

**Special Commission of Inquiry
into Healthcare Funding**

**Before: The Commissioner,
Mr Richard Beasley SC**

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

Thursday, 21 March 2024 at 10.00am

(Day 014)

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. Yes, Dr Waterhouse?
2
3 DR WATERHOUSE: I call Elizabeth Dixon and Anthony Kolbe.
4
5 <ELIZABETH DIXON, sworn: [10am]
6
7 <ANTHONY KOLBE, affirmed: [10am]
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9 <EXAMINATION BY DR WATERHOUSE:
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11 DR WATERHOUSE: Ms Dixon, could you state your full name
12 for the record, please.
13
14 MS DIXON: Elizabeth Ann Dixon.
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16 DR WATERHOUSE: Mr Kolbe, could you also state your full
17 name for the record.
18
19 MR KOLBE: Anthony Kolbe.
20
21 DR WATERHOUSE: You are both on the board of the
22 Murrumbidgee Local Health District. Is that correct.
23
24 MS DIXON: Yes.
25
26 MR KOLBE: Yes.
27
28 DR WATERHOUSE: How long have you been on the board
29 Ms Dixon?
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31 MS DIXON: Since January 2019.
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33 DR WATERHOUSE: Mr Kolbe?
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35 MR KOLBE: Since January '23.
36
37 DR WATERHOUSE: I understand you each chair a subcommittee
38 of the board; is that right?
39
40 MS DIXON: Yes.
41
42 DR WATERHOUSE: I'm going to go through some questions
43 both in relation to your board position and also your
44 individual subcommittees.
45
46 Now, if I could start with you, Ms Dixon. Which
47 subcommittee do you chair?

1
2 MS DIXON: Health care safety and quality.
3
4 DR WATERHOUSE: Have you chaired that since you joined the
5 board?
6
7 MS DIXON: No, I have chaired it for two and a bit years.
8
9 DR WATERHOUSE: And Mr Kolbe, the name of your
10 subcommittee?
11
12 MR KOLBE: Planning resource and performance.
13
14 DR WATERHOUSE: When did you become the chair of that
15 committee?
16
17 MR KOLBE: July '23.
18
19 DR WATERHOUSE: Ms Dixon, can I start by getting you to
20 outline your professional background and your experience in
21 health and other professional activities?
22
23 MS DIXON: So I'm a physiotherapist by background.
24 I spent my early years at Alfred Health in Melbourne where
25 I was a senior ICU neurotrauma physiotherapist and
26 I participated as a clinician and as a researcher.
27
28 I then moved to a sheep station in Carrathool, which
29 is in the western side of our MLHD. I worked in some
30 private and public practices there and then joined the
31 board after studying further business and governance
32 degrees.
33
34 DR WATERHOUSE: Have you been on other boards prior to
35 this one?
36
37 MS DIXON: No, this was my first.
38
39 DR WATERHOUSE: Do you still work in clinical roles?
40
41 MS DIXON: Not at the moment.
42
43 DR WATERHOUSE: What sorts of work do you do when you're
44 not working for the board?
45
46 MS DIXON: Well, I'm in agriculture and raising a young
47 family.

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DR WATERHOUSE: Mr Kolbe, can you tell us a bit of about your background?

MR KOLBE: I began as a laboratory scientist, worked in clinical laboratories for about 12 years, studied Master of Public Health and became interested in tropical public health. Then moved into a position with NSW Health as a director of public health for what was then the South West region and different entities for - after that, for a period of about 17 years.

I went to work for the SPC in Noumea, in the Pacific, for a couple of years, came back to Australia, worked at Charles Sturt University and for a period at La Trobe University, and doing some work also for University of Canberra.

Then I became a consultant, really a contractor, with the WHO office in Suva and did that until 2020. I had a brief period working with the public health team locally, associated with COVID, and have then semi-retired.

DR WATERHOUSE: Have you been on other boards or are you currently on other boards?

MR KOLBE: I have been on Hume Medicare Local Board for the period 2012 to 2015.

DR WATERHOUSE: Can you describe what Medicare Local is or was?

MR KOLBE: It preceded the primary health networks, so it was the first establishment of organisations like that to help coordinate primary health care.

DR WATERHOUSE: Why did you apply to join the board?

MR KOLBE: I'm interested in being involved in boards and also I have an affiliation with the health service in this area, and wanted to make a contribution to that board.

DR WATERHOUSE: Do you have particular sorts of interests or aims that you would like to see while you are on the board?

MR KOLBE: I would like to simply contribute my expertise

1 to the board. I do have specific interests in disease
2 prevention and would like to further that opportunity on
3 the board.

4
5 DR WATERHOUSE: Thank you. Ms Dixon, what led you to join
6 the board or to apply to join the board?

7
8 MS DIXON: I think I come from an area of world class
9 clinical care in Victoria and I moved to an area where
10 I found it more difficult to navigate the healthcare system
11 and I could see that there were gaps around there and
12 I wanted to contribute to that.

13
14 DR WATERHOUSE: Do you have a particular focus in your
15 work on the board, particular goals?

16
17 MS DIXON: My focus I guess, chairing the safety and
18 quality committee, is around patient outcomes and in
19 particular my focus is often around how we achieve equity
20 across our district.

21
22 DR WATERHOUSE: What would you see as the role of the
23 board?

24
25 MS DIXON: So we're there to provide oversight over the
26 district, to help lead and develop where the district heads
27 in terms of its strategic plan, and then to monitor its
28 progress towards that.

29
30 DR WATERHOUSE: How would you describe your own
31 obligations as a board member?

32
33 MS DIXON: Well, we need to understand the operations of
34 the district, understand the complex system that it exists
35 in, as in the networks of LHDs across the state, how
36 Murrumbidgee works and ensure that we have appropriate
37 information, understanding that we can fulfil our
38 governance and fiduciary responsibilities.

39
40 DR WATERHOUSE: Mr Kolbe, would that characterise the way
41 you would describe the board?

42
43 MR KOLBE: Yes, it would.

44
45 DR WATERHOUSE: And your own role? Do you want to add
46 anything about how you see your own role on the board?

47

1 MR KOLBE: No, I don't think so, thank you.

2

3 DR WATERHOUSE: Is there anything from a population health
4 perspective, given your background, that you would add?

5

6 MR KOLBE: Well, health systems generally are very
7 hospital focused. With the prevalence of chronic disease,
8 it is important that the health system is able to
9 transition to a point where it is able, firstly, to manage
10 that chronic disease and also, in future, to prevent as
11 much of that chronic disease as possible.

12

13 DR WATERHOUSE: When you say "manage the chronic disease",
14 are you talking about within hospital settings
15 specifically?

16

17 MR KOLBE: It may well be within primary care settings as
18 well, though, so when we're talking about secondary
19 prevention, we're really talking about an opportunity to
20 manage people who have perhaps high blood pressure or high
21 cholesterol and then prevent them from developing any
22 further illness. Primary prevention refers to preventing
23 those things occurring in the first place, and so that is
24 more linked to activities around health promotion or
25 changes in society as to how we live.

26

27 DR WATERHOUSE: In your outline for your statement, you
28 refer to the board governance charter. Can you tell us
29 what the charter is, please?

30

31 MR KOLBE: The charter outlines the role of the board and
32 contains information about listed functions of the board.
33 It describes the subcommittees and their functions - that's
34 all I have at the moment, thank you.

35

36 DR WATERHOUSE: The board governance charter, is this
37 a specific Murrumbidgee Local Health District initiative or
38 is it something that all local health districts have?

39

40 MR KOLBE: Now, that I can't comment on. I would imagine
41 all districts would have a charter, but Liz may know more
42 about that.

43

44 DR WATERHOUSE: Do you know that about, Ms Dixon?

45

46 MS DIXON: I believe all local health districts would have
47 their own board governance charter.

1
2 DR WATERHOUSE: What is the status of the charter relative
3 to the model by-laws which dictate a lot of the
4 requirements for boards and subcommittees?
5
6 MS DIXON: Sorry, could you ask that again?
7
8 DR WATERHOUSE: There are model by-laws under the Health
9 Services Act 1997 that provide for a lot of the rules
10 around the subcommittees and the board. What's the status
11 of the charter relative to the by-laws?
12
13 MS DIXON: So the charter would acknowledge the model
14 by-laws, obviously, and ensure that we're compliant with
15 them. It would then go further to say what are the
16 processes that the board and the committee will undertake
17 and, in addition, we have additional board subcommittees
18 that are not listed under the regulations.
19
20 DR WATERHOUSE: Would you agree with that summary?
21
22 MR KOLBE: Yes. Yes, thank you.
23
24 DR WATERHOUSE: How does the charter relate to the annual
25 corporate governance attestation statement that's signed by
26 the chair on behalf of the board? Ms Dixon?
27
28 MS DIXON: It is a component of the corporate governance
29 attestation statement, as in we have processes that we
30 follow that are based on that - the board charter, but the
31 corporate governance attestation statement is much more
32 comprehensive and significant than just the board charter.
33
34 DR WATERHOUSE: Mr Kolbe, would you like to add anything
35 to that?
36
37 MR KOLBE: I have nothing to add, thank you.
38
39 DR WATERHOUSE: Mr Kolbe, can you talk to me about what
40 types of data the board routinely reviews? Maybe if we
41 start with financial data.
42
43 MR KOLBE: Yes, financial data, activity and service data,
44 so in-patient statistics, ED presentations. They may also
45 look at integrated care and allied health information,
46 workforce.
47

1 DR WATERHOUSE: If we can break that up a little, what do
2 you mean by integrated care information? What sort of data
3 would you see for that?
4

5 MR KOLBE: That might be information related to the
6 service agreement, KPIs emerging out of a service
7 agreement, for example. We may also receive information on
8 capital works, efficiency projects that are under way, for
9 example. That's all I have at the moment, thank you.
10

11 DR WATERHOUSE: Ms Dixon, do you want to add any
12 references to data there?
13

14 MS DIXON: So from a healthcare safety and quality
15 perspective we look at a lot of clinical and safety quality
16 indicators and they indicate things from consumer feedback
17 all the way through to our incident data from within our
18 healthcare systems, areas where we're doing well and areas
19 where we need to improve our focus.
20

21 DR WATERHOUSE: Does this include a review of data against
22 the KPIs in the service agreement between the ministry and
23 the district? Is that the KPIs you referred to, Mr Kolbe?
24

25 MR KOLBE: Yes, that's correct.
26

27 DR WATERHOUSE: Can you expand on that at all?
28

29 MR KOLBE: Only to say that within the service agreement,
30 there are KPIs set out, and the status of those KPIs are
31 reported to the board and - or in some cases to the PRP,
32 and there's often discussion around those KPIs as to
33 whether those are being achieved or what the contributing
34 factors may be, if they're not being achieved, and they
35 cover a wide range of things. I think there might be 80 or
36 so KPIs in that list.
37

38 DR WATERHOUSE: From the point of view of the board
39 managing an organisation, Ms Dixon, maybe if I could ask
40 you this question, do you find the KPIs are helpful to
41 monitor progress?
42

43 MS DIXON: They are. Our KPIs can - will include things
44 like our patient flow and access, so our emergency
45 performance, our triage performance, our surgical
46 performance, financial performance and safety and quality
47 indicators, there's a long list of them, as Tony said.

1 They are useful. They are mostly volume based, though.

2

3 DR WATERHOUSE: What actions does the board take, if any,
4 if you find that particular KPIs are, say, consistently not
5 being met or deteriorating in some way?

6

7 MS DIXON: Then we would ask that the executive go and
8 look into it further and report back to the board.

9

10 THE COMMISSIONER: Can I just ask, when you said the KPIs
11 are "mostly volume based", do you mean they're not KPIs
12 directed to the health of the population, rather they're
13 about times and --

14

15 MS DIXON: That's correct. So they might include things
16 such as how quickly we move a patient from the ambulance
17 into the emergency setting, how quickly we move a person
18 from the emergency setting into the admission or back to
19 home. So that they are numbers, perhaps, rather than
20 patient outcomes.

21

22 THE COMMISSIONER: And I get the impression you don't
23 consider that the KPIs aren't important, but there might be
24 other important KPIs, such as what is the health of our
25 population and how can we make it better?

26

27 MS DIXON: That's correct. They are important, it's
28 important that we get our ambulances back out on the road
29 so that they can go and see other patients. All of those
30 KPIs are certainly important. But as we're progressing
31 through this, I guess, evolution towards looking at value
32 based health care and outcome based health care, I think
33 there are other KPIs that we could look at.

34

35 THE COMMISSIONER: I may as well ask this now rather than
36 wait until the end, because it might affect some of the
37 questions counsel are asking. I appreciate the question
38 I'm going to ask is really difficult, but - and I'll ask
39 both of you, but Mr Kolbe first, because in response to
40 a question from Dr Waterhouse, "Is there anything from
41 a population health perspective, given your background,
42 that you would add?" - this is about your role on the
43 board - what you said, and there was some follow-up on
44 this, but I would like to give you the chance to give
45 a fuller answer as to your opinion, you said:

46

47 *Well, health systems generally are very*

1 *hospital focused. With the prevalence of*
2 *chronic disease, it is important that the*
3 *health system is able to transition to*
4 *a point where it is able, firstly, to*
5 *manage that chronic disease and also, in*
6 *future, to prevent as much of that chronic*
7 *disease as possible.*

8
9 Now, that might well be the key issue for this Inquiry, so
10 appreciating this is a difficult question, firstly, you,
11 Mr Kolbe, what would you see as needing to be done, in your
12 opinion, to make that transition you described in that
13 answer?

14
15 MR KOLBE: Right. There needs to, I believe, be changes
16 in service models so that we are having greater integration
17 between, say, general practice, primary - the primary care
18 facilities and services that are more likely to be able to
19 contribute to the control of these risk factors. There
20 needs probably to be a change in infrastructure to achieve
21 that, and we may well have current hospital settings which
22 make a transition to that quite difficult.

23
24 THE COMMISSIONER: What do you mean by "change in
25 infrastructure"?

26
27 MR KOLBE: Away from a hospital based model to more of an
28 integrated primary care model.

29
30 THE COMMISSIONER: Community type setting?

31
32 MR KOLBE: Community type setting, yes.

33
34 And to some extent we also need a change in the skills
35 and abilities of the workforce to be able to deliver that.
36 We need people who - a workforce able to deliver primary
37 health care and also to be able then to contribute to
38 efforts around primary prevention, which is prevention of
39 disease in the first place.

40
41 Primary prevention gets quite challenging because, if
42 we're only talking about behaviour change, then that is
43 difficult to achieve without other applications. So if we
44 take, for example, wearing of seatbelts, if we had a health
45 promotion campaign, we might have some change in behaviour,
46 as far as wearing seatbelts, but if you combine that with
47 enforcement and various other processes, then they are

1 mutually supporting.

2

3 Similarly for prevention of chronic disease, we need
4 changes in society, and the way things work in society. We
5 need partnerships with local government and other
6 organisations, really, to deliver the sort of environments
7 which promote health.

8

9 THE COMMISSIONER: What would you like to say in response
10 to that? I know you've mentioned prevention as one of the
11 things in your statement, but in relation to the transition
12 to a point where we manage chronic disease and also prevent
13 as much chronic disease as possible as a health system,
14 what would you like to add, Ms Dixon?

15

16 MS DIXON: I think the state-based system for the
17 Murrumbidgee Local Health District is looking at how we can
18 prevent people from coming into our emergency departments
19 in a very sick manner. We want to be able to treat them in
20 a better way so that they don't present in that
21 emergency-type model, and that we can manage them better in
22 the community in their own environment in a much more
23 empowered way, which is better for the patient and much
24 better for the clinician, and it's better for our
25 resources.

26

27 That's about preventing people who already have an
28 illness coming into our facilities. Tony's describing as
29 well the next step, which is preventing the diseases from
30 occurring in the first place. The barriers that we have to
31 that is that has traditionally been considered as primary
32 care, which is mostly funded by the federal Medicare
33 environment. We have challenges with that across our
34 district. It is siloed and, as you can see, we're trying
35 to start this process of integrating models of care where
36 we actually put the patient at the centre rather than the
37 funding source.

38

39 THE COMMISSIONER: I guess if prevention has been left
40 primarily with primary care, if primary care is failing,
41 then prevention fails with it.

42

43 MS DIXON: Well, you can see that our population health
44 across the Murrumbidgee Local Health District, we have some
45 significant challenges, things such as obesity, smoking
46 rates, smoking rates during pregnancy, levels of cancer,
47 I think I said obesity, diabetes, renal failure. We have

1 significant challenges here. Within the Murrumbidgee Local
2 Health District we have the third largest amount of
3 preventable hospital admissions, and that is why we are
4 shifting the models of care to try and address those needs
5 of the community.

6
7 THE COMMISSIONER: Thank you.

8
9 DR WATERHOUSE: Just one other question in relation to the
10 KPIs. As the responsible body for the district, do you
11 have any role in actually setting the KPIs or prioritising
12 them when they are put into the service agreement with the
13 ministry? Maybe if I can start with Ms Dixon.

14
15 MS DIXON: No, the service level agreement, the KPIs are
16 set by the ministry and they have tolerance levels and then
17 we are rated whether we are meeting them or not meeting
18 them and that will have or may have consequences.

19
20 DR WATERHOUSE: Thank you. Any comment, Mr Kolbe?

21
22 MR KOLBE: No, nothing to add, thank you.

23
24 DR WATERHOUSE: Is the board involved in developing the
25 strategic plan for the district?

26
27 MS DIXON: Yes, heavily.

28
29 DR WATERHOUSE: Maybe Mr Kolbe, if you could start off by
30 telling me what your role is in that as a board?

31
32 MR KOLBE: Yes. The most recent strategic plan was
33 developed before I joined the board, but I'm aware that the
34 board was involved in detailed planning sessions in the
35 development of the strategic plan, and the plan and its
36 outcomes are monitored by the board.

37
38 DR WATERHOUSE: Ms Dixon, were you involved with the
39 actual process for this particular plan?

40
41 MS DIXON: Yes, I was.

42
43 DR WATERHOUSE: What did that involve from your
44 perspective?

45
46 MS DIXON: That involved a lot of preparation work and
47 then two days with the executive and with all of the board

1 directors, consultation with the PHN as well, and then
2 formulation of the strategic plan. A lot of consultation
3 with a lot of stakeholders, including within Murrumbidgee
4 Local Health District and externally, and then endorsement
5 of the strategic plan.
6
7 DR WATERHOUSE: So that consultation involved members in
8 the community?
9
10 MS DIXON: Yes.
11
12 DR WATERHOUSE: And involved staff?
13
14 MS DIXON: Yes.
15
16 DR WATERHOUSE: I'd like to just ask you about some of the
17 reports that come to you as a board, and in particular, I'm
18 interested to know if these are presented to you for noting
19 or whether you actually are required to approve them or
20 endorse them in some way. So clinical services plans - do
21 you see those?
22
23 MS DIXON: We do.
24
25 DR WATERHOUSE: What role does the board take in relation
26 to clinical services plans?
27
28 MS DIXON: So they are required for endorsement before
29 they are submitted to the ministry.
30
31 DR WATERHOUSE: What about proposals to address workforce
32 gaps that are impacting on service delivery? Maybe
33 Mr Kolbe, you could answer that?
34
35 MR KOLBE: That is - if we take an example over the
36 Christmas period, there were some changes at a particular
37 site because it was unable to be staffed during that short
38 period. Arrangements were put in place and that was
39 endorsed by the board.
40
41 DR WATERHOUSE: What about the strategic asset management
42 plan? Is that something that comes to the board?
43 Ms Dixon, would you like to --
44
45 THE COMMISSIONER: I think in relation to any question
46 you're asked, whoever is asked it or whoever starts
47 answering it, if the other of you has something you want to

1 add, just go ahead.

2

3 MS DIXON: Thank you. Yes, it does.

4

5 DR WATERHOUSE: Did you want to comment further on that?

6

7 MS DIXON: No, it comes to the board annually.

8

9 DR WATERHOUSE: What does it contain?

10

11 MS DIXON: The strategic asset management plan? It will
12 contain information about the top priorities for the
13 district.

14

15 DR WATERHOUSE: Are there particular plans for the
16 Indigenous members of your local population?

17

18 MS DIXON: Yes, there are. The board has recently
19 established a new board subcommittee for Aboriginal health
20 and wellness and that is particularly focused on "Closing
21 the Gap".

22

23 DR WATERHOUSE: What does that plan include?

24

25 MR KOLBE: There is a New South Wales Aboriginal health
26 plan. Now, as well as that, the organisation, the health
27 district, has done a lot to transform the organisation
28 itself to be an organisation which recognises and
29 appreciates Aboriginal community.

30

31 That transformation of the organisation is something
32 that is recommended in closing of the gap. It entails some
33 practical and other symbolic sort of initiatives. In each
34 facility there is a statement of commitment to Aboriginal
35 health from the board; there is a copy of the apology to
36 the Stolen Generation; and an acknowledgment of country as
37 well.

38

39 There are a range of other initiatives, which I won't
40 go into, but I believe that that takes time for an
41 organisation to accept - for those things to be embedded
42 into the organisation and for that organisation to accept
43 those things and to understand them as the way of
44 operation, the normal operation.

45

46 So the transformation of the organisation has been,
47 I think, a very significant thing in regard to addressing

1 the gap and the issues of Aboriginal health.

2

3 DR WATERHOUSE: Thank you.

4

5 Ms Dixon, did you want to add anything in relation to
6 that?

7

8 MS DIXON: On our board we are lucky enough to have two
9 Aboriginal elders that sit as board directors, two out of
10 our eight, and they provide invaluable insights. We have,
11 over the last few years, increased the importance of the
12 director of Aboriginal health to an executive director of
13 Aboriginal health, we've developed an Aboriginal health
14 strategy, and now - we've always monitored Aboriginal
15 health through the health care safety and quality but we
16 are now saying we want increased focus on this more, and so
17 we've created their own subcommittee.

18

19 DR WATERHOUSE: Thank you. Moving to a slightly different
20 area, the by-laws require that the chief executive
21 establish medical staff councils and also clinical councils
22 in the facilities. Does the board receive reports about
23 these or about clinician engagement generally?

