, they blur together.
40
41 MR GLOVER: Dr McKean, can you tell us a little bit about
42 the shire?
43
44 DR CORNWELL McKEAN: Berrigan shire, we have a population
45 of around 9,000 people. We have four core towns, Berrigan,
46 Barooga, Tocumwal and Finley. We have an age demographic
47 of approximately 55 years of age. We are one of the last

1 areas on the Murray River that has not yet been
2 overpopulated, so we are anticipating growth up to
3 32 per cent across the shire over the next five to 10
4 years, particularly the town of Tocumwal, we're
5 anticipating a 17 per cent growth.
6

7 We have hospitals in Berrigan, Tocumwal and Finley.
8 The town of Barooga, being on the Murray River and in close
9 proximity to Cobram, is predominantly serviced by Victoria
10 and not New South Wales. Having said that, the whole shire
11 is part of Murrumbidgee Local Health District.
12

13 MR GLOVER: And you've mentioned some fairly significant
14 growth expectations. What's driving that growth in your
15 shire, to your knowledge.
16

17 DR CORNWELL McKEAN: There's a few things and it is that
18 we do have vacant land that's available for development and
19 we're seeing plans being progressively lodged. Our
20 greatest concern actually is that we don't have the
21 infrastructure to support the level of growth and that we
22 will need to manage that.
23

24 The Murray River traditionally gets a lot of retirees
25 due to the advantageous weather, 300 days of sunshine in a
26 year, but it was a bit hot last week, let's be honest.
27 But, yes, we definitely do have that sporty - lots of golf
28 courses. It's a good life. It's also cheap. You know,
29 we've been cheap for a long time, and that helps retirees
30 to down-size. Many of them are from Melbourne. We're
31 three hours from Melbourne. We're seven hours from Sydney
32 by vehicle. So it's economical and it's just a great place
33 to live.
34

35 MR GLOVER: Are there any particular challenges within the
36 shire in terms of your residents accessing health care?
37

38 DR CORNWELL McKEAN: Yes, there are, and particularly
39 during the pandemic we had issues with access to GPs, long
40 queues, particularly not taking new patients. My own
41 personal experience, I moved full-time to the shire -
42 I commuted for many years before that - four years ago.
43 I could not get a GP. My GP is in Melbourne. I have to
44 travel to Melbourne. I'm not the only person who needs to
45 do that. Of course I'm not in the elderly range who needs
46 to see a GP regularly but it is a problem.
47

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

7
8 In terms of --

9
10 THE COMMISSIONER: Do the people in your town, area, that
11 have GPs in Melbourne, do they use technology to have
12 appointments as well as going face to face?

13
14 DR CORNWELL McKEAN: It is interesting that during the
15 pandemic a lot of them, particularly those with specialist
16 appointments - so generally, our specialist appointments
17 will be out of Shepparton, Albury or Melbourne, and a lot
18 of them have been utilising technology. But we've also got
19 many who don't know how to use technology, which is
20 a problem, and then we have coverage issues, so it's
21 complex.

22
23 Having said that, the hospitals in Berrigan and
24 Tocumwal, who do have - Tocumwal not - their coverage is
25 not the best but they do have IT available for people to
26 come and do telehealth from those facilities.

27
28 THE COMMISSIONER: Thank you.

29
30 MR GLOVER: Apart from access to general practitioners,
31 are there any other challenges faced by the residents of
32 the shire in accessing health care?

33
34 DR CORNWELL McKEAN: Yes. We have been campaigning for
35 nearly 20 years in the shire for an ambulance in Tocumwal
36 and I became involved in that campaign about a year ago.
37 They have a committee, the Tocumwal ambulance committee,
38 and they contacted me and asked if I could assist them.
39 I'm on the board --

40
41 MR GLOVER: We'll come back to that.

42
43 DR CORNWELL McKEAN: Yes.

44
45 MR GLOVER: So lack of access to GPs and ambulance
46 station, any other challenges faced by residents in the
47 shire in terms of accessing health care?

1
2 DR CORNWELL McKEAN: Yes. Finley Hospital, there's some
3 funding for an upgrade. There are particular issues around
4 this upgrade not including renal services - people have to
5 travel to Shepparton or Deniliquin - and CT services.
6 There are also issues around access to mental health
7 supports, particularly for younger people in the north of
8 our shire. They need to travel to Deniliquin to access
9 in-person services. They're not so inclined to use
10 telehealth because they don't want to do it at home and
11 they don't want mum to know they have travelled to
12 Deniliquin, and we have, as a council, actually put
13 financial support to the Southern Riverina collaborative,
14 so that we can actually - you know, this is not something
15 that is budgeted. We have to use our ratepayers' funding
16 for something that is not in our remit, just to make sure
17 that young people are being looked after, and that includes
18 work in relation to suicide prevention and things of that
19 nature.

20
21 MR GLOVER: Ms Ewer, did you want to add anything to that
22 answer?

23
24 MS EWER: I think she has very well covered that -
25 Councillor Cornwell McKean has, yes.

26
27 MR GLOVER: Before we go back to perhaps to some of the
28 detail, can I ask you, Ms Ewer, in your role as chief
29 executive of the shire council, what role is the council
30 taking in assisting its residents to overcome some of those
31 challenges?

32
33 MS EWER: I think increasingly, councils become - one,
34 start to put their money - have to put up money for
35 assisting things that just don't exist in rural and
36 regional areas, and also lots of advocacy, which doesn't
37 sound like it costs a lot until you realise how far we have
38 to travel sometimes just to get in front of a minister to
39 raise their awareness about what those gaps are.

40
41 And there is an increasing expectation, particularly
42 as we see people move from Melbourne, that the services are
43 there, and when they get there and they realise they're
44 not, then the pressure comes to councils to try and access
45 them, somehow make them magically appear. So it can be
46 quite time consuming and it can certainly involve a lot of
47 travel for both of us to make sure that we've got - you

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

8
9 MR GLOVER: In terms of council having to fund healthcare
10 services or initiatives, has your council taken any steps
11 in that direction as yet?

12
13 MS EWER: As mentioned by Mayor Julia, just before, I'm
14 sure - we don't tend to use our last names very often. As
15 mentioned by Mayor Julia earlier, we are putting about
16 \$65,000 a year towards mental health and wellbeing for our
17 youth in Berrigan Shire because they can't access it. To
18 catch a bus, they actually have to go the wrong way, to get
19 to their mental health facilities.

20
21 THE COMMISSIONER: What does that money go to
22 specifically?

23
24 MS EWER: It goes to the Southern Riverina Wellbeing
25 Collaborative who are delivering the Live4Life and Shine
26 Bright programs into schools, it also goes to mental health
27 first aid training, and a number of seminars that are held
28 in the community so that we can put some supports in,
29 particularly in Finley where we've had quite a high level
30 of suicide rates in our young children.

31
32 MR GLOVER: And any other work done by the council in
33 addition to that initiative?

34
35 MS EWER: As far as funding goes?

36
37 MR GLOVER: Yes.

38
39 MS EWER: No, we haven't been directly funding but we have
40 been spending a lot of money making sure that we've got
41 advocacy for the Finley Hospital and the Tocumwal ambulance
42 service in particular.

43
44 THE COMMISSIONER: Just before Mr Glover goes on, you also
45 said in one of your answers that you've got councils all
46 around you who have bought GP practices and councils who
47 are paying for housing for GPs. What councils are those

1 that you're aware of?

2

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

10

11 THE COMMISSIONER: For?

12

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

16

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

19

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

21

22 THE COMMISSIONER: -- agency nurses?

23

24 MS EWER: Yeah, that's right

25

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

30

31 MS EWER: Correct, yes.

32

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

35

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

38

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

41

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

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

5
6 MR GLOVER: You mentioned in an earlier answer some
7 advocacy on issues relevant to your shire, one of them
8 being the ambulance station. Can you just tell us briefly
9 what that issue is and then I will ask you some questions
10 about the process?

11
12 THE COMMISSIONER: You might need to identify who you are
13 asking of for the transcript?

14
15 MR GLOVER: Yes, I was thinking that as I looked up.

16
17 I'll start with Dr McKean and we'll go from there.

18
19 DR CORNWELL McKEAN: Sure. So the back story to the
20 ambulance in Tocumwal that we're campaigning for, as
21 I said, there is a committee that have been campaigning for
22 20 years. They approached me a year ago, I'm on the board
23 of Goulburn Valley Health, I'm someone who ran for council
24 on the back of campaigning for health equity. So I had an
25 interest and I needed to do some research, and I discovered
26 that they had been campaigning with the former Minister for
27 Health, Minister Hazzard, and that a report was
28 commissioned in 2020 in relation to the feasibility of an
29 ambulance station in Tocumwal.

30
31 At the time, the committee said that - seemed to
32 consider that that report said a straight-out no, but when
33 I looked more closely into the detail, it actually didn't
34 say that at all; it said that the current first responder
35 model was at its extreme use and that thought would need to
36 be given in the future for a permanent ambulance station in
37 Tocumwal.

38
39 MR GLOVER: Just before you go on, you referred there to
40 "the current first responder model".

41
42 DR CORNWELL McKEAN: Yes.

43
44 MR GLOVER: Can you describe that, please?

45
46 DR CORNWELL McKEAN: So New South Wales fire and rescue,
47 when somebody calls 000 from Tocumwal, the first responders

1 assemble at the station, they get on the truck and then
2 they go to wherever the call-out is.
3
4 MS EWER: Fire truck.
5
6 DR CORNWELL McKEAN: Fire truck. Then an ambulance will
7 follow some time after that, sometimes a very long time
8 after that.
9
10 MR GLOVER: And before I interrupted you to describe that
11 model, you were saying that the report that you examined
12 suggested that it was at its limits; is that right?
13
14 DR CORNWELL McKEAN: That is right, and in subsequent
15 documentation that we received by way of GIPAA, it
16 indicates that the statistical use of priority 1 in
17 Tocumwal is 4.1 cases a week and that for first responders
18 the upper limit is 2.
19
20 MR GLOVER: So this is the context in which the campaign
21 for an ambulance station in Tocumwal had arisen; correct?
22
23 DR CORNWELL McKEAN: Yes.
24
25 MR GLOVER: And you became involved?
26
27 DR CORNWELL McKEAN: Yes.
28
29 MR GLOVER: Can I ask you about how you engaged in that
30 and with whom?
31
32 DR CORNWELL McKEAN: Yes. So the former mayor, Matthew
33 Hannan, myself and Ms Ewer, we had attempted to get
34 a meeting with Minister Ryan Park and were successful in
35 doing so after sending some initial correspondence. The
36 initial correspondence we received back from Minister Park
37 referred to statistical area that far exceeds - in fact it
38 didn't refer to the statistical area; it said the relevant
39 area for Tocumwal had a call-out time of priority 1 of
40 eight minutes.
41
42 THE COMMISSIONER: What does eight minutes mean? Eight
43 minutes for the ambulance to arrive?
44
45 DR CORNWELL McKEAN: For average time, but it's for Upper
46 Murray, which extends from Swan Hill to Albury and has
47 a population of 42,000 people.