24

25 MS DIXON: So the MDAAC, which is the Medical --

26

27 DR WATERHOUSE: I'll come to MDAAC in a moment; I'm
28 talking about the medical staff council and the clinical
29 council.

30

31 MS DIXON: Yes. So the board receives monthly updates
32 from the chief executive about the district clinical
33 council and through our director of clinical governance we
34 will receive updates about the medical council and any
35 issues that they bring forward.

36

37 DR WATERHOUSE: Now, with the MDAAC - that stands for
38 what, do you know?

39

40 MS DIXON: Medical dental advisory committee - it might
41 be.

42

43 DR WATERHOUSE: I think it is Medical and Dental
44 Appointments Advisory Committee.

45

46 MS DIXON: Appointments, sorry.

47

1 DR WATERHOUSE: So that is something the board is required
2 to establish under the by-laws; is that correct?
3
4 MS DIXON: It is, but we don't sit on the committee. We
5 have two nominees, who is our executive director of medical
6 services and our director of clinical governance.
7
8 DR WATERHOUSE: So you don't nominate anyone outside the
9 executive to sit on the MDAAC?
10
11 MS DIXON: No.
12
13 DR WATERHOUSE: How does the board become familiar with
14 the activities of the MDAAC and the information that it's
15 reviewing?
16
17 MS DIXON: We receive an annual report.
18
19 DR WATERHOUSE: I beg your pardon, sorry?
20
21 MS DIXON: An annual report.
22
23 DR WATERHOUSE: How would the board be aware if there were
24 an issue, say a complaint about a credentialling process or
25 something of that nature, in relation to a senior
26 practitioner?
27
28 MS DIXON: So within our clinical governance reporting,
29 there is an opportunity that the director of clinical
30 governance would bring that to the committee and to the
31 board, and I think that would be the process.
32
33 DR WATERHOUSE: So it would come separate to the annual
34 report?
35
36 MS DIXON: Yes.
37
38 DR WATERHOUSE: Mr Kolbe, can I ask you, what does the
39 annual report contain in relation to MDAAC? What sort of
40 information are you presented with about the appointment of
41 senior practitioners throughout the district?
42
43 MR KOLBE: I'm sorry, I cannot answer that.
44
45 DR WATERHOUSE: Do you recall the content of some of those
46 reports, Ms Dixon?
47

1 MS DIXON: It would include information such as the number
2 of appointments that have occurred, the number of staff
3 that have come - I believe the number of staff - yes,
4 sorry, the number of appointments that have been made and
5 any issues with credentialling as a broad statement.
6

7 DR WATERHOUSE: Does it take into account temporary
8 appointments, locum appointments and so on, that are
9 filling workforce gaps?
10

11 MS DIXON: I don't believe it takes locum appointments,
12 no.
13

14 DR WATERHOUSE: So it's only looking at the permanent
15 appointment of --
16

17 MS DIXON: I believe so, but that would be a question that
18 I would need to take on notice.
19

20 DR WATERHOUSE: That's fine. I'll move on.
21

22 I'll ask Mr Kolbe first, but I would like both of you
23 to answer this: how do you satisfy yourself, as a board
24 member, that you're receiving the information you need to
25 fulfil your obligations of good governance?
26

27 MR KOLBE: Firstly, I would say that the reports we
28 receive from the executive are comprehensive, detailed and
29 professional, and that provides some level of confidence
30 about what's being received. The board exercises their
31 curiosity in regard to things that appear in those reports,
32 questioning information that might be contained in the
33 reports or asking for further information during the
34 discussion.
35

36 My view is that the executive is forthcoming with
37 further information, is well prepared to go seeking further
38 information and bring that back to the board if necessary.
39 So personally, I would say that that interaction that
40 occurs in the board gives me confidence that we are being
41 presented with accurate and - accurate information.
42

43 DR WATERHOUSE: Ms Dixon, do you want me to repeat the
44 question?
45

46 MS DIXON: No, that's fine. I think we also receive
47 information from a variety of sources, so whilst it may

1 come from the executive, we're being presented with
2 information from consumers in terms of consumer feedback,
3 patient stories, complaints, compliments, information from
4 our local health advisory committees, information from our
5 "People Matter" surveys, which tell us about what our staff
6 are thinking, information from things like district
7 clinical council. So we are getting a range of
8 information.

9
10 DR WATERHOUSE: You mentioned there the "People Matter"
11 surveys, can you explain a little further what those
12 involve?

13
14 MS DIXON: The "People Matter" surveys are undertaken,
15 I believe, at a state level, and they are a survey that our
16 staff have the option to participate in and it will look at
17 things such as staff culture, staff engagement.

18
19 DR WATERHOUSE: What is the sort of response rate in the
20 local health district in relation to those surveys?

21
22 MS DIXON: I think it sits in the 50 to 60 per cent range.

23
24 DR WATERHOUSE: Now, are there opportunities for you as
25 board members to engage with members of the community
26 whilst you're doing the role of the board?

27
28 MS DIXON: There are. So we, every second month, hold our
29 meetings out in one of our sites where possible, so we go
30 out and we visit one of our sites, we talk to - if it's at
31 an MPS, we'll talk to the residents, we'll talk to the
32 staff on the ward, we'll talk to people within the
33 facility. We also engage with our local health advisory
34 committees and twice a year there is a forum where all of
35 the 33 LHACs from across the district come together and can
36 engage with the CE and with the board representatives.

37
38 DR WATERHOUSE: Mr Kolbe, do you want to add anything?

39
40 MR KOLBE: I'm not sure that Liz mentioned the visits by
41 the chief executive officer to sites as well. Normally she
42 is accompanied by the board chair. I've also been on those
43 visits and that provides then an opportunity to meet with
44 the local council, LHAC membership and so on, at the same
45 time.

46
47 DR WATERHOUSE: What has been your experience on some of

1 those visits that you've done?

2

3 MR KOLBE: The experience is very good to hear the
4 perspective from the community. There is no doubt that
5 many members of the LHAC are passionate about their own
6 communities; they are strong advocates for their community;
7 and it is important that we listen to and communicate with
8 community members to gain their perspective, to understand
9 how things are from their perspective and also to then
10 bring back to the board. That's right.

11

12 DR WATERHOUSE: Do you meet with some of the clinical and
13 non-clinical staff during those visits?

14

15 MR KOLBE: Yes, during those visits we do meet with staff.
16 It's generally an informal sort of discussion. It's the
17 first time that they are meeting someone from the board
18 quite often, if it's a new person, for example, and so it's
19 good to get to know staff members.

20

21 DR WATERHOUSE: Ms Dixon, did you want to comment on your
22 experience in that regard?

23

24 MS DIXON: Just to add that if we are at a site visit for
25 the board, that the site manager will have - and the
26 cluster manager will have the opportunity to come and speak
27 to the board and identify areas where they feel that
28 they're going very well and areas where they're having some
29 challenges.

30

31 DR WATERHOUSE: And what would happen on one of those
32 visits if somebody, either a community or a staff member,
33 raised a concern with you as a board member?

34

35 MS DIXON: We would discuss it.

36

37 DR WATERHOUSE: I beg your pardon, sorry?

38

39 MS DIXON: We would discuss that.

40

41 DR WATERHOUSE: Discuss it?

42

43 MS DIXON: Yeah.

44

45 DR WATERHOUSE: And what sort of follow-up action might be
46 taken?

47

1 MS DIXON: It really depends on what the issue is. If
2 it's something that sits at a board level and is at
3 a strategic or an op level, then we will discuss it more
4 extensively. If it's operational, then obviously we will
5 be passing those concerns on and asking for follow-up by
6 the executive.

7
8 DR WATERHOUSE: Can you think of an example of when that
9 might have happened?

10
11 MS DIXON: Not off the top of my head.

12
13 DR WATERHOUSE: What about you, Mr Kolbe?

14
15 MR KOLBE: At one site that I visited, there was concern
16 about not having a general practitioner in the community
17 and I was uncertain about - at that time - about the role
18 of the health service in trying to advocate for a general
19 practitioner, and so we discussed that. I brought that
20 information back to the executive and they were able then
21 to communicate with the LHAC and pass on the - pass on that
22 information.

23
24 DR WATERHOUSE: What was the outcome? Did you come to
25 hear about that?

26
27 MR KOLBE: The discussion was about how they might provide
28 VMO services to that community, and that's still ongoing.
29 It's a challenging issue.

30
31 DR WATERHOUSE: Do you have much contact, as board
32 members, with local councils where there isn't, maybe,
33 a significant health facility in the area, there may not be
34 an LHAC, et cetera?

35
36 MS DIXON: So all of our councils would have a significant
37 number of facilities within them. Not all of our
38 communities would have an LHAC. We have over 500
39 communities within Murrumbidgee.

40
41 DR WATERHOUSE: So what happens if there is no LHAC? Do
42 you liaise directly with the council in those
43 circumstances?

44
45 MS DIXON: There would be LHACs in every council area.

46
47 DR WATERHOUSE: Ms Dixon, I might move on to your

1 subcommittee if I may, now, but feel free, Mr Kolbe, if you
2 have particular comments, to add those in. So you have
3 mentioned that you are the chair of the health care quality
4 subcommittee - that's correct?

5
6 MS DIXON: Yes.

7
8 DR WATERHOUSE: How would you define the role of that
9 subcommittee?

10
11 MS DIXON: We're there to ensure that there's high
12 clinical care and optimal consumer experience.

13
14 DR WATERHOUSE: Before we continue, I'm just wondering if
15 we might actually move the witnesses? I'm now finding it
16 very difficult to see them.

17
18 THE COMMISSIONER: All right. Okay. I was going to leave
19 them there, but if it's affecting you as well, we will -
20 sorry about this. The sun moves at different angles and
21 you were going to get sunburnt if you started there.

22
23 DR WATERHOUSE: I just want to go back to one thing that
24 I was asking you about before, which I apologise, I didn't
25 ask very clearly.

26
27 With 500 communities in the district, although there
28 are facilities in every local council area, there are not
29 facilities in every one of those 500 towns or areas. If
30 the local health advisory committees are populated mainly
31 with people from towns where there is a facility, how do
32 you, as a board, ensure that you are connecting in with
33 those other places that don't have a facility? If I can
34 just start with you, Ms Dixon.

35
36 MS DIXON: It's difficult. It's one of the difficulties
37 of having an incredibly large geographical area and many
38 towns with very small populations, and I talk with the
39 background of someone who has lived in one of those very
40 small populations and I do understand not having facilities
41 very close to you and needing to access health services, as
42 everyone does.

43
44 The LHACs are based in areas where there are - where
45 people access their healthcare system at the moment. So if
46 you need to see a GP or a doctor, you're going to go to one
47 of those communities. I think there is room for

1 improvement in ensuring that our LHACs represent
2 a diversified group of people, not just within the towns
3 but also geographically and - yeah, and that would help to
4 address that problem.
5
6 DR WATERHOUSE: Mr Kolbe, did you want to comment on that?
7
8 MR KOLBE: No, nothing to add, thank you.
9
10 DR WATERHOUSE: What about a formal process of engagement
11 with local government, how does that work? Is there such
12 a process to formally engage with local government in
13 relation to health?
14
15 MR KOLBE: Not with the board, as I understand. So that
16 engagement would happen between the executive - yes.
17
18 DR WATERHOUSE: Are you confident that it does happen with
19 the executive?
20
21 MR KOLBE: I would say I'm very confident. They have
22 procedures to follow in regard to consultation and so on,
23 which involves discussions with local government.
24
25 DR WATERHOUSE: Ms Dixon, did you want to comment on that?
26
27 MS DIXON: Nothing to add.
28
29 DR WATERHOUSE: Is this issue of reaching in to these
30 smaller communities without a facility something that the
31 board monitors on a regular basis?
32
33 MS DIXON: No, we don't. As I said, you're talking about
34 a substantial number of communities of very small
35 populations. We would hope that within our healthcare
36 services, that that population comes to the health service
37 when it requires hospital services, but equally, there are
38 primary care services there, that the population will be
39 accessing as well.
40
41 DR WATERHOUSE: Thank you for that answer. We might go
42 back to the health care quality subcommittee, then. You
43 were starting to explain how you defined the role of the
44 subcommittee. Could I just get you to repeat that from
45 before?
46
47 MS DIXON: We're there to ensure that the district carries

1 out high quality consumer care and optimal consumer
2 experience.
3
4 DR WATERHOUSE: What role does it play relative to the
5 board's obligations in relation to safety and quality?
6
7 MS DIXON: The board has ultimate responsibility for the
8 safety and quality of the district, but the health care
9 safety committee is there to assist it. It can take the
10 time to look specifically at those issues for its entirety.
11
12 DR WATERHOUSE: How often does the subcommittee meet?
13
14 MS DIXON: Every two months.
15
16 DR WATERHOUSE: What's the sort of membership of the
17 committee?
18
19 MS DIXON: So board representatives; the chief executive;
20 many of the leadership team, including the director of
21 clinical governance; and some consumer representatives.
22
23 DR WATERHOUSE: And is there some sort of program of work
24 that the subcommittee works through each year or on
25 a cyclical basis?
26
27 MS DIXON: There is. So we have a schedule of reports.
28
29 DR WATERHOUSE: What sorts of reports do they include?
30
31 MS DIXON: They include things such as our accreditation
32 against national standards; our patient safety and quality
33 metrics, which come to every meeting that we have; site
34 visits; service analysis --
35
36 DR WATERHOUSE: That's okay, you don't have to remember
37 all of them off by heart. If I can maybe ask you, firstly,
38 in terms of the things you've just raised about
39 accreditation, so what does that involve, accreditation
40 against the national standards?
41
42 MS DIXON: Yes, so the national safety and quality
43 healthcare standards are the standards that all hospitals
44 must meet, must be accredited against, and that occurs
45 across our district. Obviously we have many sites, so it
46 occurs in a staged process.
47

1 DR WATERHOUSE: Does it include the MPSs, the
2 multi-purpose services?
3
4 MS DIXON: Yes, it does.
5
6 DR WATERHOUSE: Do they have particular accreditation
7 requirements because of their aged care residents?
8
9 MS DIXON: Yes, we do. So we're subject to the national
10 standard accreditation. We're also subject to aged care
11 and to NDIS.
12
13 DR WATERHOUSE: How does the district find the process of
14 accreditation? Does it work smoothly? Are there
15 challenges?
16
17 MS DIXON: I think it works smoothly. It is a lot for
18 a small facility to have accreditors come on to their site,
19 often in an unannounced fashion, and it can put a lot of
20 pressure on the facility. That's part of the process.
21
22 DR WATERHOUSE: Is the intention that people are
23 maintaining quality on a regular basis rather than just
24 getting ready for an accreditation visit?
25
26 MS DIXON: That's right, and that is the intent and the
27 shift that it is moving towards, that this is a process of
28 continual improvement rather than a once every few years.
29
30 DR WATERHOUSE: Mr Kolbe, did you want to make any comment
31 about that?
32
33 MR KOLBE: No, thank you.
34
35 DR WATERHOUSE: I might move on to some of the other
36 reports that you have. There's a quality and safety
37 account that is - is that prepared by your subcommittee?
38
39 MS DIXON: It's prepared by our director of clinical
40 governance.
41
42 DR WATERHOUSE: Is it endorsed by your subcommittee or the
43 board?
44
45 MS DIXON: Yes, it is.
46
47 DR WATERHOUSE: What does that contain?

1
2 MS DIXON: It contains information about how we ensure
3 quality and safety across the district. So it will include
4 things such as governance and leadership, so how we
5 actually set up the centre and the system; what sort of
6 metrics we look at, how we actually measure that we're
7 performing against it; how we ensure that we have the right
8 policies, the right procedures in place, that we are doing
9 the right audits for quality audits against the things that
10 we're looking at; it will highlight areas of excellence
11 that we can learn from. So areas of innovation or where
12 we've delivered a particularly great service, and that's
13 part of our evolving - part of safety and quality is not
14 just looking at what went wrong but also looking at where
15 we're going right.

16
17 DR WATERHOUSE: Is the safety and quality account an
18 annual document or --

19
20 MS DIXON: Yes.

21
22 DR WATERHOUSE: And is it a requirement that you provide
23 this to anyone - any body? Is it a requirement that this
24 has to be done by the district?

25
26 MS DIXON: I believe it is a requirement but it is
27 something that we are committed to doing and we publish it.
28 It is accessible by the public.

29
30 DR WATERHOUSE: Where does it go in terms of where is it
31 sent to?

32
33 MS DIXON: For the public or --

34
35 DR WATERHOUSE: In terms of it being a requirement, does
36 it need to be sent to the ministry or the Clinical
37 Excellence Commission or --

38
39 MS DIXON: I would have to take that on notice.

40
41 DR WATERHOUSE: There was a Patient Safety First Quality
42 Health Care Framework done for the period 2017 to 2021.
43 Now, I realise this was before your time. What is the
44 status of that document, do you know?

45
46 MS DIXON: So that was refreshed. We have a quality -
47 sorry, I've got to get the right word, a clinical

1 governance framework and that is now - that was published
2 in 2023 and goes until 2027.

3
4 DR WATERHOUSE: So was that an initiative of the
5 subcommittee that you chair?
6

7 MS DIXON: It's something that was occurring but it's
8 certainly something that we look at and we endorsed it.
9 Actually, sorry, the board endorsed that.

10
11 DR WATERHOUSE: What does that contain relative to the
12 safety and quality account?
13

14 MS DIXON: So it would set - it would look at more of
15 a longer-term process of over about four years, the things
16 that - processes and systems that we have in place to
17 ensure high quality clinical care and consumer engagement,
18 but also the things that we would want to achieve over that
19 period.
20

21 DR WATERHOUSE: What types of information and data does
22 the subcommittee review?
23

24 MS DIXON: So we review a lot of clinical indicators. We
25 review things through from consumer feedback, so
26 compliments and complaints, patient stories; we review
27 metrics such as our KPIs against our service level
28 agreement that would include things such as hospital
29 acquired complications, incidents where things went wrong.
30 We also look at our clinical risk reports.
31

32 DR WATERHOUSE: If I can take you through some of these,
33 you said you hear patient stories. Can you give an example
34 of the sort of thing that you would hear as a subcommittee?
35

36 MS DIXON: So at every meeting we will have a patient
37 story given, and that will be written by a patient in their
38 own words about their experience of a health care - within
39 our healthcare system. It won't be a one-off event that
40 occurred; it may be how they have felt the health care -
41 sorry, it will be - it could be over several months or
42 several years of how they have experienced the health
43 system.
44

45 DR WATERHOUSE: Presumably, it could contain positives
46 and/or negatives; is that right?
47

1 MS DIXON: They do.
2
3 DR WATERHOUSE: Where there are criticisms, what is done
4 with that information by your committee?
5
6 MS DIXON: So it's one patient story that will be pulled
7 out of many patient stories. All of the information that
8 sits behind that is the sort of information that we're
9 looking at all the time, which may be complaints,
10 compliments, incidents that we are already looking at.
11
12 DR WATERHOUSE: So you are looking at clinical incidents
13 as part of this. What about serious adverse events?
14
15 MS DIXON: Yes, we look at them.
16
17 DR WATERHOUSE: How are they defined?
18
19 MS DIXON: So a serious adverse event is where something
20 goes wrong within the healthcare system, so a Harm 1,
21 Harm 2, and we will look at those at every meeting and also
22 then at an annual point, to look at where are the recurring
23 themes.
24
25 DR WATERHOUSE: Can you give us an example of what might
26 be a Harm 1, Harm 2 adverse event?
27
28 MS DIXON: A Harm 1 might be where something has gone
29 wrong within our healthcare system which has resulted in
30 serious injury or death to a patient.
31
32 DR WATERHOUSE: So those are investigated and does the
33 investigation report come to your committee?
34
35 MS DIXON: So our committee - they are absolutely
36 investigated, so there is a very vigorous process that the
37 clinical governance team go through with - on their own and
38 also at ministry level.
39
40 The reports themselves for each individual case don't
41 come back to our committee but we will look at what are the
42 themes coming out of them? Are there system problems
43 there? Is it a problem with a particular system, with - is
44 this a clinician problem? Is this something that - how can
45 we influence this? How can we learn from it to ensure that
46 it doesn't occur again?
47

1 DR WATERHOUSE: And what options are there for your
2 subcommittee to take in terms of directing action?
3
4 MS DIXON: The actions are very predefined already on
5 that.
6
7 DR WATERHOUSE: Can you tell me about hospital-acquired
8 complications?
9
10 MS DIXON: So a hospital-acquired complication could be
11 something such as a fall, a hospital-associated infection,
12 a clot - there are many of them.
13
14 DR WATERHOUSE: Are these formally sort of defined as
15 a set that need to be monitored?
16
17 MS DIXON: They are. They're in our service level
18 agreement.
19
20 DR WATERHOUSE: What role does the committee have in
21 monitoring those?
22
23 MS DIXON: We monitor them every month. What we're
24 looking at is what our numbers are, what the New South
25 Wales numbers are, what our specific larger hospital
26 numbers are, and it can be what our peer group is, so that
27 we can monitor how we're tracking against other hospitals.
28
29 DR WATERHOUSE: Are there any funding implications
30 associated with levels of hospital-acquired complications?
31
32 MS DIXON: They are. We receive a funding penalty if we
33 have a hospital-acquired complication.
34
35 DR WATERHOUSE: Did you want to add anything about that?
36
37 MR KOLBE: No, thank you.
38
39 DR WATERHOUSE: So you've mentioned that you hear patient
40 experiences. Do you hear, as a subcommittee, about staff
41 experiences?
42
43 MS DIXON: A lot of the people and culture information
44 comes to the board rather than the health care safety
45 committee.
46
47 DR WATERHOUSE: What about cultural issues that may have

1 an impact on safety?

2

3 MS DIXON: That's a really important point. What we tend
4 to see is - we are looking at data through all of those
5 different lenses that I explained, so consumer compliments
6 and complaints, where we're seeing incidents, and what
7 we're trying to look at is what are the themes here? If we
8 think this particular site or service seems to have some -
9 be having some problems, then let's have a look into what
10 is happening there, and that would include looking at is
11 this a cultural problem?

12

13 DR WATERHOUSE: Who would take the lead with that?

14

15 MS DIXON: The district - we would ask the executive to
16 look at it, the director of clinical governance may, but
17 depending on what the particular incident may be, it may be
18 the executive director of medical services or nursing
19 services.

20

21 DR WATERHOUSE: Are there examples of instances where that
22 has happened and there have been changes made as a result?

23

24 MS DIXON: I can't recall one specifically relating to
25 culture, but I can certainly recall them relating to trends
26 that we were seeing in data for hospital-acquired
27 complications.

28

29 DR WATERHOUSE: Would you like to give an example?

30

31 MS DIXON: A few years ago we were noticing that there
32 were some trends in endocrine complications, which is one
33 of the HACs that we - hospital-acquired complications that
34 we monitor.

35

36 When we saw that that trend was not shifting, we asked
37 the executive to do a deeper dive into it and to report
38 back on what they felt - what they felt the problems were.
39 They came back, reported what they thought the problem was
40 and also what their action plan was. We continued to
41 monitor that until we saw that the levels came back to
42 below - not just the state average but below our peer group
43 average, and we still monitor those data points now.

44

45 DR WATERHOUSE: Yesterday we heard from one of the cluster
46 managers, Mr Marchioni, who was explaining about nursing
47 staff being involved in an upcoming "April Falls" month,

1 which is going to be focusing on prevention of falls. Are
2 these sorts of details of local initiatives at that
3 coalface level matters that come to your committee?
4

5 MS DIXON: We will often have a section that highlights
6 initiatives that are going on throughout the district.
7 Falls is something that we as a committee are actively
8 watching, it's one of our HACs, it's one of our largest
9 HACs.

10
11 DR WATERHOUSE: What about quality audits? Do you see the
12 results of audits that are done at the different sites?
13

14 MS DIXON: We don't see the results of the specific audits
15 but what we're looking at is to see where are we not
16 meeting our audit obligations.
17

18 DR WATERHOUSE: Do you set the sort of content of audits
19 that need to be done, effectively guiding them?
20

21 MS DIXON: No. Our director of clinical governance would
22 do that and she would do that in conjunction with the
23 Clinical Excellence Commission as well, I believe.
24

25 DR WATERHOUSE: What about consumer feedback in the form
26 of PREMs data, the experience data that we've heard about?
27 Do you see that?
28

29 MS DIXON: We would see excerpts from it. It's in its
30 early days but it is certainly something that we are as
31 a board and as an - at that senior level, that we are
32 committed to looking at and ensuring that we are not only
33 monitoring it but changing our models of practice to ensure
34 that the patient experience measures are high.
35

36 DR WATERHOUSE: What actions can the subcommittee take or
37 recommend in response to information that you review where
38 there does seem to be a trend that's occurring that's of
39 concern to you?
40

41 MS DIXON: The endocrine example is one of those where we
42 would ask that some more work be done and that it become -
43 that it comes back to the committee for us to review until
44 we are happy that it is back within normal parameters. We
45 still continue to monitor things like those HACs every
46 meeting.
47

1 DR WATERHOUSE: In your outline you said that when there
2 is a quality and safety issue, usually the executive has
3 already identified it and has either started remedial
4 action, or corrective action, rather, or is making some
5 recommendations for endorsement. Is that correct?
6

7 MS DIXON: Yes.
8

9 DR WATERHOUSE: Is there scope for your subcommittee to
10 make its own assessment and make different recommendations
11 to the management?
12

13 MS DIXON: So within that process, we would have
14 a discussion about whether we felt that was the appropriate
15 thing to occur, and then we would ask the executive to do
16 X, Y or Z, based on what the discussion of the committee
17 would be. So if we felt that the recommendation wasn't
18 meeting - or what was proposed wasn't enough, then we would
19 ask for further to be occurring.
20

21 DR WATERHOUSE: Does that sometimes happen?
22

23 MS DIXON: Well, I can give the example again of the
24 endocrine complication, where it did. We had seen that
25 data-point for quite a long time, actually, not shift, and
26 that there were initiatives that were occurring, there was
27 a lot of education that was occurring within that
28 particular site, but we weren't seeing it shift, and that
29 was when the committee said, "We would like this to have
30 a deeper dive, a deeper look into this, because we're not
31 happy with where it was."
32

33 DR WATERHOUSE: Is there any interaction between your
34 subcommittee and the Clinical Excellence Commission?
35

36 MS DIXON: There is. So, I as the chair of the
37 subcommittee, attend a meeting once a quarter with the
38 Clinical Excellence Commission and with the other chairs of
39 the clinical committees across the district - across the
40 state, sorry.
41

42 DR WATERHOUSE: I'm going to move on to Mr Kolbe's
43 committee in a moment but I just wanted to know, is there
44 anything else you wanted to highlight in relation to the
45 work of your committee?
46

47 MS DIXON: No.

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DR WATERHOUSE: So, Mr Kolbe, am I right in thinking that the planning, resources and performance subcommittee is, in effect, the finance and performance committee that the by-laws require the board to establish?

MR KOLBE: That's correct.

DR WATERHOUSE: So what is the intent of adding responsibility for planning to this committee?

MR KOLBE: It simply provides a forum where planning processes can be discussed. That certainly precedes me as the - for the reason that planning was included there.

DR WATERHOUSE: You may also not be familiar with the reason for this, but I'm wondering, with the change in terminology from "finance" to "resources", does that mean that the subcommittee is expected to look at a broader range of resources than just financial ones?

MR KOLBE: Well, certainly it considers workforce on that committee as well, so yes, it would be broader than finance.

DR WATERHOUSE: When you say "workforce", are you talking purely in terms of numbers, or do you mean the performance of the workforce?

MR KOLBE: The focus is really on numbers.

DR WATERHOUSE: Is performance of the workforce something that your committee does review at all?

MR KOLBE: No, that is something that comes to the board rather than to the PRP.

DR WATERHOUSE: How would you define the role of the PRP subcommittee?

MR KOLBE: The PRP subcommittee has a role in reviewing and monitoring performance across a range of different areas. So those might include activity; it might include the efficiency improvement projects; the reports that come from the director of operations or the director of integrated care and allied health. There is a schedule of reports that might include ICT --

1
2 DR WATERHOUSE: I might just pause you there because
3 I want to go through a couple of those. So when you say
4 "activity", what do you mean by that?
5
6 MR KOLBE: "Activity" refers to inpatient statistics,
7 non-admitted occasions of service, for example, and also -
8 I was going to say something and I've forgotten it now, I'm
9 sorry.
10
11 DR WATERHOUSE: That's okay. What about the efficiency
12 and improvement aspect? What do you look at for that?
13
14 MR KOLBE: So there is a small team of people within the
15 district who identify and develop efficiency improvement
16 projects. That is a very important initiative and sees
17 savings coming from those projects, and the PRP takes
18 a keen interest in what those EIPs are doing. That has, to
19 my mind, been quite a successful process.
20
21 DR WATERHOUSE: Can you give some examples of the
22 efficiency improvement projects that have been successful?
23
24 MR KOLBE: I'm not sure that I can think of any off the
25 top of my head. I don't know if Liz can remember an EIP
26 that we could use as an example.
27
28 DR WATERHOUSE: Are these initiatives that come from sort
29 of facilities and are filtered back up to the district or
30 do they tend to start at the district level and be rolled
31 out across facilities?
32
33 MR KOLBE: No, these are very much localised initiatives.
34 The manager of the unit is in consultation with managers at
35 sites and so on and is active in trying to identify those
36 projects and supports the work of the local site in
37 developing those projects and seeing them through.
38
39 DR WATERHOUSE: Are there particular sort of projects that
40 have come out of the pandemic?
41
42 MR KOLBE: I can't think of anything that has come out of
43 the pandemic, as such. No. I'm sorry.
44
45 DR WATERHOUSE: That's okay. You then mentioned about
46 reports from the director of operations and the director of
47 integrated care. Can you elaborate on those?

1
2 MR KOLBE: Well, the director of operations would cover
3 issues in their portfolio. Again, that might involve some
4 discussion about what's happening with - what's happening
5 in certain facilities and so on. Integrated care and
6 allied health would talk about issues like the
7 implementation of the voluntary assisted dying process
8 which is under way; various other initiatives around
9 hepatitis C, for example, and so on.

10
11 DR WATERHOUSE: And what would be the PRP subcommittee's
12 role in reviewing that information?

13
14 MR KOLBE: Again, those reports are often for noting, but
15 there is a curiosity from the members of the committee in
16 regard to the information and so there is a process of
17 questioning and discussion around the information contained
18 in those reports.

19
20 DR WATERHOUSE: Presumably, some of those reports also go
21 to the board; is that correct?

22
23 MR KOLBE: That is correct.

24
25 DR WATERHOUSE: So how does the PRP subcommittee's role
26 differ from that of the board in relation to the
27 information received?

28
29 MR KOLBE: In a way, similar to the health care quality
30 committee, the PRP's role there is to take a deeper and
31 more detailed look at that information and then to provide
32 some advice back to the board. The board may also see that
33 information and the advice from the PRP may generate then
34 further discussion at a board level.

35
36 DR WATERHOUSE: You mentioned IT as one of the things that
37 you look at. Can you give me an outline of what that
38 involves?

39
40 MR KOLBE: Specifically at the moment, the concern there
41 is around cybersecurity, and so again, we have a schedule
42 of reports about that and there is a level of concern at
43 a board level about cybersecurity and so we have identified
44 that as something which requires close monitoring.

45
46 DR WATERHOUSE: Is that something that is being sort of
47 sent down from a state level for you to look at or is that

1 something you've identified as being a particular issue for
2 this district?

3

4 MR KOLBE: I believe it's an issue everywhere. I don't
5 believe there has been any direction from the ministry, but
6 the director of IT would have their own network across the
7 state of people who are all concerned about cybersecurity.

8

9 DR WATERHOUSE: What sort of planning do you get involved
10 with in terms of facilities and services they provide, as
11 a subcommittee, I mean?

12

13 MR KOLBE: Yes, at a subcommittee level, not really. That
14 is something that happens at a board level, and there is
15 a process in place in regard to the development of the
16 clinical services plan, and so the board's role is to
17 monitor that process.

18

19 DR WATERHOUSE: So what aspects of planning are you
20 involved with at the subcommittee level?

21

22 MR KOLBE: There are capital works type plans, which come
23 to us, again, for our information and discussion.

24

25 DR WATERHOUSE: What about from a population health point
26 of view, is there any planning that occurs in that regard?

27

28 MR KOLBE: I haven't been aware of any information about
29 population health as such. The integrated care and allied
30 health has - does have some population health-related
31 initiatives. I mentioned the hepatitis C project earlier,
32 for example.

33

34 DR WATERHOUSE: In terms of resource data and performance
35 data, what types of information do you receive, as
36 a subcommittee, compared to the board?

37

38 MR KOLBE: Yes. The finance report is a detailed report
39 of the current financial situation in terms of expenditure
40 and revenue. It also has information in there about
41 activity and FTE and workforce numbers, for example.

42

43 I'm sorry, what was the rest of the question?

44

45 DR WATERHOUSE: It was about the nature of the data that
46 you receive relative to the board data.

47

1 MR KOLBE: Yes, yeah. So that is detailed information
2 showing inpatient statistics, ED presentations, out of
3 hospital occasions of service, and so on, yes.
4
5 DR WATERHOUSE: So would it be fair to say that it is
6 similar data to what the board sees but at a more granular
7 level?
8
9 MR KOLBE: That is correct.
10
11 DR WATERHOUSE: Do you monitor as a subcommittee against
12 the KPIs in the service agreement?
13
14 MR KOLBE: Yes, that's true, that the PRP is involved in
15 monitoring those KPIs. There are some shortcomings with
16 the KPIs and sometimes there is a delay in being able to
17 acquire the data to monitor those KPIs.
18
19 DR WATERHOUSE: Can you give me an example of the
20 shortcomings?
21
22 MR KOLBE: Well, the delay and the difficulty in accessing
23 some of that information I think is the main concern about
24 that, those KPIs.
25
26 DR WATERHOUSE: Is that specific to your district or is
27 that a statewide problem to your knowledge?
28
29 MR KOLBE: I would suggest that's a statewide issue, yes.
30
31 DR WATERHOUSE: And are you able to give any specific
32 examples of the types of data that are delayed?
33
34 MR KOLBE: I cannot, I'm sorry, think of a specific
35 example at the moment.
36
37 DR WATERHOUSE: That's okay. How often does the
38 subcommittee meet?
39
40 MR KOLBE: That meets every two months.
41
42 DR WATERHOUSE: And who are the members?
43
44 MR KOLBE: The members are board members, a minimum of
45 three board members attend. That includes, at this stage,
46 the board chairperson and also the board representative on
47 the audit and risk committee, and in addition, members of

1 the executive.

2

3 DR WATERHOUSE: Do you want to make any comment about any
4 aspect of what we've been talking about with the PRP?

5

6 MS DIXON: I can give an example of the planning that you
7 are discussing. So one of the things that the health needs
8 analysis data that we obtain through the PHN was that
9 across our district, we knew that renal services were going
10 to be needed, that our need for dialysis was becoming more
11 and more, and so that goes into the planning which feeds
12 into, as a strategic plan as a district, how do we want to
13 provide these services and how are we going to meet the
14 needs of the community over the next period of time? So
15 that's an example for you.

16

17 DR WATERHOUSE: Thank you.

18

19 What actions does your subcommittee take, Mr Kolbe, if
20 you feel that the data is not showing the KPIs where they
21 should be, so there are concerns about trends or
22 deterioration, for example?

23

24 MR KOLBE: Well, we would discuss that during the meeting,
25 but if that is unable to be resolved, we would ask the
26 executive then to look at that further and bring back
27 information to the committee.

28

29 DR WATERHOUSE: You mentioned in your outline that usually
30 the district executive has already identified issues and
31 has suggested some corrective actions, similar to what we
32 were talking about with the quality and safety committee.

33

34 MR KOLBE: Yes.

35

36 DR WATERHOUSE: Does your subcommittee still have an
37 independent role to play in coming up with recommendations
38 based on its own assessment of the information?

39

40 MR KOLBE: Our recommendation would then be reported to
41 the board. So the PRP meets before the board meeting, so
42 there is an opportunity in the board meeting to provide
43 a verbal report about the PRP and also to raise concerns,
44 any concerns that might then need to be taken up by the
45 board.

46

47 DR WATERHOUSE: So is it a case of highlighting particular

1 KPIs where the trend is adverse, that sort of thing?

2

3 MR KOLBE: That may be the case, or it may be around
4 issues such as FTE levels. If the PRP gets into
5 a discussion about agency staff, for example, and the
6 impact of that on FTE, that might also be something to be
7 brought back to the board for further discussion.

8

9 DR WATERHOUSE: Ms Dixon, in your outline, you referred to
10 ageing of the population, the burden and complexity of
11 chronic diseases and workforce shortages as combining to
12 make it difficult to provide equitable access to treatment
13 in the district. Do you recall that?

14

15 MS DIXON: Yes.

16

17 DR WATERHOUSE: What do you believe could be done
18 differently to reduce inequity in the district?

19

20 MS DIXON: I think we are starting to see the evolution of
21 the next cycle of how we deliver health care and how we
22 start to really focus on what the patient need is. You
23 will have heard a lot of information about that this week
24 with things like collaborative commissioning, where we
25 actually look at how can we deliver the care that the
26 patient needs, when they need it, and where they need it?

27

28 An excellent example, I think that was given this
29 week, was our specialist outpatient clinics, which we
30 didn't have a few years ago, that we are now seeing out in
31 some of our more remote western sites. Increasing things
32 like specialist outpatient clinics across our districts,
33 not just within our larger sites but having those spread
34 right across the district, would increase the equity of the
35 access. That's just one step of many.

36

37 THE COMMISSIONER: Does that mean - and tell me if this is
38 your opinion - that we should be more looking at what are
39 the health needs of our population, what are the healthcare
40 services and initiatives that would promote best health
41 outcomes for that population, including early intervention
42 in disease or managing chronic disease to hopefully keep
43 people out of acute settings and to prevent disease, and
44 having worked out what that health system should look like,
45 then you design the funding that best adapts to or
46 incentivises that sort of health system?

47

1 MS DIXON: Couldn't have put it better myself.

2

3 THE COMMISSIONER: I'm sure you could have, but close
4 enough. Thank you.

5

6 Sorry, Mr Kolbe, do you want to add anything to that?

7

8 MR KOLBE: No, I don't. I agree entirely, thank you.

9

10 THE COMMISSIONER: Okay, thank you.

11

12

13 We have to take lunch at 12 today; is that right?

14

15 MR MUSTON: Yes.

16

17 THE COMMISSIONER: I was told - well, someone sent me
18 a message secretly. Not so secret now. We might just,
19 rather than going through for a full two hours, though,
20 I think we might give everyone a break until 11.30 now; is
21 that all right?

22

23 DR WATERHOUSE: Well, I'm about to finish. I've only got
24 two more questions, if that helps.

25

26 THE COMMISSIONER: You've only got two more questions for
27 the witnesses? Why don't we finish then? Yes, that makes
28 sense.

29

30 DR WATERHOUSE: Just one sort of follow-up question,
31 Ms Dixon. You gave the example of specialist outreach.
32 Were there any sort of primary health care examples that
33 you are able to give about how you're putting the patient
34 at the centre?

35

36 MS DIXON: So traditionally, the local health district
37 isn't engaged in primary health activities. That has been
38 the domain of GP clinics and the primary health network and
39 the federal system. I think what we're saying now, though,
40 is that if we are not really addressing some of those
41 conditions in the primary health arena, we don't see the
42 person and we don't know they exist until they present to
43 our hospitals in a very unwell, sick state. So in order to
44 help us manage our resources better, we need to have an
45 integrated and non-siloed model of care so that we can help
46 stop those people becoming so sick in the first place. So
47 that includes things like early access to diagnostics, such

1 as the congestive heart failure clinics that Emma spoke of.
2
3 DR WATERHOUSE: Mr Kolbe, I know you gave some details
4 about a similar question earlier to the Commissioner. Is
5 there anything you wanted to add at this stage given your
6 population health background?
7
8 MR KOLBE: No, I don't think so, thank you.
9
10 DR WATERHOUSE: Just one last question --
11
12 THE COMMISSIONER: Can I just - "Emma", is Emma Field?
13
14 MS DIXON: Yes.
15
16 THE COMMISSIONER: It's fine to call her "Emma"; it's just
17 that if someone did a transcript search, they might use
18 "Field" and we wouldn't pick that up.
19
20 MS DIXON: Our director of integrated care and allied
21 health.
22
23 THE COMMISSIONER: Yes.
24
25 DR WATERHOUSE: Just one final question. Is there any
26 change you would like to see at the state level that would
27 enhance the way the district can deliver services to the
28 community?
29
30 MR KOLBE: Well, I think if we are going to move to new
31 models of care, then this is not something that is going to
32 happen easily, it's going to be a complex process, so some
33 work to be done on how that is to be achieved, what is are
34 the - what's the pipeline of shifting that model of service
35 and what are the resources and what are the workforce
36 needs? There's a lot of working-up of that to be done,
37 I think I would say.
38
39 DR WATERHOUSE: Ms Dixon?
40
41 MS DIXON: I think that looking at how we deliver value
42 based care is going to be part of that, how we incentivise
43 and fund better outcomes for patients as opposed to
44 a traditional model which has been more about volume of
45 patients.
46
47 DR WATERHOUSE: Commissioner, I have no further questions.

1
2 THE COMMISSIONER: Thank you. Can I just ask you both -
3 and I think your experience prior to being on the board and
4 your experience now on the board does enable you to express
5 a view on this, but if I were to ask both of you, if money
6 is not an issue - value always will be, but if money, cost,
7 isn't an issue - other than what the LHD is doing now, are
8 there any specific initiatives you would like to see money
9 put into or taken up that you think would help health
10 outcomes in your area? It might be just more for what you
11 are doing now, more funding for what you are doing now, or
12 it might be something new. Do you have a view about what
13 that could be?

14
15 MS DIXON: My personal opinion is that in order to achieve
16 equity of outcomes across our population, we need to be
17 able to measure it and we need to be able to understand
18 what sort of outcomes our patients in this district have
19 compared to a across the state.

20
21 THE COMMISSIONER: So data is important?

22
23 MS DIXON: We need data, data about patient outcomes, so
24 that we know whether --

25
26 THE COMMISSIONER: You are scrambling in the dark,
27 otherwise.

28
29 MS DIXON: We have pockets of it. So we have pockets of
30 data that we can readily access, such as cancer rates,
31 stroke, heart attack rates and outcomes, but it's pockets.
32 It's not a comprehensive look at: do our patients receive
33 the right care, which is difficult to define, in the right
34 place, at the right time.

35
36 THE COMMISSIONER: Thank you. Mr Kolbe, is there anything
37 you would add to that?

38
39 MR KOLBE: I think Liz has made a very important point
40 there. The disease prevention workforce is relatively
41 small. Further investment in that workforce would be
42 important, as long as we are using that to fund evidence
43 based disease prevention activities, and some of that
44 money, some of those funds, could also be used in the
45 support of partnerships between agencies, to support
46 healthy environments in communities.

47

1 THE COMMISSIONER: All right. Thank you. Look, sometimes
2 giving evidence, with questions like that, you have no
3 doubt thought about these things but then you are put on
4 the spot. In relation to what I just asked, if anything
5 occurs to you after you have left the witness box, don't
6 kick yourselves, just contact us and let us know, "Look,
7 there's something else I have thought of as well that
8 I think I would like to pass on."
9

10 Otherwise, I will just check whether Mr Chiu has any
11 questions for you?
12

13 MR CHIU: No questions, thank you, Commissioner.
14

15 THE COMMISSIONER: Thank you both very much for your time,
16 we are very grateful for you coming in and giving evidence.
17 Thank you, you are excused.
18

19 **<THE WITNESSES WITHDREW**
20

21 THE COMMISSIONER: Does that mean we are free now until 1,
22 does it?
23

24 MR MUSTON: Yes.
25

26 THE COMMISSIONER: Okay, I will adjourn until 1 o'clock.
27

28 **LUNCHEON ADJOURNMENT**
29

30 THE COMMISSIONER: Good afternoon.
31

32 Mr Muston?
33

34 MR MUSTON: I call Dr Alam Yoosuff.
35

36 THE COMMISSIONER: Come forward, sir.
37

38 **<ALAM YOOSUFF, affirmed:** [1.01pm]
39

40 THE COMMISSIONER: Mr Muston will ask you some questions
41 and then perhaps Mr Chiu as well.
42

43 **<EXAMINATION BY MR MUSTON:**
44

45 MR MUSTON: Q. Dr Yoosuff, you are a board member of the
46 Murrumbidgee LHD?
47

A. Yes.

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Q. You are also a board director of the Murrumbidgee LHD?