1
2 THE COMMISSIONER: How many kilometres is that?
3
4 DR CORNWELL McKEAN: A long way, yeah. Tocumwal is --
5
6 THE COMMISSIONER: You can't drive it in eight minutes?
7
8 DR CORNWELL McKEAN: No. It is the average. We're
9 15 minutes from finally. That's for all call-outs in that
10 population which - and I have said to NSW Ambulance, it's
11 disingenuous, you should not be comparing statistics for
12 that sort of geography as to whether we are getting
13 a reasonable service in Tocumwal. So at the moment we
14 don't actually have concrete numbers about what the average
15 time is in Tocumwal, and they have advised that they are
16 not obliged to give that and that I will need to GIPAA it.
17
18 THE COMMISSIONER: Sorry, who has said to you they are not
19 obliged to give it?
20
21 DR CORNWELL McKEAN: We had a meeting on Friday just past,
22 actually, with NSW Ambulance, who advised that they are
23 only obligated to give us statistics relating to the SA3
24 area, which is the Upper Murray, the ABS area, and nothing
25 more specific.
26
27 THE COMMISSIONER: Forgetting what they're obligated to
28 give, what's the reason they wouldn't give it to you? It's
29 not --
30
31 DR CORNWELL McKEAN: I don't know.
32
33 THE COMMISSIONER: It is not national security, is it?
34
35 DR CORNWELL McKEAN: I wouldn't have thought so, no.
36 We've already drafted a motion without notice to go before
37 our council on Wednesday for the GIPAA.
38
39 MR GLOVER: So you engaged with the minister?
40
41 DR CORNWELL McKEAN: Yes.
42
43 MR GLOVER: You've referred to a meeting you had last
44 Friday but I assume there were some steps in between.
45
46 DR CORNWELL McKEAN: Quite a number of steps in between.
47

1 MR GLOVER: Can you just perhaps at a general level
2 describe what they are and then I'll ask you some questions
3 about your view as to the process.
4

5 DR CORNWELL McKEAN: Yes. So we met with the minister
6 in August of last year along with two representatives from
7 NSW Ambulance. The minister suggested that maybe a CERT
8 model would be an option. We had not heard of that before.
9

10 We subsequently wrote to the minister on two
11 occasions. We didn't get a response. And we also wrote to
12 the premier because we were still waiting for a response.
13 We eventually received a response that indicated that we
14 were eligible for a CERT model but were not a priority.
15

16 MR GLOVER: Do you have an understanding now of what
17 a CERT model is?
18

19 DR CORNWELL McKEAN: Yes, I do.
20

21 MR GLOVER: What is it?
22

23 DR CORNWELL McKEAN: It's a community emergency response
24 team. It involves volunteers. The volunteers are rostered
25 on, they have a vehicle, a specific vehicle. They travel
26 in twos. One of the persons who was rostered on has the
27 vehicle with them at all times, so there's no need to
28 actually assemble at a fire station; they can go
29 immediately from wherever they are located. It's fully
30 stocked with the sorts of things that they would need for
31 that first-level response. They have the same training as
32 the first responders.
33

34 The big difference is they are volunteers, and
35 I understand for that to work, we would need eight
36 volunteers in the Tocumwal community who would be willing
37 to contribute their time not only to be rostered on but to
38 attend monthly training, as well as deal with the emotional
39 and difficult work that it would be to do that.
40

41 MR GLOVER: So after being informed that the region was
42 eligible for this model, what was the next step in the
43 process?
44

45 DR CORNWELL McKEAN: We had a town meeting in October, and
46 talked about that.
47

1 THE COMMISSIONER: Sorry to interrupt, what do you get if
2 you're part of the CERT model? You get a car given to you,
3 do you?
4
5 DR CORNWELL McKEAN: Yeah.
6
7 THE COMMISSIONER: And the training is free, I take it?
8
9 DR CORNWELL McKEAN: Yes.
10
11 THE COMMISSIONER: Provided you've got the time.
12
13 DR CORNWELL McKEAN: Yes. But the car gets rotated, so
14 you don't get to keep the car yourself, there are not eight
15 cars. They actually have to hand them over at the end of
16 shift, so there's a bit of mucking about as well, yes.
17
18 THE COMMISSIONER: Sure. There's a designated driver that
19 rotates; right.
20
21 DR CORNWELL McKEAN: Yes. Sorry, I have lost my train of
22 thought while we are talking.
23
24 THE COMMISSIONER: Sorry, that's my fault. We have
25 a transcript for that, a running transcript, that will
26 assist getting us back on track.
27
28 MR GLOVER: I will find where we were. There was a town
29 meeting; in October, you had a town meeting?
30
31 DR CORNWELL McKEAN: Yes, we did.
32
33 MR GLOVER: What was the next engagement with either
34 NSW Health or the ambulance?
35
36 DR CORNWELL McKEAN: There was a town meeting, we had the
37 member for Murray, Helen Dalton, attended and over 100
38 locals.
39
40 THE COMMISSIONER: She is a state member of parliament;
41 correct?
42
43 DR CORNWELL McKEAN: Yes, that's correct. After that
44 meeting, we had further correspondence, we've been trying
45 to get further meetings with Minister Park. We weren't
46 having any luck. So that's when we went down the GIPAA
47 path to get some more information about the briefings that

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

8
9 MR GLOVER: Pausing there, do I take it from that answer
10 that you made a request of the previous minister and
11 received some information, but you hadn't received the same
12 level of detail from the current minister's office; is that
13 right?

14
15 DR CORNWELL McKEAN: I was not a councillor at that time.
16 I don't know the precise background. I know that Helen
17 Dalton MP was involved in getting information and
18 Minister Hazzard supplied that report to Helen Dalton
19 without any redaction, in full, which she subsequently
20 passed on to the committee and to members of the community.

21
22 THE COMMISSIONER: Sorry, when you say "that report", that
23 report is what?

24
25 DR CORNWELL McKEAN: It was a report in 2022 as to whether
26 Tocumwal was eligible for an ambulance. It was quite
27 comprehensive and it indicated in the report that there
28 would be annual reviews, and we, with our GIPAA, wanted to
29 get to the bottom of whether they had, in fact, occurred.
30 We didn't think they had. We kept asking in our letters
31 but no-one answered the question and we have indeed
32 established that they did not occur.

33
34 MR GLOVER: You have referred a few times to making GIPAA
35 requests or applications.

36
37 DR CORNWELL McKEAN: Yes.

38
39 MR GLOVER: What drove you to the view that you needed to
40 make those types of applications?

41
42 DR CORNWELL McKEAN: I wanted to get to the bottom of
43 whether the reviews had occurred since 2020. I doubted
44 they had occurred but I wanted to know one way or the
45 other. We also knew that we weren't being provided with
46 the sort of data that was available from 2020, and we were
47 trying to, I suppose, force the hand of the ambulance to

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

5
6 At that point, we didn't actually know what the upper
7 limit was for the first responders and, in fact, we didn't
8 know what the upper limit - we didn't know what a Cert was.
9 We subsequently found the upper limit for that is 4, when
10 we were actually already at 4.1, and we know that the
11 numbers that --

12
13 THE COMMISSIONER: Can you just explain the upper limit to
14 me, what that means precisely?

15
16 DR CORNWELL McKEAN: So they have - we discovered through
17 the GIPAA response that there's a table that details
18 various models - the first responder, CERT, Ambulance,
19 there's something called "blended", I've not really got to
20 the bottom of what that means.

21
22 For an ambulance full-time station, which they tell me
23 needs to be fully staffed with over 10 paramedics, which
24 doesn't sound realistic, you need to have seven priority 1
25 cases, at least seven priority 1 cases a week --

26
27 THE COMMISSIONER: Right.

28
29 DR CORNWELL McKEAN: -- and the CERT. We're in that point
30 that's between the CERT and the --

31
32 THE COMMISSIONER: And that. Okay.

33
34 MR GLOVER: So a series of requests for a response and
35 information, and then ultimately a meeting last Friday;
36 correct?

37
38 DR CORNWELL McKEAN: Yes.

39
40 MR GLOVER: I'll just ask you - I take it that your view
41 is there should be an Ambulance station in Tocumwal but
42 leaving aside for a moment for the purposes of my question
43 what I might call the merits or otherwise of that question,
44 I want to ask you about your views as to the process of
45 engaging with NSW Health and NSW Ambulance over this issue
46 at that period of time. Does that make sense?
47

1 DR CORNWELL McKEAN: Yes.

2

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

5

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

11

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

15

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

18

19 MR GLOVER: Minister Park?

20

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

27

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

36

37 THE COMMISSIONER: They're politicians?

38

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

41

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

44

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

47

1 MR GLOVER: Why do you say that.

2

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

16

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

19

20 MS EWER: NSW Ambulance service.

21

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

24

25 MS EWER: No, the department, yeah.

26

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

29

30 DR CORNWELL McKEAN: Certainly.

31

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

37

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

46

47 MR GLOVER: In that answer you mentioned the LHAC.

1
2 DR CORNWELL McKEAN: Yes.
3
4 MR GLOVER: What engagement does the council have with
5 that committee?
6
7 DR CORNWELL McKEAN: The Finley LHAC actually has some
8 very committed volunteers and we do have communications and
9 we share information and I regularly speak with Syd Dudley
10 who is the chair of the committee. We are working
11 together, we were working together before, but now that
12 we - we share concerns relating to the concept plan that
13 has been put forward and we've been advocating together.
14
15 MR GLOVER: So do I take it from that answer, insofar as
16 Finley is concerned, the LHAC, Finley and the council are
17 working closely together on issues relating to the Finley
18 Hospital upgrade; is that right?
19
20 DR CORNWELL McKEAN: Yes.
21
22 MR GLOVER: What about in other areas within the shire?
23 Do you have engagement with the LHACs in those other areas?
24
25 DR CORNWELL McKEAN: I have never spoken to anyone from
26 the Berrigan LHAC. I think I've spoken to one person from
27 the Tocumwal LHAC. I've never had any formal discussions
28 with the LHACs. We don't have an LHAC in Barooga, though,
29 as I mentioned earlier, it's part of Murrumbidgee Local
30 Health District, I don't know if that's an oversight or
31 deliberate, but that's just where it's at.
32
33 MR GLOVER: Ms Ewer, perhaps you're more on an operational
34 side of the council operation, what's your engagement with
35 the LHACs in your shire?
36
37 MS EWER: I go to regular 19(2) meetings with Syd Dudley
38 so I'm sort of across where people are moving and what
39 services are being provided and all of those sorts of
40 things.
41
42 THE COMMISSIONER: I think I know what a 19(2) meeting
43 is --
44
45 MS EWER: I really don't know, it's section 19(2) of the
46 Health Act, I'm guessing.
47

1 THE COMMISSIONER: Yes.

2

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

6

7 MR GLOVER: That's in relation to Finley?

8

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

13

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

17

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

24

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

28

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

36

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

41

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

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

5
6 MR GLOVER: All right. I diverted us to a bit about LHACs
7 from your answer, Dr McKean, about consultation about the
8 Finley upgrade, and you said you had engaged with the
9 Finley LHAC and then I interrupted you, so please continue.

10
11 DR CORNWELL McKEAN: So Murrumbidgee Local Health District
12 and Health Infrastructure - and I can't remember the date
13 of this - came to council, it was before I was mayor, and
14 they introduced to us the "How to build a hospital"
15 diagram, and they were consulting on their clinical
16 services plan, which they also call a health services plan.
17 They do have a problem with consistency, which drives me
18 crazy.

19
20 They were consulting on that. They took us through
21 how one builds a hospital. They didn't ask - didn't really
22 give us any opportunity to comment. It was a presentation
23 at you, not with you. It wasn't really any level of
24 consultation.

25
26 They subsequently put out a press release saying,
27 "Here is our health services plan" - or, "We've approved
28 a final health services plan. We will publish it shortly",
29 but they didn't. We've actually had to subsequently ask
30 for that. We didn't need to GIPAA that one, we did get
31 that. I don't believe it has actually been published but
32 we do have a copy of the final now.

33
34 In December, I believe it was 6 December, we had nine
35 representatives from Murrumbidgee Local Health District and
36 Health Infrastructure, and I believe some of them may have
37 been some of their consultants, there were three in person
38 and six online, and they were supposed to be consulting on
39 the concept plan for Finley Hospital, which Syd Dudley and
40 LHAC and the whole community was shocked at. It was not
41 \$25 million that we saw in that concept plan, and we had
42 that meeting.

43
44 In terms of the process, again, it was not
45 consultation. It was simply telling us what it is that
46 they were going to do. We had that graph come up again,
47 "How to build a hospital." Now we're here. We were there

1 before. And we challenged them and said, "This isn't
2 \$25 million. We would like to see your budget, please."
3 And, "Could you please assure us that your costings have
4 come from a suitably qualified quantity surveyor?" And
5 they started telling us the sorts of things that might be
6 included.

7
8 MR GLOVER: We'll come back to that in a moment.

9
10 DR CORNWELL McKEAN: Yeah, sure.

11
12 MR GLOVER: Other than you - the council that is - and the
13 LHAC, who else was at this meeting?

14
15 DR CORNWELL McKEAN: The LHAC wasn't at this meeting,
16 they'd had a meeting earlier in the week but we'd been
17 having discussions among ourselves, "Well, this isn't
18 right. What's missing? What should be there?"

19
20 MR GLOVER: So who was at this meeting other than the
21 council and the representatives from Health Infrastructure
22 and the district?

23
24 DR CORNWELL McKEAN: Council, council staff.

25
26 MR GLOVER: So this was a meeting just between arms of
27 NSW Health on the one hand and the council on the other?

28
29 DR CORNWELL McKEAN: Yes. Yes.

30
31 MR GLOVER: You said in your answer a moment ago that you
32 didn't think it was consultation.

33
34 DR CORNWELL McKEAN: No.

35
36 MR GLOVER: Why do you say that?

37
38 DR CORNWELL McKEAN: We were not given any opportunity to
39 provide feedback. I actually had to pull up the
40 presentation and say, "Stop now. We've got some things to
41 tell you." And they were a bit taken aback.

42
43 One person on the video actually asked if this meeting
44 was about Finley Hospital. They appeared confused.

45
46 MR GLOVER: Ms Ewer, were you at that meeting?

47

1 MS EWER: Yes.

2

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

5

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

23

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

26

27 MS EWER: Mmm-hmm, yeah.

28

29 MR GLOVER: Can you describe what those meetings were?

30

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

47

1 THE COMMISSIONER: Just stopping there, the meetings
2 Mr Glover asked you about, which he called planning
3 meetings --
4
5 MS EWER: Mmm-hmm.
6
7 THE COMMISSIONER: -- which occurred before the mayor's
8 election --
9
10 MS EWER: Yes.
11
12 THE COMMISSIONER: -- these are before the government,
13 which would be the previous state government, announced
14 there would be a \$25 million redevelopment of Finley
15 Hospital?
16
17 MS EWER: Just after. Just after the \$25 million
18 announcement.
19
20 THE COMMISSIONER: Okay, so that's been announced?
21
22 MS EWER: Mmm-hmm.
23
24 THE COMMISSIONER: And then these meetings are to discuss
25 the form of that redevelopment?
26
27 MS EWER: That's correct. And to develop the clinical
28 services plan. That was the whole point of it.
29
30 THE COMMISSIONER: And chronologically, the other meetings
31 you were talking about or the meeting you were talking
32 about, then, when Mr Glover asked Dr McKean about
33 consultation, was at a later time?
34
35 MS EWER: Correct, yeah.
36
37 THE COMMISSIONER: Had the plans of the redevelopment
38 already been released at that stage, and the nature of the
39 health services that would be provided?
40
41 DR CORNWELL McKEAN: For the second meeting in December?
42 Yes. The earlier one must have been around the same time
43 as the clinical services plan was being developed.
44
45 THE COMMISSIONER: Are we talking December 2022 or 2023?
46
47 DR CORNWELL McKEAN: 2023.

1
2 THE COMMISSIONER: So just a few months ago?

3
4 DR CORNWELL McKEAN: Just recently, yes.

5
6 THE COMMISSIONER: Thank you. Sorry.

7
8 MR GLOVER: So going back to the earlier meetings that you
9 were at, from a consultation perspective, are they more in
10 the nature of the consultation that you would expect to
11 have occurred?

12
13 MS EWER: Yes, the original meetings were much more
14 a consultative platform where people actually got to engage
15 and talk about - and they wanted to hear the stories of the
16 community, what it's like to have a baby out there that
17 needs special care and you need to drive backwards and
18 forwards with it. So they were very genuinely engaged at
19 that point. After that, that's when it's definitely --

20
21 MR GLOVER: Do I understand the concern, at the time that
22 it came to be presented what was occurring, was there was
23 a disconnect between what had been discussed at the what
24 you describe as planning meetings or whatever label they
25 had and what was presented to you - that is the council -
26 at the meeting which the mayor has referred to; is that
27 right?

28
29 MS EWER: Correct. It's very much like, "The decision has
30 been made. Now you just have to deal with it."

31
32 MR GLOVER: Do you have anything to add to that,
33 Dr McKean?

34
35 DR CORNWELL McKEAN: One of the points that was made at
36 that meeting in December was that the health services plan
37 is about services and that the concept plan is about
38 infrastructure - and this is when we challenged the lack of
39 CT and renal services being included in the so-called
40 upgrade - and, therefore, they don't need to deliver on the
41 health services plan because that's service, not
42 infrastructure. So I don't quite understand how that can
43 be part of the same diagram and there'd be a disconnect.

44
45 The other point that we did make at that meeting is
46 that the emergency department at Finley Hospital had
47 a refurb in 2019, and we couldn't understand why it needed

1 another one now, and there was a lot of talk about
2 clinicians' requirements and that the clinicians had seen
3 this and they had seen that, and what-have-you. And there
4 were two things I asked them. The first one is, "Surely,
5 without building anything, you can consider what
6 operational efficiencies you can put in place?" And I am
7 on the board of Goulburn Valley Health and I know that they
8 have done exactly that. They have had a look - make sure
9 the trolleys are closer, IT is closer, just little basic
10 things to save minutes. "Why aren't you doing that?"
11 Didn't get a straight answer at all.
12

13 When they kept talking about clinicians and
14 clinicians, I actually got a little bit upset and I said,
15 "I really don't like your vernacular. You're not talking
16 about patients or patient outcomes or service delivery for
17 patients. You're talking about making life easier for the
18 clinician." Of course, that's important, but it's not
19 number 1. The patients need to be number 1. And that
20 I really found quite troubling.
21

22 MR GLOVER: After the meeting that you have described, was
23 there any more engagement or attempts at engagement by the
24 council with NSW Health about the Finley upgrade?
25

26 DR CORNWELL McKEAN: Yes. So they - we received
27 a response, a joint response from NSW Health and Health
28 Infrastructure in - I think it was 18 December, following
29 the meeting. In the meantime, we had written to
30 Minister Park to tell him how appalled we were by that
31 meeting.
32

33 In the first letter from health and infrastructure,
34 they indicated that they weren't going to give us the
35 budget; it was commercial in confidence. In the letter
36 that subsequently came from Minister Park, which curiously
37 had the same language throughout, we were also advised that
38 the budget was commercial in confidence.
39

40 MR GLOVER: Can I perhaps try to draw the two examples
41 together? You tell me if I've got it right or wrong.
42

43 DR CORNWELL McKEAN: Mmm.
44

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

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

4
5 DR CORNWELL McKEAN: Yes.

6
7 MR GLOVER: And a lack of responsiveness to your requests
8 to information; is that right?

9
10 DR CORNWELL McKEAN: Yes.

11
12 MR GLOVER: And a feature of that latter concerned the
13 need for the council to resort to processes like GIPAA to
14 access information the council feels it needs to meet the
15 needs of its residents; is that right?

16
17 DR CORNWELL McKEAN: Absolutely.

18
19 MR GLOVER: For the benefit of the transcript, you have
20 been nodding, but do you have anything to add to those
21 answers given by the mayor?

22
23 MS EWER: Sorry. Yeah, the - I mean, the Finley GIPAA,
24 the Finley Hospital GIPAA that we've had, has been delayed
25 considerably. They haven't provided the normal process
26 that you normally go through where they would write
27 a letter say that they've accepted it, this is when it's
28 due. I've actually had to follow them up on a number of
29 occasions and it's now not due back to us until 29 March,
30 even though we put it in in January, and they've charged us
31 \$1,500 for the pleasure of getting budgets which should not
32 be - I do not believe - will not take them 38 hours to find
33 where their budget is.

34
35 THE COMMISSIONER: When you say "budgets", we know
36 \$25 million has been committed for the redevelopment of
37 Finley Hospital, this is, what, for a break-down as to how
38 that is going to be spent?

39
40 MS EWER: We want to understand how what the concept plan
41 looks like - how that is \$25 million. Where has that money
42 been spent, if it's no longer there?

43
44 THE COMMISSIONER: Or is going to be spent?

45
46 MS EWER: Yes.