A. Murrumbidgee Primary Health Network.

Q. I'm sorry.

A. Yes.

Q. Within the LHD, you are a member of the health care quality and safety committee?

A. Correct.

Q. Could you just explain to us from your perspective what you see as the key responsibilities of that committee?

A. Maintaining standards and quality and safety to provide better care and access for our people in the region, and the main focus of the committee is to keep an eye on the checks and balances, if things are heading on the right direction.

Q. What information do you gather as a subcommittee to enable you to maintain those checks and balances?

A. We would get a range of information including data, say, for example, complaints, serious adverse events, medicolegal contexts, quality assurance related data, meaning are we keeping up with national standards requirements, are we keeping up with accreditation?

We might get patient and staff related quality data, for example, "People Matters" survey, things like that. So there is a range of stuff that we get in different, you know, times of the year, to keep track of how things are happening.

Q. Are there occasions that you can recall where that information which has come to you has led you, as a subcommittee, to conclude that maybe something needs to be looked at or attention needs to be given to a particular area?

A. Yes. Maybe that's the reason for the committee to be there, because looking at complications and red flags are our role as the board. Example, we found there was quite a few things getting noted up before surgery with blood sugar monitoring and diabetic patient complications, which came up on one of our reportings, and then we did enquire more detail about it, and we found a way to manage the situation so that patients' diabetes is managed better prior to surgeries, because of the outcomes that we saw on

1 the reporting.

2

3 Q. So to the extent that you as a subcommittee have
4 identified those issues that you think require some
5 attention, what's the mechanism by which those views
6 ultimately find their way through to the people on the
7 ground who should be --

8 A. We do ask questions from the executives and then we do
9 ask for feedback on how things progress, and then sometimes
10 we might put on the calendar, say in three months or six
11 months and 12 months, a timely manner of reevaluating what
12 the process is. So that's the normal process that we've
13 been keeping track on.

14

15 Q. So in terms of the engagement between you and the
16 executive, is it the case that you, as a subcommittee,
17 identify a problem and come up with a recommended solution,
18 or that you identify the problem, bring that to the
19 attention of the executive and ask the executive to come up
20 with a solution to the problem?

21 A. Correct. Going into solution by us is a bit
22 operational, hence we would stick to the level of asking
23 the right questions and probing the right pathway to get to
24 an answer. So our focus would be to see what would be the
25 feedback or response and outcome of our questioning.

26

27 Q. So is part of that process looking at the data that
28 you've got at a later period to see whether there has been
29 any measurable change in relation to whatever issue or
30 metric it is that was causing you concern?

31 A. That's correct.

32

33 Q. Until January 2024, I think you were also the director
34 of primary care at the MLHD?

35 A. That's correct.

36

37 Q. Could you just explain to us what that role involved?

38 A. That is a very innovative role. I don't think that
39 role is there in any other local health district. It is
40 one of its first kind, where the chief executive and our
41 executive director of medical services created this
42 position, had a recruitment process and I became the
43 successful candidate for it.

44

45 THE COMMISSIONER: Q. When was that?

46 A. Just before COVID - September 2019.

47

1 THE COMMISSIONER: Thank you.

2

3 THE WITNESS: I started the job on 18 September 2019 and
4 I finished on 18 January 2024.

5

6 MR MUSTON: Q. So it was an innovative role which, to
7 your understanding, is unique to this LHD. What were the
8 functions that you had in that role? What was it that you
9 were retained to do?

10 A. My main focus was to connect and communicate and
11 network better with primary care, particularly the GP VMOs
12 in the district. Given our general practitioners who are
13 spread wide across the whole district, it is quite a task
14 to, you know, keep all of them up to date with what's
15 happening with the LHD and the LHD then to have a person
16 to, you know, talk and become the conduit or bridge of
17 getting solutions through LHD.

18

19 So I think it worked well because, in the initial
20 step, we weren't prescriptive about what it is going to be,
21 but we did - our chief executive was quite confident that
22 we will find a way to work better with primary care, and
23 that role was one of the initiatives that she took.

24

25 THE COMMISSIONER: Q. Was that what you were told when
26 the role was created - you've applied for the position.
27 Was that better connection with primary care what you were
28 told was the purpose of management or the chief executive
29 creating the role?

30 A. Yes, correct. There were two main things told while
31 the interview process and the recruitment, but one is that
32 exactly what you said. The second one is that we wanted to
33 get our single employer model, Murrumbidgee model, up and
34 going, and as part of that, we really need a significant
35 primary care focus, and the other one was that.

36

37 THE COMMISSIONER: Thank you.

38

39 MR MUSTON: Q. In that role, did you have any particular
40 projects or objectives that you were required to deliver,
41 other than improving connectivity between primary care and
42 the LHD in a general sense?

43 A. Yes, I had a significant role in getting the
44 Murrumbidgee model, single employment model, up and
45 running, because I had quite a bit of a networking and
46 collaborating approach with the federal government and the
47 Ministry of Health in Sydney and the PHN and local GP

1 practices to get to there, and there's a lot of other minor
2 players - or not minor, major players, a number of players,
3 say, for example, College of General Practitioners, HETI -
4 Health Education and Training Institute - and then ACRRM -
5 Australian College of Rural and Remote Medicine - and there
6 was a number of players that we had to work with to get
7 a project going, so that took a lot of energy and time with
8 that role. And, while doing that, it was always dealing
9 with primary care, so it allowed me to keep doing my other
10 job, too, where connecting and communicating better with
11 primary care.
12

13 Q. So in terms of all of those various moving parts that
14 you needed to bring together in order to get the single
15 employer model going, are you able to indicate, at least in
16 broad terms, what it was that you needed to get from each
17 of them in order to get that project up and running?

18 A. You know, the single employment model is a very new
19 version, of such, where the local health district or state
20 run local health district employs a GP registrar under
21 a salaried version of an employment contract, which is not
22 a thing that Australia did, and for that to happen
23 industrially you need to have AMA and a few other people on
24 board, and all the GP registrars will need to complete
25 their fellowship with the college of rural/remote medicine
26 or Royal Australian College of General Practitioners in a
27 fellowship pathway, so those colleges need to be in line
28 with what we are doing.
29

30 In that time, when we were doing it, the college of -
31 fellowship training was done via regional training
32 organisations, such as, which is known as GP Synergy in
33 New South Wales, they had a big role to play. Negotiating
34 with them was one of the things and then --
35

36 Q. Just pausing there, negotiating with them to make sure
37 there was an arrangement in place to facilitate the
38 training of --

39 A. Correct.
40

41 Q. -- the GPs? So our registrars, when we employ and
42 send them to private general practices, how do we navigate
43 them through the fellowship pathway to complete their
44 fellowship and become specialist ruralist generalists in
45 the long run, they had a significant role to play. They
46 had funding coming from the Commonwealth end to that fact,
47 so we didn't want to, you know, double-dip or, rather,

1 duplicate things in different ways; we wanted to find, you
2 know, an amicable way of working together so that it
3 doesn't cost a huge amount of burden, financially, to the
4 local health district for doing it.

5
6 Q. So that's the training organisation. Which other
7 organisations? You mentioned HETI was one of them?

8 A. Yes. HETI was --

9
10 Q. What was HETI's role?

11 A. HETI funds the advanced skill training positions in
12 whole of New South Wales. Advanced skill positions are
13 maybe anaesthetics or obstetrics, palliative care,
14 paediatrics. There's a lot of advanced skill positions
15 available, but HETI funds a few recognised important
16 advanced skill positions. So most of the Murrumbidgee
17 model registrars want to do an advanced skill position to
18 be - you know, to be a proceduralist in doing a bit more
19 advanced level of practitioner work.

20
21 Q. So that would be a GP who has an add-on qualification?

22 A. Correct.

23
24 Q. Which enables them to do, for example, obstetrics?

25 A. That's correct.

26
27 Q. Surgery, anaesthetics?

28 A. Mmm-hmm. Anaesthetics is very popular, and
29 paediatrics and obstetrics is next popular, and - as part
30 of this program, we were able to set up a palliative care
31 advanced skill position in Wagga, which we didn't have in
32 the past. We were able to facilitate that, too.

33
34 So HETI has a significant role and HETI has their
35 rural generalist director. Dr Louise Baker, is a very
36 senior GP obstetrician, so that's a wealth of knowledge and
37 expertise. It's important to get it --

38
39 Q. Does HETI have a role to play in deciding where these
40 trainee positions are located?

41 A. Correct. HETI will accredit a place so that that
42 place can be an advanced skill position, and then once you
43 accredit, the colleges will allow the registrar to go there
44 and complete the required placement, so then there can be
45 first and final exam and given the diploma or the status of
46 completed advanced skill.

1 Q. So that's for the advanced skill training. In
2 relation to the GP training, or the rural generalist
3 training, perhaps without the specialisation, who makes
4 a decision about where those employed general practitioners
5 or GP registrars get sent within your district?

6 A. At the moment it's called a WPP program, where the PHN
7 is the manager of it, but Royal Australian College of
8 General Practitioners, or ACRRM, Australian College of
9 Rural and Remote Medicine, they are the ones who decide
10 where the registrar would go. So their divisions in
11 New South Wales are different to our divisions. So PHN
12 borders are different, LHD borders are different.
13 Similarly, registrar allocating borders are different. So
14 Murrumbidgee, Far West, Western, Southern and Canberra will
15 come under one jurisdiction of where registrars get
16 allocated.

17
18 Q. So to the extent that, for example, the RACGP is
19 making decisions about where a particular GP registrar
20 employed under the single employer model might be able to
21 go to train, they are making decisions which have to take
22 into account, or take into account in some way, a much
23 wider geographical footprint than just the Murrumbidgee
24 LHD?

25 A. No, RACGP will make decisions on what the registrar
26 needs to do to fulfil fellowship. RACGP will make the
27 decision on which GP practice is accredited to keep
28 a registrar. We, as MLHD, will make the decision on where
29 our single employment model registrar will go. We can't
30 send our single employment model registrar to a place where
31 the RACGP hasn't accredited saying that this is a place
32 where you can or can't send, they'll tell us. Then we will
33 decide to send. So our decision has been based on MMM4 and
34 above towns, so it's not towns like Wagga or Griffith,
35 we're talking about towns like Young, Cootamundra, Finley,
36 West Wyalong, type of place.

37
38 Q. So to make sure I understand the process, there are
39 people or trainees who are involved in the single employer
40 mode, employed as a staff specialist by --

41 A. Employed as --

42
43 Q. Employed, sorry, as a registrar by the MLHD?

44 A. Yes, correct.

45
46 Q. The RACGP has a role to play in deciding what content
47 they need to be delivered as part of their training?

1 A. Correct.

2

3 Q. ACRRM makes a decision about which GP practices within
4 the state, potentially, but particularly within your health
5 district are accredited to receive those trainees in a
6 training position and then --

7 A. Mmm-hmm.

8

9 Q. Is that right?

10 A. No. RACG and ACRRM are both in parallel. They decide
11 where the registrars can be accredited and be sent, so --

12

13 Q. So you, as the LHD, get told, "Here are the practices
14 within your LHD which have been accredited by the colleges
15 as accredited training locations"?

16 A. Yes. And then we can work with them in the -
17 beforehand. We can actually work with the practices and
18 the colleges and get practices accredited to send the
19 registrars if we want to. Say we have a town X we want to
20 send the registrar, but if the practice is not accredited,
21 we can go through the process of accrediting them so that
22 we can send the registrar there too.

23

24 Q. Let me come back to that. So at the moment, we've got
25 a group of accredited practices within the LHD, which you
26 within the LHD, no doubt in collaboration with your
27 colleagues, make decisions about where best to deploy
28 a particular registrar under the scheme?

29 A. Yeah.

30

31 Q. Those decisions about where best to deploy a registrar
32 under the scheme are based on what sort of considerations?

33 A. Number one, it's based on the rurality. Number two
34 it's --

35

36 Q. So rurality, I think you said --

37 A. MMM4 and above. Number two, it's based on need - for
38 example, you know, we need to send an obstetric registrar
39 in Young. We might need to send a GP anaesthetic registrar
40 to Temora, things like that.

41

42 The other thing is with Murrumbidgee model, because it
43 was a pilot and negotiation between us and the federal
44 government to get it across, they have defined that we can
45 only send five registrars per year, and we had to give them
46 pre-warning that these are the places that we will send the
47 registrars, and so we had to work within that limit, when

1 I was involved.

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But since February onwards, now, this is a national program, they have morphed our Murrumbidgee model into a national version, so New South Wales regional health is running the process at the moment, and very similar to what Murrumbidgee model is.

Q. So do you have any sense of how that system is working now that the central decision-making body has taken over from the LHD in making decisions about where registrars, within your LHD, should be sent?

A. Regional health division is working with all the regional LHDs very closely, and we have been very close with them from the inception of that division, and the deputy secretary and the executive directors are very well closely known to us; hence, I think, there is not a big issue at this point in time where I'm seeing.

But I get your point, because the Murrumbidgee model was designed to be a place based solution, a solution for Murrumbidgee that suits Murrumbidgee. You cannot replicate Murrumbidgee model anywhere else. It has to be replicated to suit that place. L then it's going to work best. That's the crux of, you know, the logic of doing it.

So one of the things that regional health division is doing that I'm aware of is personalising it to different LHDs to work that - work better in those situations.

Q. We might come back to this in more detail but is it the case that the personalisation of the delivery of the scheme has to be personalised really to the individual community level rather than the LHD level in terms of --

A. Correct. It's correct. It has to be personalised to the individual LHD and the community level, both. Say, for example, in Wagga, because we have a Wagga Base Hospital, we have quite a few advanced skill positions that we can send the registrars in, and within the stream of around - surrounding Wagga, we can send them as registrars to work, and I don't think we will have that luxury in Southern, you know, because not many advanced skill positions would be there because they wouldn't have a big hospital like Wagga in there, because their biggest tertiary centre to send people is in Canberra.

Similarly, in Far West, in Broken Hill, out of Broken

1 Hill, the connection with the LHD would be not as strong as
2 what we would see in Cowra, in Western, or in Wagga, in
3 Murrumbidgee. So it has to be personalised to the town for
4 the need, meaning town meeting the need, it has to be
5 personalised to the situation, meaning the LHD.
6

7 Q. To make sure I have understood it correctly, the
8 advanced training positions which HETI decides are
9 available, they are facilitated through here, the Wagga
10 Base Hospital?

11 A. They fund - they fund the position.
12

13 Q. And are those positions delivered, in your LHD,
14 through the Wagga Base Hospital?

15 A. Mmm, and we have some advanced skill positions in
16 Griffith Base Hospital too, for anaesthetics.
17

18 Q. And is that because the delivery of the training in
19 those advanced skill positions is something that needs to
20 be facilitated in a facility --

21 A. Correct.
22

23 Q. -- that performs --

24 A. You need to have a level of supervision, level of
25 credentialling and all those things in place to be able to
26 afford that.
27

28 Q. We might come back to some of those issues a little
29 bit later.

30 A. Sure.
31

32 Q. You're also the board director of the Murrumbidgee
33 Primary Health Network?

34 A. Yes.
35

36 Q. How long have you held that role?

37 A. I've been MPHN board director since 2017, October.
38

39 Q. Do you think there are real advantages in having the
40 overlap between the LHD board position and the PHN board
41 position in a role like yours?

42 A. Reciprocal, yes, it's very good for both sides, my
43 understanding. I do understand the primary care patch
44 a lot better by being on the PHN side, and I do understand
45 the running of NSW Health and LHD process better, being on
46 the LHD.
47

1 I don't think it is an uncommon, in rural/remote
2 New South Wales, because Western and a few other PHNs have
3 very similar situations where the board directors are equal
4 on both sides. I think it gives better perspective in
5 recognising the challenges that different organisations
6 face.

7
8 Q. Do you feel that it enhances the --

9 A. It enhances the collaboration.

10
11 Q. It strengthens the collaboration?

12 A. It enhances the cooperation and it enhances a link of
13 connection or communication for that matter. But in
14 Murrumbidgee's way, our chief executive and the PHN chief
15 executive meet quite regularly and our offices are just
16 adjoining, you know, about 100 metres away, so there's
17 a very good close connection anyway.

18
19 Q. So to your observation, having worked - your
20 involvement in both organisations, at least in this LHD,
21 there is a strong level of connection and collaboration
22 between the PHN and the LHD?

23 A. Yes. I think in this organisation, knowing my
24 colleagues around rural New South Wales and stuff, I guess
25 MLHD has a strong primary care focus.

26
27 Q. Can I ask, other than the geographic convenience of
28 having the two offices 100 metres apart, is there anything
29 else about this LHD that you think explains the high level,
30 higher, perhaps, than other LHD, level of collaboration?

31 A. Few things. Number one is that close proximity of
32 office, I don't think it's the main reason, but one of the
33 biggest reasons is our geographical border and the PHN's
34 border is the same. It's not the same in other places. If
35 you go to the Western PHN, that includes Far West and
36 Western LHD and there are certain LHDs where they have two
37 PHNs sometimes. So it allows us - it gives us a lot more
38 credibility in how we can do things, given that we have the
39 same jurisdiction.

40
41 Q. I understand the credibility point, but in terms of
42 the practicalities of it, what is it about having the same
43 border between the LHD and the PHN, which enhances --

44 A. We can have the same data sources; we can have the
45 same health need assessments; we can do very similar
46 community consultations; we can have collaborations when
47 working with communities in lots of projects together, and,

1 like, our collaborative care trial and various other, First
2 2000 Days, community paediatrician trial - things like
3 that. We can do projects in the community a lot more
4 easily, without a lot of resistance compared to many other
5 PHNs. So I think that makes it a lot easier.
6

7 Q. Is that because or is one of the reasons for that
8 because, within the Murrumbidgee LHD, it is only the
9 Murrumbidgee LHD which is making a claim to or seeking to
10 have access to moneys available through the PHN for the
11 delivery of these projects, whereas a PHN that might cross
12 multiple LHD boundaries would have multiple LHDs each
13 competing for the funding that's available through the PHN
14 to deliver projects?

15 A. Possible. You could frame it that way but in the way
16 that, you know, this competition for the funding wouldn't
17 be a big issue in the way how PHN works, because the PHNs
18 work in identifying gaps and funding the gaps, or
19 commissioning services to cover the gaps, right? And there
20 isn't a significant proportion of funding coming from the
21 PHN to the LHD, as such, I'm aware of.
22

23 I might be wrong but, look, my awareness is that the
24 PHN goes and funds and runs projects in areas of primary
25 care upliftment or gap covering where there is a need for
26 it, where it is historically not the LHD's role to fund
27 things. So helping primary care and covering gaps and
28 working on issues of need inadvertently makes it better for
29 the LHD because if there's strong primary care, the LHDs
30 will have to bear less cost in managing them in secondary
31 care.
32

33 Q. The PHN has a limited budget to deliver its
34 gap-filling role?

35 A. Mmm-hmm, yeah.
36

37 Q. There are more gaps in the system than the PHN has the
38 capacity to fill?

39 A. Correct.
40

41 Q. Each LHD will have a large number of gaps that it
42 needs to fill - yes?

43 A. Yes.
44

45 Q. To the extent that a PHN crosses over two different
46 LHD boundaries, it will be in the interests of both LHDs
47 that as many of the gaps within their footprint as can be

1 filled are filled?

2 A. Correct.

3

4 Q. And in that sense, is it possible that there might be
5 some competition, perhaps not the right word, but at least
6 a desire on the part of each LHD to have as many of their
7 gaps filled as is practicable from the limited resources of
8 the PHN?

9 A. Possible. If there is that competition, it's good,
10 because we will have better productivity, I would say. But
11 what we see is PHNs and LHDs, if they are working well
12 together, we see better performance or better outcomes.

13

14 When you have an LHD which has two PHNs, or when you
15 have one PHN which has two LHDs, the LHD that communicates
16 and works well with the PHN will benefit, obviously.

17

18 Q. Do I take it from that that the personalities at the
19 head of the PHN and the head of the LHD are --

20 A. Correct.

21

22 Q. -- critically important for that to be --

23 A. Very correct. It is not only PHN/LHD business.
24 Anything to do with health, I believe it is quite
25 political, and personalities and connectors and lead people
26 in the organisation are key and significant in getting
27 better outcomes for our people.

28

29 Q. Is it your view, as someone who observes it from both
30 sides of the collaboration in this district, that the
31 people who are doing it are extremely well suited to that
32 role?

33 A. That's correct. That's correct.

34

35 Q. You're also, I think, the vice president of the Rural
36 Doctors' Association NSW?

37 A. Yes.

38

39 Q. Could I just ask you a question about that, which
40 relates to communications about patients between rural
41 doctors in private practice, so primary health care, on the
42 one hand, and the acute based health care on the other.