47

1 THE COMMISSIONER: Okay. And the commercially
2 confidential bit of that is what?
3
4 MS EWER: We're not sure why a budget would be commercial
5 in confidence. We have to publish ours every day.
6
7 THE COMMISSIONER: Okay. We went to Finley Hospital last
8 week, the Inquiry team and also people from NSW Health, and
9 there were clearly - some of the rooms there were from the
10 19 - you know, post war, 1950s.
11
12 MS EWER: Absolutely.
13
14 THE COMMISSIONER: As I understand it, those rooms are
15 going to be upgraded to modern hospital rooms. Do you know
16 what else is being done at the hospital, by way of
17 redevelopment?
18
19 MS EWER: Very little. It really looks much more like
20 maintenance. I think Julia in her position on GV Health is
21 probably better able to answer.
22
23 THE COMMISSIONER: Is that why you are using the term
24 "so-called upgrade"?
25
26 MS EWER: Yes.
27
28 DR CORNWELL McKEAN: Yes. We actually think they might
29 have spent a good amount of that money already with all
30 those consultants who are turning up at meaningless
31 meetings.
32
33 THE COMMISSIONER: Okay, all right.
34
35 MR GLOVER: In an earlier answer, Dr McKean, you mentioned
36 that one of the features of the shire is its proximity to
37 the Victorian border. Does that pose any complexity in the
38 delivery of health care services to the residents of the
39 shire?
40
41 DR CORNWELL McKEAN: It does, though I don't think it
42 should.
43
44 MR GLOVER: In what way does it, firstly?
45
46 DR CORNWELL McKEAN: Well, for example, there have been
47 times when the Victorian government, for example, have said

1 that particular services, JEV vaccine, are only available
2 to residents of Victoria, and that means, for example,
3 a Barooga resident, technically, would not be allowed to
4 attend Cobram and get one of those vaccines.
5

6 Arrangements were made during the pandemic in relation
7 to COVID vaccines and testing, so that worked okay.
8

9 In terms of advocacy in the shire, you know, we've met
10 with Murrumbidgee Local Health District with the area
11 person. That role seems to change quite often. I don't
12 think the person we met with is currently in that role.
13 They told me about the towns we have in Berrigan Shire
14 being Berrigan, Tocumwal and Finley, and I said, "I think
15 you forgot Barooga." And the fact is basically
16 Murrumbidgee Local Health District does not advocate for
17 Barooga. They do not provide anything to Barooga. We did
18 have one bus come for COVID testing during the pandemic.
19

20 The complexity I find with this is the Victorians -
21 and nor should they - are not going to advocate for the
22 people of Barooga, but neither is Murrumbidgee Local Health
23 District. So we're stuck with really no representation,
24 and that actually was the reason why I applied to get on
25 the board of Goulburn Valley Health, because I know that's
26 where we will go and get our health services and we would
27 at least have one person on our side.
28

29 MR GLOVER: Can I just break that answer up a little bit?
30

31 DR CORNWELL McKEAN: Sure.
32

33 MR GLOVER: You referred there to a vaccine only being
34 available to residents of Victoria. To your understanding,
35 was that because the delivery of that vaccine was being
36 funded by VicHealth?
37

38 DR CORNWELL McKEAN: I believe it was a directive from the
39 Department of Health but I don't believe it was actually
40 complied with.
41

42 MR GLOVER: Then you raised some particular issues about
43 Barooga. One of them was a lack of engagement from the
44 health district about the needs of that town.
45

46 DR CORNWELL McKEAN: Yes.
47

1 MR GLOVER: What steps has the council taken to engage the
2 district in relation to the needs of the residents of that
3 town and its surrounds?
4

5 DR CORNWELL McKEAN: I'm president of the Barooga
6 Advancement Group and when you have an opportunity you take
7 an opportunity, so in August last year when we were meeting
8 Minister Park, I delivered him a letter from the community
9 outlining our concerns about the lack of advocacy from
10 Murrumbidgee Local Health District.
11

12 MR GLOVER: When you say "lack of advocacy", what do you
13 mean?
14

15 DR CORNWELL McKEAN: Well, those issues, for example,
16 where there were holes in Victoria, where they weren't -
17 you know, if we needed particular things, when we had the
18 issues with the mosquitoes and Japanese encephalitis, we
19 were hearing a lot in terms of advocacy for other towns of
20 Berrigan Shire but not for Barooga because no services were
21 actually actively being delivered.
22

23 It's more about - when I talk about advocacy for
24 Barooga, it's about availability of services, service
25 delivery, making sure we've got access to GPs, patient
26 transport, all the things, but nobody actually has taken
27 responsibility to say that town needs someone to speak up
28 for them.
29

30 MR GLOVER: When you say "nobody", are you speaking of
31 nobody within the LHD?
32

33 DR CORNWELL McKEAN: Health district. Yes, they did
34 actually come to a meeting with the Barooga Advancement
35 Group. It was very cordial, but we talked at length about
36 the fact that Victoria services us, and they did say there
37 was maybe potential for services in the future - transport,
38 for example, if you had been in hospital in Shepparton and
39 you needed transport to and from the hospital; in-home
40 care. But the short story from those in attendance was
41 "Well, the hospital sorted that out for us anyway and the
42 Victorians are supplying and you didn't check."
43

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

1
2 DR CORNWELL McKEAN: There is also the issue of the
3 incentivisation for students to study in nursing and other
4 medical courses. So Victoria offers an incentive, but if
5 you take up that incentive, you need to work in Victoria.
6 New South Wales has a similar incentive scheme. The
7 difficulty is that a lot, 60 per cent, in fact, of
8 students - this is high school and primary school, I
9 imagine it extends actually higher - in Berrigan Shire
10 actually study in Victoria, but they may actually want to
11 come and work at Finley Hospital, for example. So it's
12 actually become a disincentive. They don't want to be
13 forced to work in Victoria or they don't want to be forced
14 to work in New South Wales.

15
16 MR GLOVER: What you're describing are incentives given by
17 the Victorian government to study nursing?

18
19 DR CORNWELL McKEAN: Yes.

20
21 MR GLOVER: But that is tied to employment within the
22 Victorian health system; is that what you are saying?

23
24 DR CORNWELL McKEAN: That's correct, and the same applies
25 with New South Wales. There's no cross-border arrangement
26 to - yes.

27
28 MR GLOVER: To your knowledge, is there a difference
29 between the incentives offered between Victoria and
30 New South Wales?

31
32 DR CORNWELL McKEAN: I believe both are HECS payments
33 being waived. I don't know if there's anything additional.
34 I don't think there is a financial but I wouldn't swear by
35 that. But I do know there is a requirement to work in the
36 respective state.

37
38 MR GLOVER: The issue you're raising is that a large
39 number of students from within your shire actually end up
40 studying in Victoria and then may be lost to the New South
41 Wales system by those incentives; is that the issue you are
42 referring to?

43
44 DR CORNWELL McKEAN: They could be lost but instead they
45 don't study nursing or any of those particular courses that
46 might have the subsidies at all.

47

1 MR GLOVER: Ms Ewer, did you have anything to add to those
2 answers - that is, around the features of the proximity of
3 the shire to the Victorian/New South Wales border?
4

5 MS EWER: We do have some evidence where people in Cobram,
6 because the emergency room in Cobram is actually a paid
7 emergency room, it is a private venue, will get themselves
8 to Finley in an emergency so that they go through the free
9 system and go back to Shepparton. So we're aware that that
10 puts more pressure on the Finley emergency room, and
11 that's - yeah, and then that's also the other reason, with
12 the education, while we're trying to get a country
13 university centre in Finley so that we can support getting
14 more nurses and doctors and things like that, so they can
15 train at home.
16

17 MR GLOVER: One of the threads that has run through the
18 evidence you've both given today is the engagement between
19 the council and NSW Health, NSW Ambulance and the district.
20

21 Ms Ewer, if I can start with you, what would you like
22 to see done differently so that the council may better
23 engage with each arm of the New South Wales health system?
24

25 MS EWER: I'd like them to be honest. We're not trying to
26 catch them out in anything. We're just trying to advocate
27 for our community. So making it as hard as possible
28 doesn't lend us to trust that what they're, saying is, in
29 fact anything to do with our community.
30

31 MR GLOVER: More open lines of communication; is that what
32 you have in mind?
33

34 MS EWER: That would be very nice.
35

36 MR GLOVER: And more free-flowing exchange of information?
37

38 MS EWER: Yes. I think to the level that local government
39 is expected. I don't understand why it has to be so
40 difficult to get information from a state government
41 agency.
42

43 MR GLOVER: I take it - is it the case that if there was
44 truly confidential information, the council wouldn't have
45 any difficulty in maintaining that confidentiality; is that
46 right?
47

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

4
5 MR GLOVER: Dr McKean, do you have anything to add to that
6 answer?

7
8 DR CORNWELL McKEAN: I think Ms Ewer is a hundred per cent
9 correct. I think that we just want genuine engagement.
10 Look, frankly, sometimes I feel we get treated like we're
11 country hicks. They don't expect us to actually be
12 educated people who want to represent our community. They
13 don't buy into - and I'm going get technical here, into the
14 quintuple aims of health care. It's so important that
15 health equity is available to regional areas and every day
16 of the week, we will make sure that we represent our
17 community in relation to health equity and making sure that
18 we are making inroads to achieve it. So I think they need
19 to be accountable and genuine and know that we mean
20 business.

21
22 MR GLOVER: In that answer you referred to "the quintuple
23 aims of health care". So we're all on the same page, can
24 you tell us what you have in mind?

25
26 THE COMMISSIONER: Equity sounds like one.

27
28 DR CORNWELL McKEAN: I always saved this earlier because
29 I thought I always miss one. So the quintuple aims, it's
30 a focus on health equity; clinician wellbeing; the pursuit
31 of better health; improved outcomes; and lower costs.

32
33 So it looks at the economics of preventative medicine
34 as well as making sure that people who are unwell have
35 improved outcomes, and that health equity piece. The two
36 newest pieces are health equity and clinician wellbeing.
37 Previously it was the triple aims.

38
39 MR GLOVER: Those are some areas for improvement. In the
40 current climate, does the current way in which any of the
41 arms of NSW Health engage with the council - I'll start
42 with you, Ms Ewer - affect the ability of the council to
43 meet the needs of its residents?

44
45 MS EWER: I don't believe that they are aiming for health
46 equity. I believe that it is all about the cost.