43 A. Sure.

44

45 Q. It's the case, is it, that the sharing of information
46 between those two silos is critical to quality delivery of
47 health care to the patients that --

- 1 A. Yes.
- 2
- 3 Q. -- might cross over the boundary?
- 4 A. It is very important, because continuation of care is
- 5 the hallmark of primary care - continuity. For better
- 6 continuity, we need to communicate between systems better.
- 7
- 8 Q. We've heard some evidence about discharge summaries
- 9 which come from the hospitals to primary health care when
- 10 a patient is discharged from an acute setting. Do you have
- 11 experience of those discharge summaries?
- 12 A. Yes.
- 13
- 14 Q. What experience do you have there?
- 15 A. I create discharge summaries every day and I read
- 16 discharge summaries from others every day.
- 17
- 18 Q. So perhaps we should just clear that up before we get
- 19 into the issue. You are creating discharge summaries in
- 20 your capacity as a VMO --
- 21 A. The VMO in the Finley Hospital.
- 22
- 23 Q. -- in the Finley Hospital?
- 24 A. And when I go and see patients in my general practice
- 25 as a GP I read discharge summaries of others who have
- 26 written and sent it to me.
- 27
- 28 Q. So to the extent that you happen to be the doctor at
- 29 Finley Hospital who treated, in an acute setting, the
- 30 patient who then walked through your door, no issue --
- 31 A. I write a letter to myself, yes. I write a letter to
- 32 myself and it goes to the cloud and the cloud sends it to
- 33 my computer on the other side.
- 34
- 35 Q. To the extent that you are treating patients who have
- 36 been seen by other doctors in an acute setting, what has
- 37 your experience of discharge summaries been - starting
- 38 first, say, with Finley Hospital?
- 39 A. Yes. I think it is a lot better now compared to where
- 40 we were. When we didn't have this eHealth system and, you
- 41 know, the electronic way of communicating discharge
- 42 summaries, it was quite disorganised. You know, I'm
- 43 talking about in 2008 when I started my practice in Finley
- 44 to what it is now. If I do a discharge summary now
- 45 electronically, I get it on my other computer within a few
- 46 seconds, sometimes. It goes straightaway.
- 47

1 The bigger issue I see in Finley is the communication
2 I get from the Victorian side of the hospital system, like
3 Albury Wodonga Health and Goulburn Valley Health. They are
4 not e records, they are still paper based, the vast
5 majority of their work is. So with time, when that
6 improves, I'll see a lot better improvement.

7
8 My colleagues around Wagga and Cootamundra still have
9 issues about discharge summaries not coming in time, or
10 coming a bit later than what they would like to.

11
12 Q. So coming from where?

13 A. Wagga Base Hospital or Sydney hospitals, kind of.

14
15 Q. Yes?

16 A. Yeah.

17
18 Q. So issue one with the discharge summaries for those
19 colleagues, is it that they've told you that the timeliness
20 of the discharge summary is a problem - that is --

21 A. Timeliness is an issue sometimes. Sometimes the
22 content might be an issue. Sometimes trying to trace and
23 get stuff, going through the process of getting through the
24 medical admin and medical records - sorry, not medical
25 admin, medical record systems, might be a process that
26 will - you know, a challenge.

27
28 Say, for example, you come to see me and I haven't got
29 your discharge summary, I need to write a piece of paper
30 and get you to sign, give me authority to ask for it, send
31 it to the medical records division, they look at it, they
32 look at it, and then they send it back to me. All this
33 will take a lot of time, and your time with me is only
34 15 minutes. So then you'll have to come on another time to
35 talk about what is on the discharge summary. So there
36 might be an issue like that. You know, not uncommon, not
37 a very frequent occurrence by any means that I'm aware of,
38 but it is an issue.

39
40 Q. What about the experiences you have with Victorian
41 based health services? If you have a patient who walks
42 through your door and says, "I was in Albury hospital last
43 week", you haven't been provided with a discharge summary,
44 how do you deal with that information --

45 A. I have to ask them to sign a release of information
46 form and get the medical records, "You need to send it
47 across." The vast majority of the time it's a lot more

1 easier, it happens quickly, but there are hiccups here and
2 there. But the Melbourne-based hospitals, such as Royal
3 Melbourne and St Vincent's, they've got automated systems,
4 if you go and hit the door in the hospital there, I get an
5 automatic notification saying, "Mr X came here." And "Mr X
6 is booked for a surgery", "Mr X left this place." I get an
7 automated information straightaway. It happens
8 automatically. Nobody has to send anything. So that's the
9 version that I see from the Melbourne end.

10
11 Q. Is that a useful function of the Melbourne system?

12 A. Very good function, because no matter what time you go
13 and hit the hospital there, I get the automated
14 notification saying, "You are here."

15
16 Q. And that is in addition to the discharge summary?

17 A. Yeah.

18
19 Q. Which hopefully will follow soon?

20 A. That's in addition to discharge summary.

21
22 Q. What happened while they were there?

23 A. Correct.

24
25 Q. Are you familiar with the single digital patient
26 record project --

27 A. Yes.

28
29 Q. -- that's being rolled out by NSW Health?

30 A. Yes.

31
32 Q. Do you have a familiarity with what it will involve in
33 terms of communication between the acute care setting and
34 the primary care setting?

35 A. Basic understanding, yes. I don't think communicating
36 between primary care and the acute care setting was the
37 main focus in that single digital patient record system.
38 It could improve into it, because the software that they
39 are going to purchase does that in US. I mean, it can do
40 it.

41
42 But our focus is mainly to bring all the LHDs into one
43 single record platform, whereas at the moment, if you get
44 into an ambulance, your record doesn't talk to the
45 hospital. When you come to the hospital, your record
46 doesn't talk to the GP. And when you go - when you get
47 discharged from the hospital to the community health

1 centre, it doesn't talk to certain places. If you get care
2 coordinated by a commissioned agency like Marathon Health,
3 or something like that, in this region, that record system
4 doesn't talk to any of this. So we've got a plethora of
5 siloed record systems, so now none of them are made to talk
6 to each other, and everybody wanted to guard their system
7 as the best secure and best version of it and now we're
8 trying to work out how best to send the discharge
9 summaries.

10
11 I think discharge summary is a smaller problem of
12 a bigger problem. The bigger problem is that in a day and
13 age of 2024, our systems aren't talking to each other and
14 not compatible with each other.

15
16 Q. Do you think it should be a priority in the
17 development of the single digital patient record that each
18 of those silos of information are connected up?

19 A. Difficult to say that yes for that, though, because
20 single digital patient record is a New South Wales
21 initiative to how to manage state related health services.
22 When you look at primary care data, it's more Commonwealth
23 or PHN related stuff. How do we get that together needs
24 a bit more work on it.

25
26 But there are better ways to look at it. You don't
27 have to have the same medical records system to talk to
28 each other. There is enough technological advancement that
29 can be deployed to talk to different systems, and that is
30 what Victorians are going to do. My understanding, in
31 Victoria, as a state, all their hospital systems are going
32 to have vast different types of digital record systems.
33 They will have an Epi software working on top of it to talk
34 to each other, which is possible.

35
36 Q. So perhaps I didn't frame my question correctly or
37 clearly enough. I'm not suggesting that all of these
38 various silos should be told that they have to use the
39 New South Wales single digital patient record system, but
40 to the extent that New South Wales is embarking upon a very
41 large project to implement, as a reform, a single digital
42 patient record across the state, is it your view that in
43 the building of that record or that program, priority
44 should be given to making sure that the information that
45 you've identified as being that key information, is able to
46 be shared by that system across all of the silos --

47 A. Correct.

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Q. -- in as seamless a way as possible?

A. Exactly. It will make a lot of difference for general practice and for patients.

Q. What about information flow the other way? Is there value in having primary health care information readily accessible to people within an acute setting?

A. Yes. A lot --

Q. So you obviously in Finley, delivering both forms of care to often the same patients, would see the benefit of that?

A. Of course.

Q. What is it?

A. The main thing is investigations and information. For example, if I see a patient in my general practice and do certain pathology tests and x-rays and CT scans and stuff, it'll be in my medical records system, but it doesn't go into the hospital system unless, you know, sent through a different mechanism.

When the patient comes into the hospital system for an acute care, if you don't readily see what is done in the past, your approach might be different, number one. Care might be delivered until you get them, number two. Number three, the most important thing is you kind of duplicate things, you might do the test again. It's costly. Pathology and radiology is a costly business for health care.

I think we can save a lot of money and time if there is a repository where you can look at the investigations. Things are slightly improved now, that's since recently pathology reports are going to the eHealth record where we can, you know, access it, but so many clicks to get to it. You won't see it readily on a patient record, as such.

Q. So this is the Commonwealth My Health Record that we're talking about?

A. Correct, yes. You can see quite a few of the pathology and radiology reports on it now, if the patient has allowed to be uploaded, or if the company that does that investigation is uploading the stuff. There is no mandate for it, but you can see it, you have to click so many things to get to see certain stuff, and it's not, you

1 know, a lot more conducive method to have a medical record
2 in that form in the hospital system.

3
4 Q. Can I ask you now to put on all of your hats at once,
5 to turn to what you see as the key challenges for the LHD
6 in managing the clinical services that it delivers to its
7 population? Obviously it is a very large LHD?

8 A. Yeah.

9
10 Q. What sort of challenges does that present?

11 A. It is quite a dispersed population, small population
12 all over the place.

13
14 Q. What sort of challenges does that really manifest?

15 A. Because you need to treat everyone equitably. You
16 need to be able to keep services available for every corner
17 of the district, right? So Murrumbidgee is twice as big as
18 Tasmania, with 250,000 people, and with 508 towns, 33-odd
19 local health districts - local government areas, but 32
20 health posts. So to keep track with all those and doing
21 the right thing by everyone is a challenge. It's a quite
22 complex task as a local health district.

23
24 So the biggest thing, challenges that we're seeing
25 with time, is medical workforce, general practitioners and
26 not - more than general practitioners for the LHD what we
27 are seeing is the rural generalists, the clinicians who
28 work in community general practice as well as the hospital,
29 both together, is going down with time.

30
31 Q. I will come back to workforce in a minute because
32 I understand that's the challenge. In terms of the
33 population that's spread across that wide geography, we
34 hear repeatedly that rural areas have an ageing population;
35 that's the case in the Murrumbidgee LHD?

36 A. Yes, correct. If you look at our ageing data, you
37 know, breakdown, profile, it's very similar - what our
38 current profile is, what Melbourne and suburbs is
39 predicting in another seven to eight years time. Their
40 profile is going to be very similar to what ours is like
41 now. So we understand that as a significant challenge.

42
43 Q. What are the particular challenges presented by
44 a widely dispersed and increasingly ageing population?

45 A. More home care needs; more people needing services at
46 home; more spots for aged care residential situation.

1 Q. We'll come back to aged care.

2 A. Yeah. And then general practice has to stretch itself
3 to provide better aged care. And transport, a significant
4 problem. Housing and availability of housing for key
5 workers such as education, police and health is
6 a significant problem, because you can't find anyone to
7 get - you know, if you find a new doctor, you can't find
8 a house.

9

10 One of our first few - one of our first few registrars
11 in the single employment model, in the Murrumbidgee model,
12 ended up staying in a caravan until we found a right place
13 to send the person. It was - we started, you know,
14 recruiting them in 2020 around the COVID time, so there was
15 too much trouble there, so --

16

17 Q. Just pausing there, I assume that the prospect of
18 staying in a caravan makes recruiting people into programs
19 like the single employer model challenging?

20 A. Yes, that's correct. Look, if the system is
21 supportive, they will stay with us, they have stayed with
22 us, and we've done everything we could do to get there.
23 But if there isn't any housing in the market to rent, then
24 that's quite a challenge. We have that problem a lot in
25 many places in Murrumbidgee and around Albury-Wodonga.

26

27 Q. Can I ask you, to the extent that the population is
28 dispersed across I think you said 503 towns --

29 A. I think 508, yeah, somewhere there.

30

31 Q. 508 towns and communities, and was it just over 30 of
32 them have a health delivery facility in them?

33 A. Yes, mmm-hmm.

34

35 Q. So that's, for example, Finley Hospital, but the
36 facility at Berrigan would be another example within your
37 area?

38 A. Yeah.

39

40 Q. Those facilities have an LHAC attached to them?

41 A. Yes.

42

43 Q. And we've heard some evidence about the level of
44 communication between the LHACs and the LHD and its board?

45 A. Yeah.

46

47 Q. And briefly, what's your view about the quality of

1 that engagement between the LHACs and the LHD board?

2 A. LHACs do send a report once a month, which comes on
3 the board papers, and we have understanding of what's
4 happening at each of their meetings, number one. Number
5 two, there's LHAC forums twice a year which the board do go
6 and represent and involve, and LHACs are in - LHAC members
7 are quite readily involved in the community advisory groups
8 and clinical councils with the PHN, and through that, we
9 get quite a good interaction and communication and
10 relationship building through that. So some towns might be
11 small but no health post.

12
13 So, for example, just take the example of Finley.
14 Finley is a town - Finley is a town, Blighty is around
15 Finley, Mayrung is around Finley, and then Berrigan,
16 Jerilderie, and there are smaller towns around Finley. But
17 Finley LHAC doesn't only have Finley people, we might have
18 Mayrung people, we might have Blighty people. So the
19 Finley LHAC doesn't mean that we've forgotten Blighty, but
20 Blighty is - people are part of the Finley LHAC too.

21
22 So similarly, in Tumut, Tumut is a bigger town
23 compared to Finley, there is a town by the name of Brungle,
24 which is vast majority are Indigenous population. It
25 hasn't - they haven't got any more than 200 people. So
26 they are part of the Tumut LHAC. So we have been working
27 with many smaller towns in different ways to avoid people
28 getting missed out in their representation or their voice
29 being heard by the local health district.

30
31 The other thing I want to bring is, in whole of
32 Murrumbidgee, we have 285 GPs, and all these GPs are
33 working through 83 GP practices. So all these GP practices
34 are dispersed in different towns too, and they're connected
35 to us in different modalities, through the PHN, through the
36 hospital system and stuff. So there is plenty of ways that
37 the community is connected and integral with the local
38 health district.

39
40 Q. What about the local councils? Is there a formal form
41 of engagement between the LHD and local councils within the
42 LHD boundaries?

43 A. Yeah. I think the councils are part of LHACs. Every
44 council - sorry, every LHAC has a council member in it, and
45 that is kind of the accepted model, and the - we do go to
46 the country, rural - Country Mayors' Association gatherings
47 and listen to what they've got to tell us and communicate

1 with them, and our executives are very proactive in dealing
2 with councils. Councils have a significant role in
3 providing better health in many aspects.
4

5 Q. What do you see as that role?

6 A. Many councils had GP practices owned by them. At the
7 moment, there isn't a lot because that is kind of a dying
8 trend from what I have understood. But some councils still
9 own the premises, even though the clinicians run their own
10 business in it. And then the council does have some
11 aspects of social work and, you know, infrastructure
12 support. And councils do have a role in transport and
13 access for certain aspects.
14

15 Councils do help with recruitment, say, for example,
16 finding the partner a job, finding the right place to live
17 and expediting the process so that we can recruit a new
18 doctor into different places. So they do play a role in
19 advocating for us.
20

21 For example, when the COVID time was there, when the
22 border issues were there between Victoria and New South
23 Wales and it was abruptly closed, council had a significant
24 role in communicating between different parties and, you
25 know, what is it, the border commissioner and people like
26 that. So in my experience, councils are a significant
27 component that we need to keep as an ally on our side to
28 work together so that we can provide better care.
29

30 Q. Is there any formal mechanism by which the views of
31 councils are picked up by the PHN?

32 A. Yeah. I think the councils do - councils are part of
33 their clinical advisory committee and council is part of -
34 some of the council representatives are part of the
35 clinical councils that the PHNs have. Like, we have one
36 district clinical council, like that, the PHN has four
37 clinical council - one for Wagga, one for Riverina, the
38 other one for western and the other one for border, so
39 those councils do have council representation in some
40 instances. So I think there is quite good interconnected
41 relationship.
42

43 Coming to your point, do we have a formal mandated
44 mechanism of dealing with them? I don't think, other than
45 the fact that LHACs need to have a council member in it -
46 other than that formality, I'm not sure of any other formal
47 arrangement.

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Q. Do you think it would be useful to have a more structured arrangement whereby the views of councils were being fed in to the LHD?

A. Reciprocal, yeah, both ways. It will be good for them, it will be good for us, too, yeah.

Q. You spoke a minute ago about the roles councils were playing in recruitment, which brings us nicely to the workforce challenges. What do you perceive to be the real workforce challenges that are faced in your area?

A. I think rural generalists, or generalism, is kind of a dying art at the moment. We are seeing less and less people wanting to do that, because of the demands that we had.

In 2008 when I started as a GP VMO in Finley, it was standard that I'm the only one, one and only man, and I look after the whole town and when I want to take time I take off and I don't have - and I don't want to take time off, I keep working, but now that's not the trend. That's not the way how people work. New generation doesn't want to work like that.

So what we're seeing is, out of the 300-odd, close to 300-odd GPs that we have in Murrumbidgee, about 100, 110, do some GP VMO work with us. Of that, regular, significant contribution GP VMOs, about 80 or close to 90, I would say. And there are towns - there are towns in our region where you have 14 GPs in town but none of them want to come and work in our - in the smaller regional hospital in the town.

That makes it significantly harder for us to, you know, provide better care, because some of the places, the smaller hospitals, have, you know, aged care settings attached to it.

Q. So what's disincentivising work in the small hospitals, in those communities?

A. Multitude of things. Bureaucratic process is one.

Q. In what way?

A. Meaning how the credentialling process happens with how a doctor can come and work in the hospital system and how the credentialling process, how a doctor can come and work in general practice is completely different, and the standards are different, and say, for example --

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Q. Does that mean a doctor might come to work as a GP in a particular community and be accredited to do that, but not have an accreditation to provide services as a VMO --

A. Correct.

Q. -- in the small hospital?

A. That's right. So if you are an Australian-trained clinician, you come to work in a town X, to work as a GP in the town, and you will directly get accreditation into working in the hospital system, be it supervised or unsupervised, based on your experience.

If you are an international graduate, if you haven't had any Australian hospital experience, your likelihood of coming into the hospital system and working in the hospital system is very limited, unless you have - can get proper recognised supervision or placements or a way of getting through that process.

As you would know, in the whole of New South Wales, rural New South Wales, 85 per cent of our medical workforce, their first degree is from overseas.

Q. So internationally trained doctors are a critically important part of the solution to the workforce challenges; would that be right?

A. That's correct.

Q. Is there anything that the system could do that might overcome this credentialling issue that's causing problems in terms of having those doctors working as VMOs in small hospitals?

A. They could do many.

Q. What are your thoughts?

A. If there was - there is an opportunity to recruit internationally trained medical graduates to get exposure into hospital system before they come into rural settings. A good example is the project that Campbelltown Hospital is running for years now. They got a premier's award for that project 13 years ago, meaning the project has been there since about 20 years now. It's still doing it.

They recruit 25 to 30 international medical graduates who are given a contract to work in the hospital system for two years, and vast majority of them end up coming into

1 general practice, particularly rural general practice,
2 because the work visa condition is such you need to be on
3 certain areas for you to be able to get a proper provider
4 number, area of need type of recommendation.
5

6 So the vast majority of - quite a number of, quite
7 a number, not vast majority but quite a number of our GP
8 VMOs in our district are from that program from
9 Campbelltown, and I can't see why the state health can't do
10 something similar with Wagga, Bathurst, Dubbo and Orange,
11 given that, in the foreseeable future, we are going to be
12 dependent on international medical graduates to patch up
13 our workforce needs.
14

15 Q. So in order to provide that training program, it would
16 need to be delivered through a larger hospital than, say,
17 Finley?

18 A. That's - Finley could do it. I think Finley is not
19 the ideal place for that type of thing. I think Griffith
20 or Wagga or Deniliquin, Young, type of place would be the
21 idea type of place, because you need to have an onsite
22 doctor all the time to be able to supervise such an
23 international graduate for us to fulfil the criteria for
24 the Medical Board.
25

26 Q. Is it your view that by running a program like that
27 through facilities based in Murrumbidgee LHD, you would
28 have a greater capacity to fill --

29 A. We will have a better pool to recruit, and we will
30 have a better opportunity to send GPs into smaller towns
31 such as Berrigan, Batlow, where they will work in the
32 hospital, aged care as well as the community.
33

34 Q. You mentioned a moment ago the fact that doctors in
35 this day and age like to take time off, not unreasonably.
36 Is that something that the community's expectation has not
37 quite caught up with?

38 A. Not quite. I know there are certain parts of the
39 community who think that, in Finley, in 1985 they had their
40 appendix out, they had their knee done, they had their hip
41 done, they had their babies born, "And now you guys are
42 talking about that you can't even run an emergency
43 department", you know? There is that notion in the
44 community. But the vast majority of the community do
45 understand the context is different and the circumstances
46 are different, and they want better care, too.
47

1 Q. There is presumably more to that shift than just the
2 fact that doctors working in small communities like to have
3 a reasonable work/life balance. Have there been changes in
4 medicine that have occurred over the last several decades
5 which mean getting all of those procedures done in a
6 hospital like Finley is no longer realistic?

7 A. That's correct. I don't think I'd want my appendix
8 taken out in a smaller hospital where there is no operating
9 theatres or standards maintained to the level of what Wagga
10 would do. If I don't want it, then I don't want my
11 patients to have it, too. That's as simple as that. You
12 know, I think that time has gone. We know that. But
13 people know it too, but they do point out - when something
14 is getting lost, they do point it out, to say, "Look, this
15 is what the situation was."
16

17 Q. Is there more to it than the facilities and the
18 standards or accreditations within facilities? Is there
19 also the fact that the surgeon who might be taking out an
20 appendix in a small facility might do one or two a year
21 whereas someone in Wagga might do one every morning?

22 A. Exactly. Exactly. It's more the fact that there
23 isn't the workforce to do it anymore. You might have had
24 it in the past but there isn't the workforce to even employ
25 emergency trained nurses in smaller hospitals like mine,
26 and let alone doctors. So I think the necessity or,
27 rather, the situation is such, we just don't have the
28 people to do it.
29

30 Q. Can I ask - and this might be a bit circular - to the
31 extent that there are procedures that could safely be done
32 in smaller hospitals, would doing them in those hospitals
33 act as an incentive to GP VMOs with advanced training to
34 head out to those areas?

35 A. Correct. Very correct. Very correct. I might just
36 pick up some numbers, but they're not exact numbers.
37

38 Q. Yes, please.

39 A. You might find better numbers, if you read on it.
40 I think we have about close to 20,000 procedures happening
41 in whole of Murrumbidgee. Of that, nearly 16,000 or so
42 happen in Wagga Base Hospital. And nearly 2000 or so
43 happen in Griffith Base Hospital. About 1,500 to 2,000
44 happen in smaller hospitals such as Deniliquin, Young,
45 Cootamundra and Tumut. Very minuscule amount of work.
46

47 If there is a mechanism that we can utilise the

1 situation that we have now to do more procedural stuff in
2 the smaller towns out of Wagga and Griffith, we would see
3 more proceduralists who are happy to come and work and live
4 and do things in those settings. That is a significant
5 carrot for Australian-trained clinicians in the future to
6 come and settle and work in our system.