47

1 MR GLOVER: Dr McKean?
2
3 DR CORNWELL McKEAN: I agree. They are going through the
4 motions, that's it.
5
6 MR GLOVER: Thank you, Commissioner. That's all I have.
7
8 THE COMMISSIONER: Mr Chiu?
9
10 <EXAMINATION BY MR CHIU:
11
12 MR CHIU: I might just start with the issue about the
13 Finley Hospital \$25 million upgrade, as it were.
14
15 Ms Ewer, you referred to an earlier process after,
16 I think, from late 2022 onwards, where there was
17 consultation.
18
19 MS EWER: Mmm-hmm.
20
21 MR CHIU: Is that correct?
22
23 MS EWER: Yes.
24
25 MR CHIU: As I understand it, there were about four
26 sessions or four meetings involving the local council?
27
28 MS EWER: Yes.
29
30 MR CHIU: And were you aware that besides those four
31 meetings, there were also a number of other meetings with
32 other interest groups in the community as well?
33
34 MS EWER: Certainly. I attended quite a few of those
35 meetings.
36
37 MR CHIU: Yes.
38
39 MS EWER: And you thought that those planning meetings, as
40 it were, were actually quite constructive in terms of
41 discussion about what was needed?
42
43 MS EWER: They were.
44
45 MR CHIU: And the meeting which you were not so
46 enthusiastic about was the recent meeting in late last
47 year; is that correct?

1
2 MS EWER: The last two meetings.
3
4 MR CHIU: The last two meetings
5
6 MS EWER: Yes.
7
8 MR CHIU: Is that around the time that an early design was
9 released, in November 2023?
10
11 MS EWER: Yes.
12
13 MR CHIU: And as you understand it, that early design,
14 I understand your complaint is, or your concern, if I might
15 put it that way, is that the earlier design didn't seem to
16 reflect a spending of \$25 million?
17
18 MS EWER: Correct, but it --
19
20 MR CHIU: That was one concern?
21
22 MS EWER: Yes, but it also did not address the clinical
23 service consultation that we had had.
24
25 MR CHIU: Indeed. And were you also aware that, as part
26 of release of this early design, the local health district
27 invited stakeholders like yourself to provide written
28 responses?
29
30 MS EWER: I did not know they asked for written responses,
31 no. I would have certainly put in a submission.
32
33 MR CHIU: That, in fact, right now, they're in the process
34 of collating responses to that early design?
35
36 MS EWER: No, they didn't let us know that in the meeting,
37 certainly.
38
39 MR CHIU: Are you aware that there's going to be, after -
40 well, that there's going to be --
41
42 THE COMMISSIONER: When is the deadline for submissions?
43
44 MR CHIU: It's imminent, Commissioner, I believe.
45
46 THE COMMISSIONER: Imminent?
47

1 MR CHIU: Yes. I might have to seek some further
2 instructions about that.
3
4 THE COMMISSIONER: Can you put in a submission online?
5 I'm asking you too much detail.
6
7 MR CHIU: I don't know the answer to that.
8
9 THE COMMISSIONER: Don't worry.
10
11 MR CHIU: I'm really on the run with this.
12
13 THE COMMISSIONER: Yes, that's all right. We're still
14 getting submissions for this Inquiry.
15
16 MR CHIU: I'm still getting instructions as we speak.
17
18 As part of that process, the plan is that there would
19 be a further design to be provided to be released to
20 community later in 2024; were you aware of that?
21
22 MS EWER: No.
23
24 DR CORNWELL McKEAN: I did know it was a concept plan and
25 it wasn't a final plan, so I was aware that we would
26 receive something further.
27
28 MS EWER: But we're not aware of the - they didn't make us
29 aware of those matters in those meetings that we've had
30 with them and I haven't received any - normally you would
31 receive an information in your email system that says - you
32 know, to invite you to put submissions in, so I get them
33 from lots of other places, so no.
34
35 MR CHIU: I will certainly follow that up. Was there any
36 discussion as to the reasons why the budget, as in the
37 break-down of the money being spent, might be commercially
38 in confidence, such as, for example, it hadn't gone out to
39 tender yet?
40
41 DR CORNWELL McKEAN: There's a reference in both of the
42 letters of something about - I can't remember exactly -
43 that some line items might be too detailed. I can't
44 remember exactly. But it was in both of the correspondence
45 from Minister Park and from the health service.
46
47 MR CHIU: So you specifically requested the budgetary

1 information from Minister Park and that was declined --
2
3 DR CORNWELL McKEAN: Yes.
4
5 MR CHIU: -- from the minister?
6
7 DR CORNWELL McKEAN: Yes, and we've subsequently done
8 a GIPAA for it, yes.
9
10 MR CHIU: And that GIPAA hasn't come back yet?
11
12 DR CORNWELL McKEAN: No.
13
14 MR CHIU: I take it you intend to continue to be engaged
15 in this process, despite your disappointment at the present
16 time?
17
18 DR CORNWELL McKEAN: I think it's important.
19
20 THE COMMISSIONER: I just found this online. There's
21 a survey for the community which was open until 6 December
22 last year. Is that what you are referring to?
23
24 MR CHIU: I don't believe that's what I'm referring to.
25
26 THE COMMISSIONER: A different thing, okay.
27
28 MR CHIU: Commissioner, because I'm dealing with this
29 somewhat on the run --
30
31 THE COMMISSIONER: No, and I'm completely sympathetic
32 about that, don't worry about that.
33
34 MR CHIU: I'm hoping to put what's necessary to the
35 witnesses but then obtain some further evidence.
36
37 THE COMMISSIONER: Of course, yes. No drama at all.
38
39 The document I'm looking at actually anticipates
40 construction starting this year, which, if that's the case,
41 would anticipate planning approval fairly soon, I would
42 imagine.
43
44 MR CHIU: As I understand it, there's no planning approval
45 as yet.
46
47 THE COMMISSIONER: There's not?

1
2 MR CHIU: There's not. And by "construction this year",
3 I don't know whether that means --
4
5 THE COMMISSIONER: Local councils must move - oh, I
6 suppose - well, I don't know who --
7
8 MR CHIU: That could mean December.
9
10 THE COMMISSIONER: Who is the consent authority, the
11 council or the --
12
13 MR CHIU: It would be the local council.
14
15 THE COMMISSIONER: Anyway, sorry to distract you. I was
16 just seeing if I could help. I probably just made it
17 worse.
18
19 MR CHIU: Thank you, Commissioner.
20
21 If I could just ask you both now the other topic about
22 engagement with NSW Ambulance. Again, I'm just trying to
23 clarify the history of the engagement. In July 2020 the
24 minister met a delegation from Tocumwal to hear the request
25 for an ambulance station.
26
27 DR CORNWELL McKEAN: I don't know if it was July. It was
28 2020. It was the pandemic - I understand that
29 a representative actually came to Tocumwal that year and
30 there was a subsequent meeting with the ambulance
31 committee. But I don't know the precise date.
32
33 MR CHIU: I think we might be talking about separate
34 events. There was an ambulance delegate that came to
35 Tocumwal.
36
37 DR CORNWELL McKEAN: Yes.
38
39 MR CHIU: And separately there was a delegation that went
40 to the minister.
41
42 DR CORNWELL McKEAN: That's correct.
43
44 MR CHIU: Ms Ewer, you were around then and --
45
46 MS EWER: No, well, I wasn't. I was 2021. I have rightly
47 been told I started in 2021, in June. No, they did

1 definitely have a delegation to the minister. We know that
2 because of the lovely comment that was made to us as we
3 came up the stairs.
4
5 DR CORNWELL McKEAN: And I met with the committee just
6 last week and we were talking about the dates and trying to
7 work out what month it was. So it definitely occurred
8 about the time of that minister's report.
9
10 MR CHIU: I don't think it's critical.
11
12 DR CORNWELL McKEAN: No.
13
14 MR CHIU: Do you recall - I think this might be directed
15 at you, Ms Ewer, because you were around at the time - that
16 one of the reasons given at the time for not providing that
17 ambulance station in Tocumwal was that NSW Ambulance had
18 done a service planning process to determine need? Do you
19 recall that, first of all?
20
21 MS EWER: That's what the report said, yes.
22
23 MR CHIU: And then did the report also explain that they
24 look at gaps in current demand coverage, including data on
25 the number of 000 calls?
26
27 MS EWER: Yes.
28
29 MR CHIU: And what they found was that, on average, 450
30 calls originate from the Tocumwal area each year. Do you
31 recall that, the 450 calls?
32
33 MS EWER: I've heard that in the budget estimates
34 recently. I had not heard that previous to then.
35
36 MR CHIU: Okay. And that only about half of those
37 required a lights and sirens response. Again, that's not
38 something you have specific recollection of.
39
40 MS EWER: We didn't actually receive the report - council
41 did not receive the Minister Hazzard report until a year
42 after it was published.
43
44 MR CHIU: That was one of the things --
45
46 DR CORNWELL McKEAN: I am familiar with all those
47 statistics, and the regrettable thing is the data gets

1 mixed up by financial year and calendar year so nothing
2 quite matches, but I've heard all of - you know, of various
3 numbers around that.

4
5 MR CHIU: So as part of the consultation process, one
6 thing that could potentially be improved is the
7 presentation of the data to assist you understand it?

8
9 DR CORNWELL McKEAN: Definitely.

10
11 MS EWER: Absolutely.

12
13 MR CHIU: And again, this might be directed at Ms Ewer
14 because it's 2020: in the meeting, or at least one
15 meeting, maybe more meetings at the time, was there
16 a discussion about how they reached that decision,
17 prioritisation of different ambulance stations?

18
19 MS EWER: I wasn't at the 2020 meetings.

20
21 DR CORNWELL McKEAN: We did have a meeting last Friday
22 where this was discussed and we were told that Tocumwal was
23 about 20th on the list. We were taken through a whole
24 range of different demographics on these matters.

25
26 MR CHIU: I take it you don't know one way or the other
27 whether that same discussion had occurred previously to
28 last Friday?

29
30 DR CORNWELL McKEAN: Various words around that were in
31 that report and correspondence, and the subsequent GIPAA.

32
33 MR CHIU: If I were to suggest to you that between January
34 2023 and last Friday, there had been, in fact, four
35 meetings where this issue was discussed, does that sound
36 correct to you?

37
38 MS EWER: Not between December and January.

39
40 MR CHIU: Four meetings since 2020?

41
42 MS EWER: Since 2020? Three of those would be with us -
43 two of those, three of those? I don't know.

44
45 DR CORNWELL McKEAN: Two with us. I don't know about
46 anything else.

47

1 MR CHIU: Last Friday when you had this meeting and the
2 CERT was raised, was one of the issues that you need to
3 find quite a large number of volunteers to be able to
4 provide that?
5
6 THE COMMISSIONER: I think you said eight.
7
8 DR CORNWELL McKEAN: Eight, yes.
9
10 MR CHIU: It's eight volunteers. Is that something that
11 the community in Tocumwal would be able to provide?
12
13 DR CORNWELL McKEAN: I expressed serious doubts.
14
15 MR CHIU: In terms of the outcome of the meeting last
16 Friday, first of all, you received some information; is
17 that correct?
18
19 DR CORNWELL McKEAN: Yes.
20
21 MR CHIU: You were not happy with the information you
22 received in terms of whether it was adequate?
23
24 DR CORNWELL McKEAN: The meeting was most cordial. It was
25 the most cordial meeting that we've had in relation to any
26 health issues in recent times. It was very polite
27 conversation. I asked for the statistics on - we were
28 given some rough numbers, because the person who was there,
29 who was the numbers person, had had a look and said
30 something like, "Maybe 17 minutes" - it was all a bit
31 vague. And then I said, "Can you give me that data", and
32 then he said, "Oh, I'm only obliged to give you SA3", and
33 I said, "Don't worry about it, I'll GIPAA it".
34
35 MR CHIU: Did you also say at the conclusion of the
36 meeting that regardless of the data, this is something that
37 you and your community believe they will need and will
38 continue to push for?
39
40 DR CORNWELL McKEAN: Yes.
41
42 MR CHIU: No further questions.
43
44 THE COMMISSIONER: Thank you. Did anything arise out of
45 that?
46
47 MR GLOVER: No, Commissioner.

1
2 THE COMMISSIONER: This is for you, Mr Glover, I think at
3 first. There has been a series of answers that have raised
4 whether the questions included information like the report
5 provided by Minister Hazzard, correspondence redactions -
6 I take it none of that material is in the tender bundle
7 yet?
8
9 MR GLOVER: Not at the moment.
10
11 THE COMMISSIONER: What will we do about that?
12
13 MR GLOVER: There's a list, as I understand it, being
14 compiled, and we will acquire it, to the extent relevant,
15 through an appropriate process.
16
17 THE COMMISSIONER: It's being followed up?
18
19 MR GLOVER: Yes.
20
21 MR CHIU: Commissioner, I could perhaps assist.
22 A statement is being prepared from NSW Ambulance which will
23 contain all of this material and the entire background and
24 I will speak with my learned friend about that.
25
26 THE COMMISSIONER: Very good. Thank you for that.
27
28 MR GLOVER: If my friend takes it on, all the better.
29
30 THE COMMISSIONER: Thank you very much both for your time.
31 We are grateful and you are excused.
32
33 <THE WITNESSES WITHDREW
34
35 THE COMMISSIONER: For the next witness, first of all, how
36 long do you anticipate they will be?
37
38 MR GLOVER: Mr Muston is taking them.
39
40 MR MUSTON: I think --
41
42 THE COMMISSIONER: I won't hold you to it.
43
44 MR MUSTON: No, I think a higher authority might hold us
45 to it because I'm told that we can't sit on.
46
47 THE COMMISSIONER: We can't?

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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.

1 Q. What are those subcommittees?

2 A. There's health care safety quality committee, planning
3 resource and performance, audit and risk committee, there's
4 Aboriginal health and wellbeing committee. We have
5 a working group, it's a committee with the PHN, that's
6 a new one that we have started.

7

8 Q. Do you, as chair, sit on any of those committees?

9 A. We've just had a revamp of our membership. We're
10 trying to get more specialised membership of those
11 committees. So I'm on the planning resource and
12 performance committee and the PHN working party group.
13 There is also the Murrumbidgee Health and Knowledge
14 Precinct. I'm - actually, that's another one, that's a new
15 one that I'm on. I'm not a formal member of the health
16 care safety quality committee now, but I will be attending
17 as chair.

18

19 Q. So going through each of those committees, could you
20 just give us a brief description of what each of those
21 subcommittees feed in to the board?

22 A. Okay. The healthcare safety quality committee is the
23 clinical governance key one, and a lot of our work that we
24 do is looking at metrics that come to the board. We're
25 looking at --

26

27 Q. Just pausing there, where do those metrics come from?

28 A. From - management give us reports and we have certain
29 reports during the year and then there's always a monthly
30 or, sorry, every two months, this committee meets, so
31 bi-monthly there's set data, every time it could --

32

33 Q. Just dealing with that, the healthcare safety and
34 quality subcommittee, what do the metrics relate to?

35 A. Well, every meeting, there's always healthcare
36 acquired complications, so, for instance, it could be
37 infections in health, in health care; it could be falls; it
38 could be delirium. We also look at sentinel events or
39 harms to patients while in care. And then every few months
40 we might have a particular focus on an area of our health
41 services - it could be cancer services, it could be renal,
42 it could be aged care.

43

44 Q. And what does the subcommittee do with the information
45 once it has collected those metrics?

46 A. Okay, we look at the data and when - we'll look at,
47 like, trends, it could be that could indicate particular

1 facilities might be experiencing an issue that is abnormal
2 and we might raise that with management and ask questions
3 about, you know, what's happening, for instance. There
4 might be a higher incidence of falls at one facility and
5 they'll --
6

7 Q. Just to be clear, having had one of those
8 irregularities, if I can call it that, drawn to the
9 subcommittee and the board's attention, do you see it as
10 the board's function to come up with a solution to it or is
11 it more you then look to management of the LHD to explain
12 what they see as the cause of the problem?

13 A. Exactly.
14

15 Q. And what they're doing about it?

16 A. Yeah. No, we don't come up with the solution. We
17 basically highlight this as a problem and we ask management
18 for an explanation and they might - they're probably
19 already aware, because they're providing the data into the
20 report anyway, and so it triggers an alarm for them as
21 well, and so then when it does come to the board often
22 they're prepared with an answer, you know, with a good
23 explanation. Sometimes, if we're --
24

25 Q. Just pausing there, is there a follow-up, then, on
26 whether or not the answer they've given you in future
27 reporting periods has provided effective solution?

28 A. Yeah, correct, yeah. If we're not satisfied with the
29 answer they have given, we'll ask for what we might call
30 a "deep dive", where they have to come back to a future
31 meeting and there's an action item, so that it's followed
32 up, and they come back with a more detailed explanation,
33 and then we will track that metric in future statistics.
34

35 Q. I think we can infer what the audit and risk
36 subcommittee does. Moving to the next one, I think that
37 you listed, the planning, resources and performance
38 subcommittee --

39 A. Correct.
40

41 Q. -- what's the function of that subcommittee?

42 A. Yeah, it's - looking at all the finances of the
43 district is probably a key area there, and then the
44 performance. And by "performance", we're talking about
45 volume of activity, so we often have targets that we have
46 to meet through inpatient activity or mental health
47 admissions.

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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 --

1 A. Correct.

2

3 Q. -- which is aimed at collaborating with the PHN?

4 A. Yes.

5

6 Q. While we're on that, how does that collaboration
7 operate in a practical sense?

8 A. Yes. Well, it started in 2022 and the two boards got
9 together with executive staff and we realised, you know, as
10 a health system we are one. You know, public, they don't
11 differentiate between what's state funded, what's federally
12 funded, this primary versus hospital care, you know, they
13 just want a seamless service.

14

15 So we looked at ways we could collaborate and we've
16 signed a new agreement last year, and so collaborative
17 commissioning - you've probably heard that mentioned a few
18 times - that's one of the areas, and that could include
19 things like a diabetic strategy, for instance - you know,
20 the patients will come in to us, but if we can go upstream
21 and say we need better screening, we need better services
22 in the primary care setting to educate people to - well, it
23 could be to do with cardiac issues, if people are screened,
24 and if the primary care is done better, then it takes
25 pressure off our hospital system.

26

27 Q. So one of the other subcommittees, I think, is a
28 medical and dental appointments advisory committee?

29 A. Yes.

30

31 Q. What's the function of that subcommittee?

32 A. Appointment and review. I don't have a lot to do with
33 it. The board doesn't have representation on that. We
34 have appointed our director of clinical governance and
35 director of medical services on that committee.

36

37 Q. So what does that appointee feedback in to the board
38 from their involvement?

39 A. We do get an annual report from them.

40

41 Q. What does that report tell you in general terms?

42 A. Just - well, it's overall more governance and it's
43 really just, you know, the comings and goings, any issues
44 during the last year.

45

46 Q. Comings and goings and issues with what?

47 A. Oh, with any of the credentials of any of the medical

1 appointments, if there was any that, you know, had to leave
2 for certain reasons.

3
4 Q. We're at cross purpose. My understanding of
5 "appointments" was a different one to that. So we're not
6 talking about appointments that you make and attend; we're
7 talking about appointments, as in an appointed clinician?

8 A. Correct, yes.

9
10 Q. And I think the last one you referred to was the
11 Aboriginal health and wellness subcommittee?

12 A. That's right. That's a new one.

13
14 Q. What do you see as the function of that subcommittee?

15 A. Well, particularly as, you know, there is a strong
16 focus that the Ministry of Health has to improve the health
17 outcomes for Aboriginal people, "Closing the Gap". We feel
18 that, as a committee, just solely focused on the Aboriginal
19 health and wellbeing, and we have two of our board
20 directors who are Indigenous, which is a very high
21 proportion of our - percentage-wise, of our eight, only
22 two, so we're very pleased to have strong representation
23 there, so they will be on that committee, I will be
24 attending, and another board member.

25
26 We're only just starting that committee, so I can't
27 really speak too much about it at this stage.

28
29 Q. So what is it that you hope that that subcommittee
30 will feed in to the board in terms of information and
31 direction?

32 A. It will look at how our strategies are going, the
33 "Closing the Gap", and just, you know, are we getting the
34 traction that we should be in Aboriginal services.

35
36 Q. How is that subcommittee going to go about assessing
37 that performance against objective?

38 A. By, yeah, reviewing reports and looking at the
39 metrics. At the moment, the board gets a number of
40 metrics, which I think will be going to this committee in
41 future. For instance, one of the items that we see
42 regularly is the unplanned discharge of people from their
43 health care. Indigenous people have a high proportion of
44 unplanned discharge, and it's chiefly around the renal
45 area, and so we're looking at how --

46
47 Q. When you say "unplanned discharge", do you mean

1 self-discharge?
2 A. Correct, yeah. For instance, say if a renal patient
3 came in and they should be in the renal clinic for
4 a certain period of time - could be hours - sometimes, you
5 know, they will cut that short and they will leave, and
6 particularly it's a sensitive issue with Aboriginal people.
7 We need to have the right atmosphere and just explain the
8 reasons of why you need to be there for the full course of
9 that treatment, but it's an ongoing process, that sort of
10 explanation and training.

11
12 Q. To what extent does the board interact with or engage
13 with the Aboriginal community controlled health
14 organisations in relation to the particular issues we're
15 talking about now - that is, the advancement of First
16 Nations health?

17 A. We have a director of Aboriginal health that reports
18 directly to our chief executive, and that's only probably
19 in the last 12 months it's been elevated to that level. It
20 was previously a manager level, but it was something the
21 secretary of the ministry was very passionate about and it
22 was advocating that Aboriginal leadership needs to be
23 elevated in the executive of our districts, and so that
24 role will certainly have a lot more leadership and
25 gravitas, I guess, to do more connections with our - the
26 rest of our services.