7
8 Q. And it's the case, is it, that a proceduralist who
9 came to work as a GP in a small rural community would
10 almost necessarily also have to work as a VMO in the
11 hospital, if they wanted to perform that procedure?

12 A. Yes, mmm-hmm. That's correct.

13
14 Q. Is it your view that that would be advantageous in
15 terms of assisting with workforce challenges in those
16 smaller hospitals and smaller communities that are around
17 them?

18 A. One, yes. Most importantly, continuity of care. If
19 you are - if you have an obstetrician in the town, that
20 means that's the only surgeon you have in the town. If you
21 are in trouble, that person will be there to do a lot of
22 stuff. Not only will they be delivering babies, they can
23 do a lot of stuff to help. If you have an obstetrician in
24 the town, the town will have an anaesthetist. If you have
25 an anaesthetist in the town, you are not going to only
26 anaesthetise procedural stuff in your theatre, you will
27 have an anaesthetist who can help you when there is
28 a significant life-threatening emergency. You have an
29 anaesthetist who can help the existing doctor who is in
30 trouble with a complex situation. So a proceduralist in
31 town is not only about doing the procedural stuff on the
32 theatre, but they are a significant asset to a lot of other
33 things.

34
35 Q. In order to maintain the skills and confidence of that
36 proceduralist in a small town that might not have a large
37 number of procedures, is there scope for them to go and
38 spend a short window of time, say, in Wagga Base or
39 Griffith?

40 A. Yes.

41
42 Q. Doing a higher turnover of procedures at the moment?

43 A. We do it in Murrumbidgee, quite often.

44
45 Q. How does it work?

46 A. In Murrumbidgee, some places deliver only, what, 40 to
47 50 babies per year, and if those obstetricians want some

1 time to work in Wagga Base or Griffith Base Hospital, we're
2 more than happy to accommodate and find the opportunity for
3 them. There are certain funding mechanisms that they can
4 get incentives to do that, too, because when they come and
5 work in bigger places like Wagga and Griffith they have to
6 leave their general practices, so that means they leave
7 their income back when they come to work with us. So there
8 are means to cover that cost, too.

9
10 Particularly in our single employment model,
11 Murrumbidgee model, the registrars who - for example,
12 a registrar who went to Cootamundra as a GP obstetrics
13 registrar, because he didn't have enough workload to keep
14 his skills up to date, we were able to make him work
15 10 days in Cootamundra, one full day in Wagga Base
16 Hospital, to get that skill. So the MLHD and many other
17 LHDs are also quite open to doing that, and there's
18 a process of doing it.

19
20 Q. Other than workforce challenges, which need to be
21 overcome, and maybe overcoming them is - more procedures in
22 smaller hospitals is part of that challenge, but is there
23 anything else which is disincentivising the LHD from
24 delivering more procedures in smaller hospitals?

25 A. I think proceduralists - procedures done out of base
26 hospital is not measured as a key performance indicator.
27 If you had an inpatient in the emergency department in
28 Griffith Base ED for more than 24 hours, that will alert,
29 and it is a reportable thing to the CE, and it will even
30 get alerted at the state level.

31
32 THE COMMISSIONER: Q. Can I just ask, procedures in
33 smaller hospitals - what are we talking about?

34 A. Endoscopies, minor surgeries, cholecystectomy type of
35 thing, lump, bump, skin cancer excisions, that sort of
36 thing and --

37
38 Q. That's the sort of thing we were told was being done
39 at Tumut, for example?

40 A. Correct, yes, caesarean sections.

41
42 MR MUSTON: Q. Uncomplicated obstetrics?

43 A. And I think we do certain things like cataracts and
44 some joint replacements and things like that, too, in some
45 of the --

46
47 THE COMMISSIONER: Q. Not in Tumut because I remember

1 asking that. But maybe there are other small hospitals
2 that do joint replacements, are there?

3 A. Correct. I think - I don't think in Murrumbidgee -
4 I don't know, I need to check that. I know in --

5

6 Q. There is someone at the back shaking their head. That
7 might be a tip. But perhaps hips and joints might only be
8 done in Wagga Base.

9 A. Big hospitals.

10

11 THE COMMISSIONER: I'm now getting a nod, so let's go with
12 that.

13

14 MR MUSTON: Q. So you started mentioning that procedures
15 performed in the smaller hospitals didn't trigger any KPIs?

16 A. Mmm-hmm.

17

18 Q. Do you think it would be useful to have KPIs which
19 incentivised the delivery of procedures through smaller
20 hospitals?

21 A. I think yes.

22

23 Q. And in terms of the funding model, a number of the
24 smaller hospitals are block funded?

25 A. Yeah.

26

27 Q. Do you have a view about what the nature of block
28 funding might mean in terms of an incentive or disincentive
29 to perform procedures in smaller hospitals, block funded
30 hospitals?

31 A. I don't know a lot about it. I know except for
32 Griffith, Wagga and Deniliquin, everything else is block
33 funded. I think block funding is kind of one spoon measure
34 to everyone. That is not the best deal for us if we are
35 looking at better performance. That's my broader
36 understanding about it. The intricacies of whether that
37 would be better than this is beyond my capacity to answer.

38

39 Q. Let's move on to another little issue which is
40 associated with the dispersed population and large
41 geography. Access to specialist services to patients
42 across the LHD - what are your observations of that?

43 A. I deal with many LHDs, given my position in the
44 border. I deal with Albury-Wodonga, I deal with
45 Murrumbidgee, I deal with the Victorian sector in the sense
46 Shepparton and Melbourne. The significant problem I see in
47 Murrumbidgee's context is not having public outpatient

1 clinics for many things, which will incur quite a lot of
2 out of pocket costs for patients.

3
4 Q. So is that a workforce issue? Is that the absence of
5 the public clinics or is it a --

6 A. It's a historical way of how we work and system issue,
7 I would say, because in Albury-Wodonga and Murrumbidgee
8 historically, the practitioners are seeing patients in
9 their own private practices, and then if they need any
10 procedures, they book them through the base hospital
11 allocations for theatre list.

12
13 Q. So do I take it from that that the historical system
14 prevents or creates a blockage in terms of wide access to
15 specialist services by people within the LHD?

16 A. Could be said that, yes, in the sense if we had public
17 outpatient clinics, we could have - some of our patients
18 who have had difficulty in getting to different places or
19 paying the out of pocket costs could have had better and
20 quicker care than they would have otherwise had. So that
21 would make a difference.

22
23 Q. Are there particular areas of specialisation - let me
24 take it back a step. The contemporary model for the
25 delivery of medicine involves not only specialisation but
26 sub-specialisation into a great array of different
27 sub-specialties?

28 A. Yes.

29
30 Q. You're not suggesting that within the LHD there should
31 be public clinics for each of these various sub-specialties
32 of which they're no doubt almost infinite in number?

33 A. No, I wasn't suggesting anything in that line. What
34 I was suggesting is that if I have a patient who needs to
35 see a cardiologist, example, I can send them to Goulburn
36 Valley Health outpatient clinic where they will get triaged
37 and get seen by a physician or cardiologist, and what needs
38 to be done will be done, there will be no cost.

39
40 Q. Let's take the example and turn it into a wish list.
41 Are there particular areas of specialisation that, from the
42 perspective of a deliverer of primary health care in
43 Finley, you think it would be useful to have available
44 through public clinics? Are there specialties that you
45 think really are so heavily relied upon by patients in the
46 region that it would be useful to have them as a public
47 clinic?

1 A. Yes. In my practice as a GP - this is I'm talking as
2 a GP in Finley - cardiologist, ophthalmologic, cataract
3 surgery and orthopaedic surgery, they are the main
4 blockages that you have, and neurologist, I can't get to
5 one for years if I want to in this region. I send all of
6 them to Melbourne.

7
8 Q. Is that a common occurrence, sending a patient to
9 Melbourne for a neurologist?

10 A. In my place, yes. Not in Wagga. Wagga has two
11 neurologists here. There's quite a lot of backlog to wait
12 and see, despite the out of pocket cost, but in certain
13 regions going to Canberra or going to Melbourne would be
14 the quickest option, if you want to see someone quickly.

15
16 Q. So we've got cardiologist, ophthalmologist,
17 orthopaedic surgeon?

18 A. And paediatrics for autism spectrum disorder or
19 behavioural problems - very difficult to get in to one.

20

21 Q. Are you aware of public clinics for any of these areas
22 of specialisation being available in other LHDs within
23 New South Wales through your other roles?

24 A. Yes. I think there is public clinics in Sydney. Many
25 LHDs do have, if I'm not mistaken. I know - I was involved
26 with the ACI in consultation for how to formalise and make
27 a referral system so that - how to refer to public health
28 clinics. So that was kind of a dreamy situation for me in
29 Murrumbidgee's context, when I had a look at it.

30

31 So I'm not - I haven't been to a public outpatient
32 clinic in Sydney but I'm quite aware that my understanding
33 is that there is public outpatient clinics in the metro
34 area, but not in the regional settings such as
35 Albury-Wodonga or in Murrumbidgee.

36

37 Q. We're told a lot about the increasing burden of
38 chronic illness. Would greater access to public outpatient
39 specialist clinics do anything to reduce that heavy burden?

40 A. Yes.

41

42 Q. In what way?

43 A. People who need specialist care, vast majority of them
44 are the complex ones, and vast majority of them are the
45 ones from lower socioeconomic situations, and the more
46 rural you go, the more difficulty that you see.

47

1 We see quite a lot of people who haven't got savings
2 to last a day or two, max. In that situation, bearing the
3 cost of \$200 or \$300 out of pocket for a consult means, you
4 know, things won't be right for another three, four months
5 in their lives. So that, on top of it, you know, the
6 transport and other costs, comes up too. So I think the
7 most needy, the most vulnerable are the ones which will
8 fall through the gaps by not having a public access for
9 certain specialties or clinics, and if we can tighten that
10 up, we will have better outcomes.

11
12 Q. It might be obvious as a medical practitioner, but
13 just to make sure it is right, those who fall between the
14 gaps in the way that you've just described have inferior
15 health outcomes --

16 A. Correct.

17
18 Q. -- to those who don't?

19 A. Correct. For example, if you have a client who has
20 cancer, who wanted to do a trial in Wagga or Albury, then
21 if they haven't got the finances to go up and down and do
22 it, they might say, "Look, I don't need to worry about a
23 trial, I'm not going to go and take part."

24
25 And then if I want to see - if I want a patient to see
26 a cardiologist once a year, because he is complex and he
27 needs to be seen, he might say, "Look, I'd better see him
28 every three years, I don't have the money to spend every
29 year for this." So people cut corners based on what they
30 can cut corners, when they have the opportunity, so health
31 comes at that cost.

32
33 When you have a patient who doesn't look after their
34 heart disease properly and if heart failure sets in a lot
35 earlier than what it should, we will pay the cost when they
36 come to hospital.

37
38 Q. You've told us a little bit about the cross-border
39 challenges that you face in terms of getting patient
40 records from Victorian hospitals where patients that you
41 see in a primary care setting go into those facilities.
42 Are there any other cross-border issues that you think
43 impact on the way in which you and the LHD respectively are
44 able to deliver health care to the communities that you
45 respectively serve?

46 A. It was a big problem during COVID time because of
47 border issues, and other cross-border things are

1 jurisdictional stuff, say, for example, if you go and go as
2 a patient in the Victorian side of the hospital, and want
3 to get discharged, to have, after hospital discharge, some
4 help at home - we call it ComPacks - you can't get it if
5 you were in a Victorian hospital, in the New South Wales
6 side. They need to get transferred to a New South Wales
7 hospital and discharged from a New South Wales hospital to
8 get that one.

9
10 Number two, say if I'm a really bad COPD patient and
11 I need home oxygen and I've been looked after by
12 a Victorian respiratory physician, I will have to do the
13 blood test and testing and stuff in the New South Wales
14 system to be able to upload it to get home oxygen,
15 otherwise I will have to pay for oxygen by myself. So
16 there are subtle intricacies such, and which makes
17 a significant impact or burden on patients in the long run.

18
19 The other thing is, when you have a critically ill
20 patient - say in Finley, I had a patient who had a cardiac
21 arrest, needed an air ambulance to come and airlift and
22 take the person. In the current New South Wales system, to
23 Finley, if you want an air ambulance, it will come from
24 Orange or Bendigo or Canberra. So if they come from
25 Bendigo or Orange or Canberra, they will decide where the
26 patient will go, not what the patient or myself want.

27
28 If they decide to take the patient to Canberra, then
29 the family and then the whole component around that
30 patient, until the patient gets better and comes back home,
31 have to drive up and down four and a half hours and bear
32 the cost of doing that. So that's one of the border issues
33 that we see a lot in patient transport and patient
34 emergency transport situation, because in NSW Health
35 ambulance situation, they won't take any patient by land
36 route more than 250 kilometres. If it is more than 250
37 kilometres, it has to be air route.

38
39 So then, from Finley, example, you will have a patient
40 who needs to go by air route, and land ambulance will come
41 and take the patient from my hospital to Tocumwal
42 aerodrome, from Tocumwal aerodrome, the patient goes by air
43 to the Essendon airport, from Essendon another land
44 ambulance comes and takes you to the real hospital in
45 Melbourne, so that takes quite a drama. You know, you can
46 drive twice back and forth to Melbourne by that time from
47 Finley. So that's the protocol or procedure, because we

1 have to stick to the rule that if it is more than 250, you
2 can't go by land route.

3
4 Q. Putting your LHD hat on, to the extent that you're
5 trying to make an assessment of communities' needs within
6 the LHD and perhaps also the PHN, is there a good
7 information flow between the Victorian health service and
8 either the LHD or the PHN in terms of services which might
9 be being accessed by local LHD, Murrumbidgee LHD patients
10 across the border in Victoria?

11 A. I think yes, with Albury-Wodonga. I'm not sure with
12 the other places, because Albury-Wodonga and our executives
13 have regular catch-ups and there is a process of working
14 together.

15
16 I am not aware of the other jurisdictions, as such,
17 but it's patchy, I would say. It's not the ideal. But it
18 is patchy because the mechanism how the Victorian system
19 works is completely different to what - how we work here,
20 and NSW Health and devolved LHDs is not their mechanism.
21 Their mechanisms, they have their own hospital boards, they
22 run their own system. So there is a gap there.

23
24 Q. Just coming back to a topic we touched on a bit
25 earlier, you were giving us a list of the organisations
26 that you needed to liaise with in order to get the single
27 employer up and rolling and one of the organisations
28 I think you identified was the AMA?

29 A. Mmm-hmm.

30
31 Q. What was the AMA's role in relation to that
32 negotiation?

33 A. I think my - if my memory is correct, AMA was involved
34 in ratifying or, rather, endorsing our industrial relations
35 component of our contract. We had to devise a new contract
36 for these registrars, state employees, and AMA was involved
37 in giving feedback for that.

38
39 Q. The other issue we have heard a lot about is the
40 state/federal funding divide.

41 A. Yes.

42
43 Q. Does that present any particular challenges, as you
44 see it, to the delivery of health care in Finley and also
45 the wider LHD?

46 A. I think it is a significant problem.

47

1 Q. Why?

2 A. When it comes to people's health, you know, whether
3 state does it or federal does it, it doesn't really matter
4 to them. They worry about getting the best to them - for
5 them at that situation.
6

7 When you go out of metro, when there isn't as many
8 markets for service provisions, when, say, for example, in
9 Murrumbidgee, only after hours clinic in the whole of
10 Murrumbidgee is Wagga Wagga after hours clinic; there is
11 another small version of it which is a telehealth version.
12

13 So what happens is when there is fragmentation or
14 segmentation of what we need to do with our people, either
15 you duplicate things or you miss things, create gaps. So
16 that's what I have been seeing for the whole time that I've
17 been in Finley as a GP. The federal and state divide to do
18 the same thing or, rather, if the federal component is
19 strong and works well, there would be less impost on the
20 state component, to be honest, and the state component is
21 devised to look after acute care, but now has to go and top
22 up and do things in primary care because there isn't anyone
23 else to do that. So that is causing - in my opinion, it
24 causes financial challenges to the LHD because it causes
25 a significant burden to LHD's budget.
26

27 And the way how primary care is defined, it doesn't
28 allow the proper integration that we would love to see in a
29 rural community to happen. And then you need to look for,
30 you know, bespoke situations such as Finley/Temora type of
31 places, where the locals have got together and made it work
32 well. The system hasn't made it work well.
33

34 So my observation is that I don't think an Alam or
35 another doctor in Temora needs to be a champion in making
36 the system work well; the system needs to make those
37 clinicians work well. So we're doing the other way around
38 rather than what we should be.
39

40 MR MUSTON: I note the time, Commissioner. I know it is
41 not a regular breaking time but we did have a short session
42 in the morning and we're having a long one in the
43 afternoon. For the benefit of the people who are having to
44 take this down as much as for the witness, a short
45 adjournment might be --
46

47 THE COMMISSIONER: How long do you suggest? 10 minutes,

1 15 minutes?

2

3 MR MUSTON: I'm happy to meet the needs of others.

4

5 THE COMMISSIONER: If it is 15, will we still finish the
6 next witness as well?

7

8 MR MUSTON: I think so - how long do you think --

9

10 THE COMMISSIONER: He's going to take five minutes to
11 decide --

12

13 MR MUSTON: We'll say 10 minutes.

14

15 THE COMMISSIONER: -- let's take 15 minutes and we will
16 come back at 2.45.

17

18 **SHORT ADJOURNMENT**

19

20 THE COMMISSIONER: We are ready to resume. Can I just ask
21 a question before you restart.

22

23 Q. Just in that last question that Mr Muston asked you
24 about federal/state division of funding and you talked
25 about the difficulties as you - or you were talking about
26 the difficulties as you perceive it, one of the things you
27 said right near the end before we took the break was this:

28

29 *And the way how primary care is defined, it*
30 *doesn't allow the proper integration that*
31 *we would love to see in a rural community*
32 *to happen.*

33

34 Should I understand that to be, for better or worse, in
35 Australia, we tend to define primary care as the first
36 service you go to outside of a hospital or a specialist
37 setting, whereas I think I'm right, the World Health
38 Organization has a different view about what primary care
39 is, where it's a much more integrated series of services
40 that are to meet the health needs of the person? Is that
41 what you were talking about when you were talking about the
42 way that primary care is defined and that lack of
43 integration?

44

45 A. Yes. I think yes, in a way what I was trying to
46 say is, in the Australian context of general practice, we
47 are shackled with the Medicare billings and it is more
GP-centric. 95 per cent of our consults are seeing or

1 dealing with a GP. You see the equivalent in NHS in UK,
2 55 per cent of the consults are dealing directly with the
3 GP. If you look at how the Scandinavian system works, my
4 recollection of that is even better.

5
6 So meaning, GP has a pivotal role in giving leadership
7 for the primary care team, but there is a lot of other
8 people who can actually be involved and included in better
9 service provision, which is hindered by the way how this,
10 you know, what do you call bulk billing or rather itemised
11 billing works. So that doesn't get incentivised.

12
13 And then when you look at the funding divides how it
14 works through Medicare system in the primary care and then
15 Rural Doctors' Settlement Package or sessional hourly rate
16 in the hospital setting, it won't allow that, you know,
17 seamless approach to utilise the clinicians' work in
18 different settings easily.

19
20 The most significant issue comes is that, you know,
21 funding, the way you pay, or way you employ, the contracts,
22 they're all kind of siloed in a way. We can't make it work
23 together or, rather, we create - or on our own we create
24 a situation that we can't work together, and then we think
25 that's the best way to do it, and not changing it is my
26 main bugbear.

27
28 So in Finley, where you visited, where most of you
29 guys visited, if you look at a situation where primary
30 care - say, suppose, myself, okay, just take myself, if
31 I was remunerated as a staff specialist to run the Finley
32 health service which includes primary care, aged care and
33 acute care altogether, I would have had much more time to
34 teach the med students better. I would have had much more
35 time to train the international medical graduates and
36 registrars better. Right now, I have to focus on who comes
37 into my room and goes into my room because that's the only
38 way I can bill Medicare and that's the only way I'll make
39 my practice financially viable. If I don't do it, other
40 things will run, I won't get an earning.

41
42 So my practice, other people who are working for me,
43 get paid when I earn, when all the other doctors earn too.
44 So the way how it is set up is not the most conducive way
45 to grow the best.

46
47 That's one of the principles of why I was behind the

1 Murrumbidgee model in defining and helping Jill Ludford and
2 Len Bruce and others to get it going, because Murrumbidgee
3 model, in its core, recognises a medical student who has
4 a rural intent and follows through the whole pathway until
5 they become a consultant rural generalist GP to help them,
6 support them and find the right, you know, support
7 mechanisms.

8
9 There is a remuneration mechanism to do that. There
10 is a contract or contractual agreement to do it, there is
11 a system to do it. We don't have that.

12
13 MR MUSTON: Q. Do you think that the salary model would
14 operate as a greater incentive to rural generalists and/or
15 GPs with advanced skills to go into rural areas than the
16 market-based model currently does?

17 A. I would say yes, but I would want to make the focus a
18 bit beyond just merely the salary model.

19
20 Q. What are the other aspects of it?

21 A. I'll just explain this to you, if I'm not - if my
22 English understands well, you know. What I'm trying to get
23 is the process is not the game here. Purpose is the focus,
24 needs to be. Purpose needs to be about if two-thirds of
25 our workforce in the rural setting in New South Wales are
26 IMGs, how do we get those two-thirds of the medical
27 workforce useful for our hospitals setting and the
28 community setting? That's the - I mean, the purpose.

29
30 The process is taking priority about purpose at the
31 moment. You can see the Kruk review. The Kruk review was
32 on how IMGs need to be dealt with. If you look at all
33 those papers that they put across and then so many, seven
34 pages or so report that went to national cabinet, it says
35 "We will have one repository where they send all the
36 information. We will have the process streamlined better.
37 We will have more exam intakes. We will have more
38 assessments."

39
40 They're streamlining and purposing and making the
41 process better, but they aren't - for my perspective, as
42 a Murrumbidgee person, they aren't making the purpose any
43 focused, meaning, they haven't done anything to make
44 international graduates fit for purpose to work in
45 community hospital settings in my region.

46
47 If that's not done, how much better you do with the

1 process, it doesn't make a difference for me in another
2 five years' time, because I worry in another 10 years'
3 time, will there be ever a doctor in Berrigan, you know?
4 That would be an issue. How are we going to keep up with
5 the current trend and the challenges in another decade to
6 come? What is it going to be, our rural hospitals, in a
7 few years to come? Because the vast majority of all these
8 hospitals have aged care attached to them, community
9 nursing attached to them, some form of virtual care
10 attached to them. Then these things are good to continue
11 providing services and not letting service failure, but by
12 themselves, can't exist on stand alone. We need the
13 workforce, meaning the ED trained clinicians and the
14 medical workforce to be able to, you know, make it
15 sustainable, and we don't see that. We don't see that in
16 the plans of what we see.

17

18 Q. Would it be right to say that your focus on the
19 purpose means that a system should be looking to deliver
20 integrated primary health care across all of its
21 communities, and then working out as - within the system
22 how best to fund that, rather than allowing the funding
23 models --

24 A. Correct.

25

26 Q. -- to determine the way in which primary health care
27 and acute health care and aged care are going to be
28 delivered within a community?

29 A. Yes. I think you're right on the target, yeah.

30

31 Q. And does that mean that in some communities,
32 particularly in larger built-up areas, there will be
33 a perfectly viable market based model for the delivery of
34 primary health care to the community within that area?

35 A. Yeah.

36

37 Q. And it should be supported in as many ways as it needs
38 to be supported to maintain viability - yes?

39 A. Yes. That's correct.

40

41 Q. Work should be done as between the market based
42 deliverer of primary health care and the acute setting to
43 make sure integration between the two is maximised?

44 A. Yes, correct. I might rephrase it this way.

45

46 Q. Yes, please do.

47 A. Blacktown, Parramatta type of place, whether you do it

1 fee for service, MBS, or whether you do it, whatever the
2 way you do, it will work, because there is the workforce
3 for it, there is the people there, there is the competitors
4 for the businesses to thrive. You can't expect that to
5 happen in Finley. You can't expect that to happen in Lake
6 Cargelligo. So if you allow the same process that we
7 allowed in Blacktown and Parramatta to happen in Lake
8 Cargelligo or Hillston, it won't work.

9
10 Q. So in those areas where a market may not be able to
11 sustain the adequate delivery of primary health care to its
12 community, or to that community, do you see scope for the
13 state to step in and provide, in an integrated manner, the
14 delivery of that primary health care and thereafter enter
15 into whatever negotiations it needs to with the
16 Commonwealth about how collectively the state and the
17 Commonwealth might go about funding that endeavour?

18 A. I should say yes for that, but with a qualification,
19 though.

20
21 Q. Yes?

22 A. Because hospital system, LHDs, aren't good at
23 providing primary care. They are geared, or they are made,
24 to do acute care. So when there is service failure, they
25 pop up and do the patch-up thing for it, in a sense, fill
26 the gap. Not only in New South Wales, you can look at WA
27 and certain Far North Queensland type of situations, where
28 the hospitals are - hospitalists, are the primary care
29 provider. It works, it serves the purpose of that need at
30 that time. But hospital providing primary care is an
31 expensive deal, you get - I've been talking to a few other
32 colleagues about this. I told them, if you can buy
33 something for \$3, which is the standard, if you want the
34 hospitalist to provide for our primary care, you'll buy it
35 for \$15. It's very costly. It doesn't - it is very
36 difficult for me to explain, but if you look at data, it
37 will be very evident that providing - hospitalists
38 providing primary care is going to be very expensive model.

39
40 If NSW Health is looking at providing primary care in
41 market failure situations in a primary care perspective -
42 example, Four Ts example in western - and a single
43 employment model version in Murrumbidgee, similar to that,
44 if we look at primary care in that scope in hospital
45 setting, yes, it will. Otherwise, it might be a lot more
46 expensive, running it in a hospital setting, just an
47 example.

1
2 One other example about the numbers. If I'm a GP
3 seeing a patient, seeing patients in my practice, I see
4 about 25 to 30 people, and that's my routine. If I'm a GP
5 working on a sessional contract in a hospital, I can't see
6 more than 12 to 15 at a time, because that's the process.
7 So then you see the gap and that gap will amount to
8 a significant cost.
9

10 Q. Is there a role for the state, through an employed
11 model, to replicate the type of arrangement that a GP VMO
12 might be playing within a community? Would that solve some
13 of the problems of the hospitalisation of primary care?

14 A. Possibly, yes.
15

16 Q. So a GP much like yourself but employed by the state,
17 delivering primary health care through rooms in a small
18 town, with an obligation to, as required, provide what is
19 the equivalent of the VMO type services through the small
20 local hospital?

21 A. Correct, yes. I think --
22

23 Q. Would a scheme like that help some communities?

24 A. Yes, it will help some communities.
25

26 Q. And working out precisely what will serve one
27 community over another is going to be a very bespoke and
28 individual assessment?

29 A. Correct. Mmm.
30

31 Q. Which will take into account the needs of the
32 community?

33 A. That's correct.
34

35 Q. The viability of the market?

36 A. Yes.
37

38 Q. As it exists, and could potentially exist?

39 A. That's right. Look, that type of model will work in
40 some smaller towns - example, you know, Barham, Batlow type
41 of smaller towns. If you tried to do that in Cootamundra
42 or Tumut type of town, it will upset the existing market of
43 how things are happening.
44

45 I guess in principle, your concept is right, and that
46 should work, or, rather, will work, because there wouldn't
47 be other alternatives.

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Q. Can I ask you a question about that last comment you made around upsetting the existing market. I take it that that comment is directed at the possibility that if you set up a state-funded primary care service in a town or centre where there is an existing market of some sort, there would be a perception, perhaps a reality, that the viability of that market would be further undermined by the presence of the state funded service?

A. Correct. Exactly.

Q. How do we manage that situation, in your view, where the existing market may not be sufficient to provide the needs to an entire community? That is to say, do we not step in as a state to deliver primary health care within that community in order to protect a market which is already insufficient to serve the needs of the whole community within that small town?

A. Good question. Complex question. There is no one answer for it. I think the best answer is collaboration, because if you take an example, there is a good market for current general practice to exist but it is not sufficient for the demand. Many towns are like that in our region, and if there is better collaboration, we can do better.

Example, maybe this is right or not, wrong example, I'm not sure, but Deniliquin is one of the examples, right? Deniliquin has a good market for the GP practices to run a business and provide primary care. But they had quite a bit of a strain in providing hospital care, and they are still not taking any new patients - all the new patients are driving hundreds of kilometres away to see a GP for the last two and a half to three years.

My point, what I'm trying to get, is over the last few years, we were working in collaboration with GP practices in the town. Some GP practices don't want to work with us, some GP practices want to work with us very closely, so we decided to work with the ones who want to work with us very closely. Then we ended up into a situation where there is quite good co-habitations between the primary health care sector and the hospital sector, and we have no gaps there now to cover in the acute care setting.

I know there isn't enough appointments for general practitioners, but that is one very good example to the very similar situation that you brought up, and doable, and

1 the answer would be collaboration and communication with
2 the sectors better.

3
4 Q. Just before we had the break, you made the observation
5 that, in places like Finley and Temora, it's the locals
6 who've got together to make it work well; the system hasn't
7 made it work well.

8 A. Mmm.

9
10 Q. What is it that the locals are doing to make it work
11 well, first?

12 A. I think one is community focus, and both places, in
13 Temora and Finley, the council, the LHACs, many other
14 stakeholders came to one party in having one objective, and
15 in both places, making a viable, profitable general
16 practice wasn't the sole purpose of the business of it, and
17 in both places, our vision was the clinicians should be
18 able to do community general practice as well as the
19 hospital care and the aged care - that's the only way you
20 can have a place-based solution.

21
22 In both places, we had very good connections and
23 communication and collaboration with the LHD and the PHN.
24 So it comes to the fact that, as we all always know, which
25 is not rocket science kind of stuff, that where things
26 work - where things work together with lots of different
27 stakeholders in one - you know, towards one strategy or one
28 goal, it will work better; and where things work in silos,
29 where there isn't the leadership to do that, it might not
30 work that well.

31
32 Q. Is there anything you think the system could do, or
33 any changes that could be made to the system, which would
34 enable that sort of success to be revisited in other
35 communities that aren't lucky enough to have the right
36 people?

37 A. Yeah. I think system is not growing the right people
38 to do that. You know, you need to forcefully become the
39 right person to do it in this current trend - my feeling
40 is.

41
42 Q. How would the system go about growing the right
43 people?

44 A. If we had a GP VMO leadership in a lot of other towns,
45 other than Temora and what, Cootamundra, we would have had
46 better international medical graduates being trained and
47 got into hospital system and then we wouldn't have had the

1 medical workforce issues that we have right now, number
2 one.

3
4 Number two, if we had the GP leadership in some towns,
5 we would have had - we would have got to better utilising
6 of some of the PHN commissioning services or grants, some
7 of the new opportunities that we can deal with the local
8 health district, the primary care would have been a lot
9 more stronger and, you know, a kind of sphere heading in
10 the right direction if there was.

11
12 At this point in time, that leadership needs time,
13 focus and effort. That's not rewarded readily. That's not
14 rewarded everywhere readily, in the sense - I'm talking now
15 out of Murrumbidgee's context, you know? If you look at
16 rural/remote, the New South Wales context, that focus is
17 not happening.

18
19 Q. How could the system be rewarding it, do you think?
20 Or how should the system be rewarding it?

21 A. I think that's what I'm coming up to. I'm trying to
22 say that we're not incentivising the leadership roles. We
23 are not, you know, recruiting or, rather, growing the
24 leaders to come to that position. We're just waiting and
25 seeing if somebody is popping up, then, okay, let's go with
26 that kind of situation.

27
28 So maybe I should just put this example this way,
29 though. If there is a classroom of students who are kids
30 of professionals and teachers and coming from a bit of
31 a higher or middle socioeconomical group, that classroom
32 will perform a lot better, and you will see performance
33 indicators, with time, far better, and outcomes at the end
34 of the day will be better.

35
36 If a classroom of students who are challenged with
37 certain socioeconomic contexts, didn't have the background
38 or influence from their parents as much as the other
39 classroom that I was talking about, you will end up with,
40 you know, less quality or standard than the other. But
41 they will all perform okay at the end, right? They will
42 all be good citizens and stuff, but that classroom will do
43 better than this.

44
45 I think our medical workforce in rural/remote is also
46 very similar to that. Over the past decades, or few
47 decades, we've let the ball fall and we've grown up

1 a situation - to a situation that we are creating people
2 who are providing high-volume, low-value care, rather than
3 providing - you know, creating people who really want to
4 look after communities. So when you do that, after a few
5 decades, you'll end up not the standard outcome that we
6 would want to.

7
8 So I used that analogy, without using personal
9 stories, to show that, you know, that is what happens, and,
10 like what I said, there is vast majority of us are IMGs.
11 Who employs IMGs? We employ IMGs. Past IMGs who are not -
12 who are citizens and established practitioners now employ
13 IMGs too. So this is a vicious cycle, you keep going, and
14 I think as a system, federal and state governments can have
15 a role in making it right, say, for - if school system is
16 not working well, you've changed the curriculum to make it
17 work well; like that, you can make this work well too. But
18 we're so focused on process. We're so focused on process
19 rather than purpose.

20
21 Q. In terms of that workforce and perhaps the classroom
22 that we're dealing with within the LHD, what's the impact
23 of locums and agency staff on the composition of that
24 classroom, as you said?

25 A. Locums are necessary. You can't exist without locums,
26 because locums are going to be an integral part, no matter
27 what.

28
29 What we are dealing with now is not locums; what we
30 are dealing with now is a locum becoming a fashion, so that
31 you can game the system to make more money by doing less
32 work. That's my personal opinion. So we have allowed the
33 market forces to define this story. Corporates and certain
34 locum agencies can, you know, challenge us with what
35 actually costs for exorbitant prices.

36
37 So now, we're not only dealing with what locum is;
38 we're dealing with a different business force or market
39 force with locums in the name of locums in this situation.
40 That is a bit troubling.

41
42 You know, I don't see a lot of locums in my context
43 because, around my area, we don't get a lot of locums. In
44 smaller hospitals such as, you know, Berrigan, Tocumwal, if
45 there's no doctor, there's no doctor, you know, you just do
46 a virtual doctor instead. You can't put locums there.
47 There isn't enough work for a locum to see one or two

1 patients per day.

2

3 But I see this a lot with the nurses. A lot of my
4 nurses who are working with us are telling, "What's the
5 point?", quit the job, work as the agency or a locum
6 instead, and I see many of my senior nurses are going and
7 working as locum for about two or three weeks in the
8 Northern Territory and Queensland and different other
9 places and they come back and they'll work a few shifts
10 here and there.

11

12 So it is affecting the nursing workforce from my
13 perspective a lot more than the medical workforce, and
14 people who we lose for locum are the senior nursing
15 colleagues. Senior nursing colleagues are important as
16 much as the senior GP supervisors. So we're losing that
17 part too.

18

19 Q. Is there anything that the system could do to try and
20 arrest that loss of senior people to the agency or locum
21 market?

22 A. Standardising prices and, you know, blocking where
23 LHDs could compete with each other with, you know, pricing,
24 and looking at issues, such as when there is a locum who
25 wants to come and work, tell them "Look, don't apply for it
26 right now, just leave it, leave it till the last moment,
27 then you will get emergency rates. That's better rates
28 than the rates that you would get now", that kind of, you
29 know, gouging, gaming the system. You can identify them.
30 They can be worked on.

31

32 I guess as a system, there is lot that we can do,
33 a lot we can do to eliminate negative aspects of the locum
34 business at the moment.

35

36 Q. Is it your view that a more centralised approach to
37 the contractual arrangements between agencies and the state
38 would potentially enable some of that change to be done?

39 A. Yes and no, though. I think centralised version would
40 be good in a way with pricing and reducing competition and
41 making use of things. No, is it'll add a lot of
42 bureaucratic process, and one of the main things about
43 locum, getting locum into gaps, is that you can get them
44 without going through a whole heap of bureaucratic process
45 that has to go through normal recruitment pathways. So if
46 you add that up, then you end up, you know, stagnating the
47 process. So I think if there is a way that you can get

1 good off both sides, yes.

2

3 Q. We've spoken a lot about the single employer model.
4 As it's currently rolled out one the Murrumbidgee LHD, do
5 you think it is sufficient to meet the demand or the needs
6 of the community in the primary health space?

7 A. No.

8

9 Q. How much bigger do you think it would need to be in
10 order to better meet the needs of the community?

11 A. I wouldn't know to answer how much, but I'm aware that
12 it is certainly not, because we embarked in Murrumbidgee
13 model as a pilot of five. We weren't, deciding that number
14 of five based on - based on a need basis; it was just
15 a picked up number, five, right? So that's how it was
16 designed, because that's the only way we could get to the
17 next step: okay, we will do it and show it, it can work.

18

19 Now it's working, now it's gone into regional health
20 division, so they've got two divisions, two sectors that
21 they're going to be introducing the employment model,
22 looking at embarking on employing 80 people. Of that whole
23 region of 80 people there they want to send, I think
24 there's only 54 registrar positions. Even if we had 80
25 people, we wouldn't have been able to employ more than 54
26 because there's only 54 registrar positions in the areas we
27 wanted to send them.

28

29 Q. What's the blockage there? Is it the RACGP?

30 A. Accredited positions. And then the biggest thing is
31 from that - the biggest thing is even out of those 80 - 50
32 or so many positions, I think only about 40 per cent get
33 filled because no-one is there to come and work, because we
34 belong to this whole area of Canberra, Southern,
35 Murrumbidgee, Far West, that whole big sector, the vast
36 majority of our registrars are around - in Canberra or
37 around Canberra. We have only got very little, right? So
38 per year, per year, Murrumbidgee will have 12 to 16 AGPT
39 Australian-trained doctor registrars, who are coming into
40 our sector. Last year it was less than 10, very less. The
41 year before it was less than 10, very less.

42

43 So what we are seeing is, we're having less
44 opportunity to send our graduates, who have been through
45 our rural clinical school, our base hospital in Wagga, to
46 go into general practice training, to become rural
47 generalists. That's one of the aspects the single

1 employment model wanted to change, because we will decide
2 our people's destiny through the Murrumbidgee model by
3 doing that. We will send them to the right places. We've
4 got that upper hand with the single employer model
5 Murrumbidgee model, and with time to go, I think states
6 will have - the New South Wales state will have that, but
7 it is still in its infancy of starting up.

8
9 Q. Under the current Murrumbidgee model, though, is it
10 right that the registrars are trained in a salaried
11 position, but at the end of their training - do they remain
12 in a salaried position or is it hoped and expected that
13 they will transition from the single employer model out
14 into the market based delivery of primary care within the
15 region?

16 A. Yes, that's correct. Once they finish their training,
17 they are a consultant and they'll go through the normal
18 process that we have. At the moment, there is no single
19 employment model that we have for the registrars who are
20 completing the pathway, and - because we couldn't define
21 that in our pilot, because our pilot was exclusively a
22 training pathway. Once you've finished the training
23 pathway, the pilot wasn't talking about it.

24
25 Q. Through your knowledge of the pilot, at least thus
26 far, do you have any sense of a strike rate in terms of the
27 number of participants in the pilot who you think will
28 likely move into the market based delivery of primary
29 health care within the LHD?

30 A. To date, everyone who has completed has come into the
31 current existing models of recruitment and they're happy
32 with it. And they would - some of them would prefer
33 a salaried model, but given that we don't have a salaried
34 model, they are content with what we are having now,
35 because if you really go into the details, there's not
36 a lot of big difference, except for less administrative and
37 paperwork.

38
39 But, you know, given that we have states, such as
40 Queensland, which is making it much more attractive for
41 a salaried model hospitalist, that type of hospitalist, we
42 might end up losing people to it, but that is how it works,
43 to be honest.

44
45 I think what we know with the single employment
46 Murrumbidgee model is almost everyone who completed are in
47 rural/remote, meaning MMM4 and above, and we have more than

1 90 per cent retention rates at the moment, and everyone had
2 stayed in Murrumbidgee, as yet, except for one. The one
3 who left Murrumbidgee also went to Thursday Island, you
4 know, a much more rural setting. So we are very happy with
5 where we are.
6

7 Q. So we've probably already covered this, but in terms
8 of your knowledge of the candidates who have been through
9 the model, and particularly those who you have suggested
10 might prefer a salaried model, at least conceptually, do
11 you think the existence of a salaried model might enable
12 them to be placed in areas where - communities where the
13 market based model is simply not functioning?

14 A. I would say yes, but if you asked the same question
15 from the registrars and the new generation, they would have
16 a very resounding yes.
17

18 Q. In terms of collaboration that various entities do,
19 can I ask, does the collaboration within the LHD and PHN,
20 as you experience it, draw in the Aboriginal community
21 controlled health organisations, like RIVMED?

22 A. Yes. I think our LHD has a significant focus on
23 Indigenous health. We work very closely with RIVMED and
24 GAMS in Griffith, and we - GAMS is supporting the Hay
25 Aboriginal health service, and we have been working very
26 closely with the community in Brungle, in Tumut, so our
27 dealings and, you know, negotiations are very strong and
28 have been happening for quite a long time.
29

30 I think it comes up from the premises of where our CE
31 is quite strongly involved with RMRA. I don't know what
32 RMRA stands for, that's the core Indigenous body which
33 advises on certain stuff related to health, education and
34 a lot of other things in this region. So I know Jill is
35 quite, you know, involved with RMRA, and the PHN has
36 a particular interest in doing things with the Indigenous
37 community. So that's a good thing for us.
38

39 Q. What about the collaboration with aged care and the
40 private aged care sector?

41 A. Private aged care sector had a lot to do with us
42 during COVID time, because they had issues with, you know,
43 infection control, public health related stuff. Our
44 dealings have strengthened and got a lot better.
45

46 Usually, in general, normal pathway, there is not
47 a lot of dealings between the LHD and the private aged

1 care, but, you know, LHD by itself is the biggest aged care
2 provider in the region. You know, you think what - I think
3 we've got about 3,500 aged care beds in the whole of
4 Murrumbidgee, including Albury-Wodonga, and of that, we own
5 400 plus aged care beds, and I don't think there is any
6 aged care provider as big as that in the whole of the
7 district.

8
9 So aged care becomes a significant component of - you
10 know, number of aged care beds is bigger than Wagga Base
11 Hospital's aged care beds - sorry, Wagga Base Hospital's
12 total beds. So aged care is a significant role that we
13 have to play. But our involvement is through MPSs and
14 SRACFs, state run aged care services, such as - in Leeton
15 is the only one, if I'm not mistaken, I think Leeton and
16 Corowa is the only state run aged care services that we
17 have in the district. All the others are MPSs now.

18
19 Q. We have heard some evidence about the impact on the
20 private aged care sector and aged care facilities run by at
21 least one local council of the different awards and
22 structures that exist across the various sectors for
23 nursing staff.

24 A. Yes.

25
26 Q. Do you see that the different conditions and awards
27 are an impediment to collaboration between the private aged
28 care sector and the state to try and deal with some of the
29 workforce crises in relation to nursing staff?

30 A. Yes, in a way, because --

31
32 Q. What way?

33 A. -- smaller towns such as Coolamon and Finley type of
34 places, many private aged care nurses who get used into the
35 Australian health system do come into the hospital system
36 at the end. So actually, private aged care nurses are our
37 patch of recruitment for some time.

38
39 Maybe it might not be the case now, because after the
40 new Royal Commission in aged care and, you know, wages
41 anomaly being fixed, we might not be that attractive in the
42 future. But for some time, we were more - LHD was more
43 attractive than the private aged cares, I agree. But the
44 calibre of people that we employ and they employ were
45 different, but that was the stepping stone for some
46 internationally trained nurses, to come into aged care in
47 the private sector and then move into the hospital sector.