27
28 Q. So do you know the extent to which that individual
29 engages with the ACCHOS?

30 A. Sorry with the?

31
32 Q. Aboriginal community controlled health organisations
33 like RIVMED?

34 A. That I don't know. I'm not sure. Like, you mean the
35 Aboriginal medical centres in the --

36
37 Q. Yes.

38 A. That I'm not sure.

39
40 Q. So coming back to my question, are you aware of any
41 direct engagement between the board and the Aboriginal
42 medical centres?

43 A. We don't have any direct relationship with them. We
44 get a report through the director of Aboriginal health
45 services, which will detail the scope of our services and
46 whether we're reaching our KPIs. So that's probably - what
47 you're talking about is probably more the operational level

1 between our Aboriginal health team and the medical centres.

2

3 Q. You're aware that a substantial amount of the health
4 care which is delivered to First Nations people is
5 delivered through organisations like the Aboriginal medical
6 services across the LHD?

7 A. Mmm - yeah.

8

9 Q. Are you aware of that?

10 A. Yeah, but we - we don't get any reporting or any
11 metrics from those individual medical centres.

12

13 Q. Do you think it would be useful from the point of the
14 board's objectives for there to be some more direct level
15 of engagement between the board and those entities?

16 A. Yeah, I believe so, and I think this new governance
17 wellbeing committee that we're starting, that is probably
18 one area that we can certainly, you know, bring in to that
19 committee.

20

21 Q. Do you think that a slightly closer engagement with
22 those Aboriginal medical services might assist you - you,
23 the board - in developing an understanding of the
24 particular needs of that community within the wider LHD?

25 A. Oh, yeah, I agree.

26

27 Q. Putting that to one side, how else do you, as chair,
28 go about familiarising yourself with the wider LHD and the
29 needs of - health needs of the community that exist within
30 it?

31 A. One of the roles I do is with our chief executive, we
32 visit every single facility during the year, and we will
33 visit the facility, I guess, view it, its infrastructure,
34 its services, but importantly meet the staff, meet some of
35 the patients and get a bit of a feel, you know, for the
36 vibe of the place.

37

38 We'll also then sit down with the LHAC
39 representatives, often the chairman and a few others,
40 whoever wants to come. Then we also invite along the local
41 mayor or general manager or their delegates, and it's
42 really a two-way discussion. We will talk about the
43 services we're providing and elaborate on what we plan to
44 do for that community. But in return, they will feed in to
45 us and talk about their concerns or their issues, and
46 probably one of the big ones - and I think you've been
47 hearing it in this hearing - is the workforce issue.

1
2 We see working with LHACs and the councils as a great
3 way of partnering with our local communities to address
4 that workforce issue. For instance, you were talking
5 earlier about Finley. One of the things that Syd Dudley
6 does, the chair of LHAC, is every new staff member who
7 arrives at work, he will turn up on their first day and he
8 will give them a briefing, you know, about the town, the
9 services, what to do, what not to do in the town, and just
10 really give a warm welcome to them. And we've sort of
11 taken that to our other LHACs to say, well, let's develop
12 a welcome package for new staff, you know, because we're
13 very much wanting to retain them.

14
15 The other thing at Finley is that we have spoken to
16 council about critical worker accommodation and they've
17 proceeded to get accommodation that we can use for, say,
18 nurses on short-term basis. Rental accommodation is very
19 hard to find in a lot of our small communities, it is
20 either expensive or just not possible. So by us engaging
21 with councils at our visits, we often find we can get their
22 support to establish things like this, you know, critical
23 worker accommodation.

24
25 Q. In relation to the recruitment of workers in some of
26 these particularly more remote hospitals, can you just
27 explain, at least insofar as you're aware of it, who is
28 responsible for the actual day-to-day task of advertising,
29 interviewing and hiring a new recruit, say a nurse, you
30 know, in the hospital, for example?

31 A. Yeah. We have a people and culture department within
32 MLHD and they will sort of moderate the recruitment
33 process. We have actually gone overseas just recently to
34 try and recruit more nurses. We've found, you know, with
35 COVID and the closure of the borders, that sort of dried up
36 a lot of that immigration of nurses that we used to get,
37 and then the actual recruitment will be done at the local
38 level for those nurses.

39
40 Q. When you say the "recruitment", we're talking about,
41 for example, dealing with getting visas for them and
42 accommodation?

43 A. Well, our people and culture will assist in all that,
44 yes.

45
46 Q. So which part of it is done by the LHD and which bits
47 of it are done by, say, the director of the facility down

1 in Finley, as an example?

2 A. Well, it'd be a nurse unit manager. It's chiefly done
3 through the people and culture department, and then
4 obviously the nurse unit manager would be part of the
5 interview process and, you know, screening of applicants
6 and helping them.

7

8 Q. Do you know what sort of efforts are made to determine
9 whether or not a town will be a good fit for the potential
10 recruit, as opposed to the extent to which the recruit
11 might seem to be a good fit for the job, if you understand
12 what I mean by that rather convoluted question?

13 A. Well, I think I do. Probably the example -
14 I mentioned about the overseas recruitment. That was to
15 England and Ireland. We did secure I think it was close to
16 100 in that recruitment drive, but they all chose, you
17 know, the Waggas, the Griffiths, I think maybe some went to
18 Deniliquin. So we were really trying to get some of the
19 small facilities but, you know, none came there. So in
20 future we're going to tweak that recruitment plan to be
21 more, you know, targeted at a smaller centres, you know,
22 the benefits of a small centre, rather than just an open
23 chequebook, so to speak.

24

25 Q. You told us a little while ago about the importance of
26 the LHACs and your engagement with the LHACs in the tour
27 you take around the LHD.

28 A. Mmm-hmm.

29

30 Q. Just correct me if I've misunderstood this, but your
31 tour is to each of the facilities which are located in some
32 of the towns, but not all of the towns, around the LHD?

33 A. Yes.

34

35 Q. The LHACs tend to be built around those facilities?

36 A. They are, yes.

37

38 Q. So, for example, the LHAC for Finley would ordinarily
39 be made up of people from Finley?

40 A. True.

41

42 Q. And similarly, a facility at Tumut would have an LHAC
43 populated by people from Tumut?

44 A. Yes.

45

46 Q. Do you see the LHD as having a responsibility to
47 deliver the health needs of the community across the entire

1 LHD - that is, the LHD board, I should say, has
2 a responsibility to deliver for the needs of the entire LHD
3 not just those --

4 A. I didn't understand your point there. What was --

5

6 Q. So hospitals are located in some of the little towns.
7 LHACs tend to be populated by people from those little
8 towns that are associated with those hospitals. Those
9 hospitals and the wider network of hospitals within the LHD
10 actually serve a much wider population than that which
11 exists in those towns.

12 A. Right. So you think, like Wagga, for instance, has
13 a huge catchment because it's a referral hospital bringing
14 in from right across the district?

15

16 Q. Or even an example, you may have been sitting here
17 while your predecessors were giving their evidence, the
18 town of Barooga, for example, doesn't have a facility?

19 A. That's right, yes.

20

21 Q. It doesn't have an LHAC. Nevertheless, it has
22 a population?

23 A. Yeah.

24

25 Q. Do you see the LHD board as having an obligation to
26 deliver for the health needs of the people of, say, in that
27 case, Barooga?

28 A. Mmm.

29

30 Q. Yes or no?

31 A. It's historically tended to be per facility - per
32 facility, as your introductory comment made. We haven't
33 sort of gone to the next stage of saying, you know, what
34 about all the little communities that don't have a facility
35 but could be, you know, represented. For instance, for
36 Barooga, could Barooga people join the Finley LHAC? They
37 could, and then contribute to those services.

38

39 Q. I suppose the first question is: do you see the LHD
40 board as having a responsibility for delivering for the
41 health needs of the people in all of those small
42 communities within the LHD, including, for example,
43 Barooga?

44 A. Yeah, yes.

45

46 Q. And the next question is to what extent, recognising
47 that they tend not to be part of any LHACs, is the board

1 seeking to assess the needs of and engage feedback from
2 individuals within those smaller communities as part of its
3 wider planning remit?

4 A. Mmm.

5
6 Q. The answer might be not at all, but my question to you
7 is, to what extent does it currently happen?

8 A. Yeah, it doesn't currently happen.

9
10 Q. Do you think it should happen, or it would be an
11 improvement to the system if it did?

12 A. I think it would be an improvement to have
13 representation from those communities. But there is
14 nothing to say Barooga people can't now join the Finley
15 LHAC. I guess we haven't been active, knocking on doors in
16 Barooga, saying, you know, "Please join Finley LHAC to
17 improve services".

18
19 Q. While we're dealing with Finley, were you involved in
20 any of the planning around the upgrade to Finley Hospital?

21 A. Not directly. I know that the - well, I first used
22 the facility probably five years ago, and obviously could
23 see, you know, it was in need of an upgrade.

24
25 The previous government made the commitment of the
26 \$25 million in November 2021, and that would have been
27 based on the client service plan - the clinical service
28 plan, rather. And I understand it was probably quite dated
29 by then, so, you know, it is using old figures.

30
31 Q. As in the clinical services plan was quite dated?

32 A. Oh, well, the costings for getting to that
33 \$25 million, because we recently finished Tumut and it was
34 something like \$60 million, and then, when it was announced
35 that Finley was going to get \$25 million, most of us were
36 surprised about how small it was, you know, in comparison.
37 And I remember when I did visit Finley I was talking to
38 Syd Dudley - this was about the time of the changeover of
39 government - I said to him, you know, "Just hope you keep
40 your \$25 million because the new government may find there
41 is no money and it may disappear, you know, because under
42 the new government it is a whole new ball game." But the
43 new government did stick with the \$25 million.

44
45 I think most of us realise that it is not enough. It
46 will end up just being a refurbishment, unfortunately, not
47 a big, brand new hospital, which they would all love to

1 have.

2

3 Q. So there are two components to that. There is the
4 clinical services planning?

5 A. Mmm-hmm.

6

7 Q. That process is identifying the needs of the community
8 which ought be delivered through a facility like Finley?

9 A. Yeah.

10

11 Q. To what extent do you see the board as having a role
12 in that clinical services planning process?

13 A. Yep, we received that clinical services plan, it would
14 have been a few years ago, and we signed off on it. You
15 know, we have to endorse it, and that was based on, in the
16 best case scenario, you know, all these new services or
17 improved services.

18

19 Q. So in terms of the sign-off or endorsement process,
20 what information do you, as the board, gather in order to
21 determine whether what is set out in the clinical services
22 plan that you have been presented with actually reflects
23 the clinical needs of the community that that facility is
24 intended to serve?

25 A. When those clinical service plans are prepared, they
26 do go through a consultation process with the communities,
27 and whether it is local LH --

28

29 Q. Is the board involved in that consultation?

30 A. Not at that stage. It's done - it's all delivered to
31 us after that due process is done, you know, the
32 consultation is done, and it's basically presented as a
33 "This is a final" - "this is a recommendation to proceed
34 for clinical services for this site."

35

36 Q. Do you as a board - or, insofar as you are aware, does
37 the board make any independent assessment of whether or not
38 what has been presented to you as a recommendation is the
39 appropriate recommendation to adopt?

40 A. Well, we would look at the health needs of that
41 community. When you get a clinical services plan, it will
42 have the population health data for that population, you
43 know, what are the health needs, and so we're guided by
44 that in making that determination.

45

46 Q. Do you know where that information, that populates
47 that part of the report, comes from?

1 A. I think it's BHI, the health information bureau.
2 Yeah. But just in relation to Finley, I think my
3 understanding of what happened was the clinical services
4 plan was the ideal; then when the money came, it wasn't -
5 it's not going to be enough, and so, you know, it is
6 a matter of now doing the conceptual, leading to master
7 planning, on a, you know, prioritised basis. You know, if
8 you can't spread the Vegemite thick enough, you know, how
9 thin do you do it and so what are the priorities for
10 delivering services?

11
12 Q. So do you see the board as having a role in deciding
13 how to spread the Vegemite, to use your nice phrase?

14 A. It's often driven by Health Infrastructure, you know,
15 they have - and then our executive team will be working
16 with them, and I think from the discussions that we heard
17 from the previous two witnesses, it's a matter of going
18 back to the community and going through, "Well, these are
19 the concepts now, based on the reality of the dollars", and
20 then we will be informed as a board.

21
22 Q. So when you say you will be informed, you will be
23 informed of what? Of what is going to happen?

24 A. We will get an update on the planning once it goes
25 through this next consultation phase, yes.

26
27 Q. Do you see the board as having a role in deciding, for
28 example, whether renal beds should be prioritised over,
29 say, some other service, assuming that the dollars won't
30 stretch to both?

31 A. We can have a comment about that and ask the
32 questions, you know, based on, again, the data we might
33 have about number of renal patients and needs.

34
35 Q. To what extent, as part of that process, do you, as
36 a board, seek to independently engage with the community
37 either through the LHACs or other means?

38 A. It's the - well, we have the visits I was talking
39 about; we do have the twice a year LHAC forums, but those
40 sorts of forums are more general, where we might talk about
41 overall strategies, you know, we might have a new strategic
42 plan, and we will do a few presentations on a particular
43 focus that we're looking to do - could be workforce
44 recruitment; it could - you know, "grow your own", you've
45 heard that phrase quite a bit. That's something that we've
46 really been pushing hard. So we will do more those,
47 I guess, global initiatives at the LHAC forums but we

1 won't, you know, at that forum, be sitting down with say
2 Finley or Tumut and going through, you know, their
3 individual health needs at that point.
4

5 Q. Is there any process whereby the board makes an
6 independent assessment, through engagement with LHACs or
7 otherwise, of those needs?

8 A. Well, each month we get a report from each of the LHAC
9 meetings and it's a summary of the issues that they have
10 raised and it's basically from their minutes, and it could
11 be particular concerns and it might have then an action
12 item that the executive have addressed. They might send
13 one of the executive team out to explain to them about the
14 new services that are coming or what has changed, or
15 sometimes it might escalate to us and ask us for a bit of
16 advice or just, you know, to do more, I guess, activation
17 of a problem.
18

19 Q. So who is seeking advice from you in that context?

20 A. Well, that's in the LHAC report we get - we get this
21 every month and it's summarised for each LHAC, and so it
22 might come to us with a comment, you know, that there needs
23 to be more work around - could be, say, renal services at
24 Finley, you know, and so we will then ask the questions,
25 "Well, what are we doing to address that?"
26

27 Q. So those questions you are asking of management of the
28 LHD?

29 A. Correct, yep. But it's fed through from the LHAC
30 meetings through this report to the board and then we,
31 I guess, query management as to, you know, "What are we
32 doing to address that?"
33

34 Q. And in terms of the querying of management, do you see
35 the board as having a role in directing what should be done
36 in relation to that or is it more just making sure that
37 management hasn't overlooked it or not thought about it?

38 A. It's probably a bit of both, I would expect.
39

40 Q. In the case of the --
41

42 THE COMMISSIONER: I'm sorry, I don't want to stop you and
43 make the witness come back if you are nearly finished, but
44 I just need to check, first of all, is it okay for us to
45 keep going for a little longer?
46

47 THE WITNESS: Yes, I'm happy.

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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

1 a way in which they provide information. That information
2 from them filters up to the board.

3 A. Mmm.

4
5 Q. Is there a mechanism whereby information filters from
6 the board back down to the LHACs?

7 A. Well, that's with the twice a year forum where the
8 chair and other board members attend that forum, and I will
9 address them and talk about, I guess, what's on my heart as
10 far as, you know, the current state of the district and
11 where we're heading and what issues are on our plate.

12
13 Q. So through those forums - I think you indicated
14 earlier that they operate at a slightly higher level than
15 the particular needs of say Finley or Tumut hospitals?

16 A. Correct.

17
18 Q. Is there a way in which the board engages with - that
19 is to say information is passed from the board to the LHACs
20 about those more particular needs of their facilities and
21 decisions that are made about the particular needs of their
22 facilities?

23 A. Yeah.

24
25 Q. What is that process?

26 A. Well, that would be more informal, like, at the LHAC
27 forum, if one of the LHAC groups, you know, took us aside
28 and said, "Look, we are concerned about this", and then
29 I guess I would take it on to talk with management about
30 that concern that they have, but we really rely on the more
31 regular monthly report that we get as far as the LHAC
32 meetings.

33
34 Q. Do you think there would be utility in that monthly
35 provision of information going both ways - that is to say,
36 do you think there would be utility in having the board
37 communicating with the individual LHACs about the issues
38 that they might raise with you?

39 A. Yes, there probably would be, but often it's - it
40 could be a general - a generic sort of response as to, you
41 know, the services we're providing or our plans.

42
43 Q. Do you see the LHACs as having a role to communicate
44 information about the facility and decisions made around
45 the facility to their communities?

46 A. Not so much about the facilities. Like, it's only an
47 advisory committee. So, you know, I would put the onus on

1 them to have to front the community and say, you know,
2 "We've only got \$25 million for this building", and
3 explain - you know, that's our responsibility as the
4 district, to go to our communities. So the LHACs are - you
5 know, for them, it's - they might go to the community and
6 talk about, you know, more health services rather than the
7 infrastructure, and then their communities will feed to
8 them, you know, their concerns, whether - you know, for
9 instance, suicide, youth suicide is an issue in rural
10 New South Wales, so they might pick that up from things
11 like the men's shed or just, you know, talking around the
12 PCYC and that sort of thing, and then the LHAC can bring
13 that information back to their group and then it feeds in
14 to management and the board.

15

16 Q. But you don't see the LHACs as having a role to play
17 in, while perhaps not fronting public meetings and saying
18 "We're not going to give you a renal chair", for example --
19 A. Yes.

20

21 Q. -- do you not see them as potentially having a role to
22 play in communicating and engaging with their own community
23 in a way that at least explains decisions that have been
24 made in parallel with the explanation that has been given
25 by you and the executive?

26 A. Yeah, just - yeah, to some extent, that's right, yep,
27 particularly with the health services that are provided;
28 they can be an advocate for our decision-making.

29

30 Q. Would that role be better facilitated by a clearer
31 provision of information to the LHACs about decisions that
32 are made around those issues that are important in their
33 communities?

34 A. Yes, I think that probably would help.

35

36 Q. Can I ask you, an issue that we've heard a great deal
37 about is patient record systems and the fact that both
38 within - between primary health care and the acute care
39 setting, they don't talk to one another. Do you recognise
40 that as being a significant issue within your LHD?

41 A. I don't sort of see it as - you know, from the board,
42 I don't hear that, you know. I hear more about, you know,
43 the interstate lack of integration between health records.

44

45 Q. What is the particular issue?

46 A. Well, because we have a long border with Victoria, for
47 instance, and a lot of our patients will go to referral

1 facilities into Victoria, and so there is no integration of
2 data; and likewise with the ACT, you know, when we talk
3 about Boorowa, Young, going into Canberra hospitals, it's
4 the same. You know, we might have our EMR, eMeds,
5 discharge summaries all electronically, but there is no
6 talking between the states. That's what I see, you know,
7 at a board level, the bigger issue. I'm not really
8 familiar with the primary care issue you were talking
9 about.

10
11 Q. So the issue that you at board level hear more about
12 is the fact that the Victorian patient record systems -
13 system or systems - such as they might be on the other side
14 of the river do not communicate with the equivalent systems
15 in New South Wales --

16 A. Correct.

17
18 Q. -- in the regular particular patient flow?

19 A. And I understand Victorian hospitals, each have their
20 own, like, EMR as well, so often they don't talk between
21 themselves.

22
23 MR MUSTON: I note the time, Commissioner. I think
24 I don't have any further questions for this witness.

25
26 MR CHIU: I have nothing.

27
28 THE COMMISSIONER: Thank you very much for coming in, sir,
29 we are very grateful for your time. You are excused.

30
31 **<THE WITNESS WITHDREW**

32
33 THE COMMISSIONER: All right. There is no reason to start
34 at any time other than 10 tomorrow?

35
36 MR MUSTON: No.

37
38 THE COMMISSIONER: All right. We will adjourn until
39 10 o'clock tomorrow. Thank you.

40
41 **AT 4.15PM THE COMMISSION OF INQUIRY WAS ADJOURNED TO**
42 **TUESDAY, 19 MARCH 2024 AT 10AM**

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\$1,500 [1] - 1246:31
\$25 [14] - 1240:41,
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\$38 [1] - 1202:40
\$400 [1] - 1204:29
\$450 [1] - 1202:39
\$60 [1] - 1273:34
\$65,000 [1] - 1227:16

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1 [10] - 1147:33,
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 1148:10, 1230:16,
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1.30 [1] - 1211:29
10 [10] - 1144:2,
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 1194:23, 1203:34,
 1207:44, 1224:3,
 1235:23, 1280:34,
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10.00am [1] - 1139:22
10.09am [1] - 1143:27
100 [2] - 1233:37,
 1271:16
10AM [1] - 1280:42
11 [1] - 1178:23
11.17am [1] - 1177:5
11.30 [1] - 1176:45
12 [5] - 1157:18,
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130 [1] - 1167:16
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16 [1] - 1204:8
17 [3] - 1203:37,
 1224:5, 1260:30
18 [2] - 1139:22,
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19 [2] - 1247:10,
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