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Q. Do you see scope for collaboration between the two sectors to try and collectively harness and utilise a pipeline of --

A. Yes, possible, yeah. I think --

Q. -- nurses, for example?

A. -- why not? It should.

Q. The last question I have for you relates to extent to which research and clinical trials and the like are run within the district. You gave some evidence a while ago about a patient who might have to drive a very long way to participate in a medical trial, might say. "Why would I do that", but first of all, is there much in the way of medical trials and research happening in the region at the moment?

A. Look, medical trials is not my area of expertise, but I'm aware that there is paucity in access to different medical trials, because some of my patients are well enough to go to Peter Mac in Melbourne for their cancer treatment, some of them aren't, so they end up in - locally in Albury-Wodonga or Shepparton, a startling difference, and there's a difference --

Q. Startling difference between --

A. Startling difference in quality of care, quality of care, yeah.

Q. Between Peter Mac on the one hand --

A. Yeah, plus --

Q. -- and Albury and Shepparton on the other?

A. Yeah. If you take - just take Shepparton as the example, Shepparton versus Peter Mac, I see a difference in quality of care and I see a difference in opportunity for different options in clinical trials compared to - Peter Mac to Shepparton.

And I'm of the view - I'm of the view that if we can incentivise medical schools, saying, "If you take this many rural based students we will fund you more positions" or "we will give you more money", we could always tell our metro-based cancer centres to say that "If you do this well and collaborate with rural sites to do better with providing better access to clinical trials and better care, we will incentivise you in this way", I think it will work,

1 because that's a carrot and stick approach.

2
3 I know I did say that to you on preparation, as my
4 evidence, too, hence I spoke to the oncologist in Albury
5 before I came here, saying, "Look, does that actually make
6 sense if I say that?" He said, "Yes. He said, "Yes", and
7 then he said, "Teletrials", such as, you know, you can do
8 clinical trials using virtual and face to face together,
9 and if you will eliminate some of the geographic narcissism
10 in, you know, whose patch, who owns what, we could do
11 better to provide better care for our people.

12
13 Q. And that would be to the benefit of patients living in
14 your region in your little area in what way?

15 A. In the way of better life expectancy; better
16 involvement in decision-making and better care; access to
17 otherwise not available medication through routine,
18 standard process; access to more regular intensive
19 investigations sometimes.

20
21 We talk about clinical trials a lot, about cancer
22 patients, because that's where it's more concentrated.
23 I think it is time that we get out of it and talk about
24 clinical trials about doing a lot of other things, with,
25 you know, primary care and secondary care and many other
26 things. But I think - I personally think we can do a lot
27 better than what we are doing now.

28
29 Q. That's the patients. In terms of recruitment of
30 a medical workforce to regional areas, do you think
31 a greater reach of that medical research and trials into
32 the regions would have any impact on the recruitment of the
33 medical workforce to your areas?

34 A. Yes. I think more than medical workforce, when you
35 talk about research and clinical trial, if there is an
36 expert on this, they will tell you better, but from what
37 I heard from my oncologist colleague in Albury, is that
38 what actually matters is administrative support and
39 clinical trial expertise, research and funding related
40 support. More than the medical workforce by itself, other
41 accessories in place to make the existing medical workforce
42 do clinical trials and provide better care for patients is
43 what - what matters, than getting more oncologists or more
44 clinicians to do it.

45
46 MR MUSTON: Thank you, Dr Yoosuff. I've got no further
47 questions for you. The Commissioner or Mr Chiu might.

1
2 THE COMMISSIONER: Yes, Mr Chiu?

3
4 **<EXAMINATION BY MR CHIU:**

5
6 MR CHIU: Q. Dr Yoosuff, my name is Chiu and I represent
7 NSW Health in this Inquiry. I just wanted to ask you a few
8 questions about that issue of how you see the role of the
9 state, ie, NSW Health, including the districts, in primary
10 care. You recall there were some questions about that. As
11 I understand your evidence, you see the role of the
12 district, and potentially more broadly NSW Health, as one
13 of identifying where there are gaps; that's correct, that's
14 one thing?

15 A. Mmm-hmm, yes.

16
17 Q. Coordinating what is there, but also to bring things
18 that are new to meet those gaps; is that correct?

19 A. That's correct.

20
21 Q. Facilitating that coordination so that it works better
22 together and continues to work into the future?

23 A. That's correct.

24
25 Q. And potentially stepping in to train, to bring in
26 workforce, to fill in those gaps as well? Those sorts of
27 things?

28 A. Yes. I would say - I would say NSW Health facilities
29 such as in Murrumbidgee and certain places has no other
30 alternative, other than providing primary care through the
31 acute care settings in places where there is certain market
32 failure. We've got no option.

33
34 Q. But you see that as a last resort when all of those
35 other steps fail?

36 A. At the moment, the way how it works is it becomes the
37 last resort. But what I see is that it is inevitably going
38 to happen and it is on the horizon that it will happen, so
39 we might as well get ready to do it properly rather than
40 becoming a last-resort situation. That's my feeling.

41
42 Q. Yes.

43 A. I think we can do better in a way that we are ready or
44 we are - how do I put it? I think we can do it better in a
45 way that we recognise the fact that there will be certain
46 places where no viable marketplace would exist, and unless
47 for state or a federal entity to go there and set up, there

1 wouldn't be anything else exist possible.

2

3 Q. So other than in those situations, though, I think you
4 gave some evidence earlier that that is actually not the
5 most efficient way to provide primary care, if it can be
6 avoided?

7 A. That's correct. I think hospitalists providing
8 primary care is not the best deal, from what I can see.
9 I might be wrong, but I don't see that is going to be
10 cost-effective.

11

12 THE COMMISSIONER: That's a different thing, though.

13

14 MR CHIU: Yes.

15

16 Q. But in a sense, the models that you have provided,
17 such as the single employer model and the collaborative
18 commissioning process in Murrumbidgee are ways of trying to
19 facilitate what's already there to avoid a situation where
20 you do have to step in?

21 A. Correct. Yes. They are, you know, initiatives that
22 try to get many people collaborating, yes.

23

24 Q. So in an ideal world, you would see the district and
25 NSW Health's role more as one of leadership rather than
26 ownership of primary care?

27 A. In market failure situations, yes. Say NSW Health
28 can't be - my opinion - my opinion - NSW Health can't be
29 the primary care leadership role in Blacktown or
30 Campbelltown.

31

32 Q. But in a regional area?

33 A. But in Hillston or Lake Cargelligo, yes.

34

35 Q. It needs to take a leadership role?

36 A. Yes.

37

38 Q. And one of the challenges is, rather than have that
39 leadership role develop organically, if there are
40 personalities to do it, it needs to be a more systematic
41 approach in regional areas --

42

43 THE COMMISSIONER: What is a leadership role as distinct
44 from --

45

46 MR CHIU: Q. So we had identifying the gaps,
47 coordination, facilitation, things like collaborative

1 commissioning and single employer model. You understand
2 those to be what I mean by a leadership role?

3 A. I think they're innovative approaches, my
4 understanding is.

5
6 Q. Innovative?

7 A. Innovative approaches, and NSW Health would need to
8 take such innovative approaches and make it business as
9 usual with time to come, and that's one way that we would
10 face the avalanche of many smaller towns having market
11 failure issues. That's my feeling.

12
13 THE COMMISSIONER: Q. I mean, if there is market failure
14 of primary care and the state does nothing and the
15 Commonwealth does nothing, what happens?

16 A. You will see more people in hospital. And whoever
17 comes to our door, we'll have to provide.

18
19 MR CHIU: Q. Ultimately the question that we all face is
20 how do we avoid that failure or how do we solve that
21 failure? Do you agree with that?

22 A. That's right. Look, that's a complex question.
23 There's no one answer for it. But, you know, being
24 cognisant of that is happening is an important thing too.
25 I don't really think we are 100 per cent there. We're not
26 realising that this is happening and this needs attention.
27 You don't need a lot - information on that, for example -
28 I'll give you an example, you know, out of 250,000 people
29 in Murrumbidgee, 150,000 people come to the emergency
30 department, right?

31
32 In Sydney Local Health District, out of 800,000
33 people, only 40,000 per 100,000 come to the emergency
34 department, right? In Murrumbidgee, 60,000 per 100,000
35 come to the emergency department. You see the startling
36 difference. Meaning, our emergency departments have become
37 a default primary care providing place already, already.

38
39 THE COMMISSIONER: Q. Because the Sydney LHD has
40 a competitive general practice market; right?

41 A. That's right, yeah. So what I'm trying to point out
42 is we already are providing primary health care service in
43 the name of ED care or hospital care in our smaller towns,
44 non base hospital towns, and we've got to recognise that
45 this is a problem and it is going to only grow and then --

46
47 Q. Because ideally, that's for acute care?

1 A. That's correct. That's correct.

2

3 MR CHIU: Q. Yes, and it's an inefficient way of
4 providing primary care?

5 A. Correct.

6

7 Q. An expensive way of providing primary care?

8 A. That's correct. It is expensive, yes.

9

10 MR CHIU: No further questions.

11

12 THE COMMISSIONER: Anything arising out of that,
13 Mr Muston?

14

15 MR MUSTON: Just very quickly.

16

17 <EXAMINATION BY MR MUSTON:

18

19 MR MUSTON: Q. You gave an answer or were asked
20 a question about whether you saw a state stepping into the
21 delivery of primary care as a last resort when all other
22 steps have failed and the answer you gave was:

23

24 *At the moment ... how it works, it is*
25 *because --*

26

27 THE COMMISSIONER: Can you just give me a line so I can --

28

29 MR MUSTON: I'm sorry. It's 1627, line 28.

30

31 THE COMMISSIONER: Thank you.

32

33 MR MUSTON: Q. Your answer was:

34

35 *At the moment, the way how it works is it*
36 *becomes the last resort. But what I see is*
37 *that it is inevitably going to happen and*
38 *it is on the horizon that it will happen,*
39 *so we might as well get ready to do it*
40 *properly rather than becoming a last-resort*
41 *situation. That's my feeling.*

42

43 Am I right in my understanding that the "last resort"
44 situation that you are talking about is a situation in
45 which the market has completely failed in a particular area
46 and that community has been, for some period of time,
47 without adequate primary health care? Is that --

1 A. Correct.

2

3 Q. That's the last resort?

4 A. Correct, yes.

5

6 Q. So dealing with it, to use your terminology, as a last
7 resort measure, you wait until it's failed and people have
8 been denied or unable to access the health care they need,
9 and then you step in and try and fix it?

10 A. Yes. If you - look, I think --

11

12 Q. I'll let you elaborate, but can I just ask this
13 question?

14 A. Yes.

15

16 Q. Is your suggestion that we should actually be
17 planning, aimed at saying we should be looking at providing
18 solutions to this problem before we endure a period where
19 people are unable to access the primary health care that
20 they need, rather than sitting back and waiting until it's
21 going to happen, or until it happens, I should say?

22 A. Yeah, look, I think it is a complex question. I don't
23 think I have a right answer for it. But what I'm trying to
24 get to is what you said is correct, we do wait till market
25 failure happens and then see the burden on us and then pick
26 up on it, and it's a two-way process, though.

27

28 If we get to know about it early, we would start
29 stepping in, and if we get to know late, it might be late
30 to step in. But we, as an LHD - I'm talking about we as an
31 LHD - can't set up primary care services at this current
32 method that we deal with. So we won't go and set up a GP
33 practice, nor we will run a GP practice through an
34 emergency department. But what will happen is if there is
35 no doctor in town, eventually, patients will travel far
36 away to get a doctor. If they can't get, they'll come to
37 the local hospital emergency department and our nurses and
38 our virtual doctor will provide the gap service there. So
39 that's what I meant by saying that bit. But my prediction
40 is, with time to come, we'll have more trouble than what we
41 already have.

42

43 Q. You said a minute ago that we can't do it with the
44 current system. There are models like the Four Ts model
45 where it has been done by adjusting the system to fit that
46 model?

47 A. Mmm-hmm.

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Q. And so it's possible that the state can develop a system to deliver that primary health care through a salaried model and then negotiate with the Commonwealth about the way in which that's going to be funded as between them?

A. Possible, yes.

Q. And where market has not provided adequate or is unable to provide adequate health care to a community, that would produce superior health outcomes for that community?

A. That's correct.

Q. You were asked several questions about the delivery of primary health care by the state, and I think it was put to you a few times that the delivery of primary health care by the state was inefficient or less efficient, or the least efficient model. Just so we have a clear understanding of your evidence, the inefficiency exists, is it right, where that primary health care is being delivered in an acute setting through an emergency room?

A. That's right.

Q. There's no inefficiency or greater inefficiency associated with a salaried GP practice model, as it were - that would be no more or less efficient than a market based GP practice model, would it, in terms of the costs required to deliver that service; it's just that the funding would be coming from a different source?

A. I think even that is going to be inefficient, or, rather - I would say - not use the word "inefficient", I would use the word "costly", than what normal general practice would deliver, for the fact that --

Q. Is that because the support services around the practice would be funded by the state and not by the practitioner who, through a viable market, is able to accommodate those costs?

A. Correct, yes. That's right.

MR MUSTON: Thank you. I have no further questions.

THE COMMISSIONER: Thank you. Nothing arose out of that?

MR CHIU: No.

THE COMMISSIONER: Thank you very much, Doctor, for

1 coming, and we really appreciate your time and your
2 evidence. You are excused.

3
4 <THE WITNESS WITHDREW

5
6 MR GLOVER: I call Professor Lenert Bruce.

7
8 <LENERT DESMOND BRUCE, sworn: [3.44pm]

9
10 <EXAMINATION BY MR GLOVER:

11
12 MR GLOVER: Q. State your full name for the record,
13 please?

14 A. Lenert Desmond Bruce.

15
16 Q. You are the executive director for medical services
17 for the Murrumbidgee Local Health District; correct?

18 A. That is correct.

19
20 Q. You've held that role since 2020?

21 A. That's correct.

22
23 Q. You're also the general manager of the Wagga Wagga
24 Base Hospital; is that right?

25 A. That's correct.

26
27 Q. And you assumed that role in about April 2023;
28 correct?

29 A. That's correct.

30
31 Q. Are you affiliated with an educational institution?

32 A. Yes. So I hold an academic appoint with the Charles
33 Sturt University for their rural medical school.

34
35 Q. What role do you perform in that appointment?

36 A. So I'm the head of the Riverina campus, which is the
37 Wagga based campus.

38
39 Q. And in your role at that campus, do you oversee the
40 delivery of training?

41 A. Yes, I do support education of medical students but
42 I also teach for UNSW as well.

43
44 Q. Just dealing with the Riverina campus, what training
45 and education is delivered on that campus?

46 A. So we have medical students that start off at Orange,
47 so they do normally their first and second year in Orange

1 and then they move to a different number of campuses
2 throughout New South Wales. So in Murrumbidgee we have
3 a campus in Griffith and Wagga; the Griffith campus is
4 managed separately. There's also students in Albury. And
5 then they would, you know, start with us in third year, do
6 a number of rotations. Probably what is unique is there's
7 a big focus on rotations in general practice and in primary
8 care that does not only include the medical component of it
9 but, for instance, the medical students will rotate through
10 the ambulatory care service at Wagga Base Hospital where
11 they will go to the rapid access clinic but they'll also
12 accompany the nurses that do "Hospital in the Home" to do
13 home visits to actually see what care is provided in the
14 home. The students rotate through the Aboriginal medical
15 service, where they get exposed to the full scope of
16 services provided to the Indigenous community.

17
18 Q. And are these students able to complete their entire
19 training in rural and regional settings?

20 A. They can, yes.

21
22 Q. That's prior to moving on to specialist pathways; is
23 that correct?

24 A. Yes.

25
26 Q. And you mentioned you do some teaching for UNSW?

27 A. That's correct, yes.

28
29 Q. Where do you do that?

30 A. So I do that at the campus at Wagga Base Hospital. So
31 I'm an anaesthetist by clinical background and I've also
32 been teaching basic sciences since 1995, so I'm in my 30th
33 year of teaching basic sciences, I have an interest in
34 physiology and pharmacology.

35
36 Q. Can you just describe in general terms your day-to-day
37 responsibilities as the executive director for medical
38 services of the district, please?

39 A. Yes, so as the executive director of medical services,
40 my role is to provide strategic advice to the chief
41 executive, the other members of the executive and also to
42 the directors of medical services at Wagga Base and
43 Griffith Base Hospital.

44
45 A lot of that is really supporting the medical staff
46 to be able to deliver care to patients. A large part of
47 the role is credentialling and scope of practice for

1 medical practitioners, because I chair the appointments,
2 a component of our medical and entry advisory committee.

3
4 Q. Let's just break that up a little. When you say you
5 that your role is to provide strategic advice to the chief
6 executive and other members of the executive, what sort of
7 topics are you providing that advice on?

8 A. Well, it really depends. There would be industrial
9 matters, which is probably the bulk of the work we do.
10 Part of it is also service needs analysis, what type of
11 medical staff do we need, the numbers of staff we need,
12 what is the best way to engage them, you know, what
13 instrument is most appropriate.

14
15 I obviously also meet with the ministry. I also
16 represent the MLHD in the liaison committee, with the Rural
17 Doctors' Association, of NSW Health.

18
19 Q. This is all in the workforce space; correct?

20 A. That's correct, yes.

21
22 Q. You mentioned in your earlier answer credentialling
23 and scope of practice for medical practitioners?

24 A. That's correct, yes.

25
26 Q. What is your role in the credentialling process?

27 A. So I'm a member of the credentials committee and
28 I chair the appointments committee.

29
30 Q. So what does that committee do?

31 A. Well, so what we do is we actually determine the
32 services that senior medical and dental staff can provide
33 in the Murrumbidgee Local Health District. So all
34 specialists are credentialled through MDAAC. Locum medical
35 staff don't go through the formal credentialling process
36 but there is a more streamlined process for them.

37
38 Q. So this is a process that identifies the particular
39 functions that particular specialists can perform within
40 the district's facilities; correct?

41 A. That's right. And it's also determined by the site
42 where they practise.

43
44 Q. Why?

45 A. Because facilities have different role delineation, so
46 the classic example is that a clinician may be able to do
47 oesophagectomy at Wagga Base Hospital but when they

1 credential to provide services at Young, that is not within
2 the scope of that particular facility.

3
4 Q. Because of the nature and --

5 A. And the resources required to do the particular
6 procedure. It's a bit of an extreme example but, you know,
7 it is just the - it's not that the doctor cannot do it but
8 it's probably not appropriate at that particular site.

9
10 Q. And you mentioned in your earlier answer scope of
11 practice for medical practitioners. What is your role in
12 that process?

13 A. So I'm part of the credentials committee and we're
14 very lucky that NSW Health now has a model scope of
15 practice document that we utilise as the basis, and that's
16 normally something that's discussed during the interview
17 process, but it really determines what particular
18 procedures or type of work a clinician can conduct in
19 Murrumbidgee.

20
21 Having said that, the model scope for general practice
22 is not available yet, so for, you know, for GP VMOs, we
23 have a scope of practice for GP obstetrics in Murrumbidgee
24 and we also follow the previous JCC guidelines for GP
25 anaesthetists.

26
27 Q. Is it conceivable that a particular specialist might
28 be credentialled to do a certain type of procedure in your
29 district but may not be credentialled to do that in another
30 district?

31 A. It would be difficult. It really would depend on if
32 the facilities are like for like. You know, I expect that
33 if we felt that a doctor can do a procedure at Wagga Base,
34 if you had an equivalent hospital, they should be able to
35 do it. Sometimes, though, having procedures has got other
36 impact in terms of funding the cost of procedures, so
37 a particular health service may decide not to do
38 a particular procedure.

39
40 Q. So there might be all sorts of influences on the
41 credentialling decision that is in addition to the
42 particular qualifications and skill of the individual
43 specialist?

44 A. That's correct, yes.

45
46 Q. In preparation for giving your evidence today, an
47 outline of your anticipated evidence was prepared; correct?

1 A. Yes, that's correct.
2
3 Q. Do you have a copy of that with you?
4 A. No, but I'm happy to --
5
6 Q. I can give you one.
7 A. Thank you.
8
9 Q. You've seen that document before?
10 A. I have, yes.
11
12 Q. Have you read it before giving evidence this
13 afternoon?
14 A. I have.
15
16 Q. Is it true and correct?
17 A. Yes. It looks - let me have a look --
18
19 THE COMMISSIONER: Q. You have read it before,
20 Professor?
21 A. Yes.
22
23 MR GLOVER: Q. It accurately reflects the evidence
24 you're prepared to give to the Commission; correct?
25 A. Yes.
26
27 MR GLOVER: Commissioner, I propose to tender it in due
28 course. Perhaps it can be MFI 2 for the moment and we'll
29 wrap it up.
30
31 THE COMMISSIONER: Certainly thanks.
32
33 **MFI #2 OUTLINE OF EVIDENCE PREPARED BY PROFESSOR BRUCE**
34
35 MR GLOVER: Q. Go to paragraph 4, Professor Bruce, of
36 this outline.
37 A. Mmm-hmm.
38
39 Q. There you describe a number of challenges, or you
40 identify that the district experiences a number of
41 challenges in attracting medical doctors and graduates; do
42 you see that?
43 A. Yes.
44
45 Q. I take it you refer in that paragraph to "medical
46 doctors and graduates" because that is the focus of your
47 work; correct?

1 A. That's correct.

2

3 Q. And are you aware whether similar challenges are
4 experienced in relation to nursing staff and allied health?

5 A. We definitely face challenges in the context of
6 nursing staff and allied health. In my other role as the
7 general manager of Wagga Base Hospital, we do experience
8 challenges in recruiting especially specialised nursing
9 staff, so nursing staff experienced in intensive or
10 critical care, perioperative nursing staff, and
11 particularly - some particular allied health professions is
12 also challenging for us.

13

14 Q. Are those challenges similar or different to the
15 challenges that you refer to in attracting medical doctors
16 and graduates to the district?

17 A. I think some of the challenges can be similar but it
18 would depend on individual circumstances. I think in terms
19 of medical practitioners, there's a larger risk of being
20 a sole practitioner in a very stressful and complex
21 situation, while for allied health staff, they would
22 normally be part of a slightly larger group or even
23 a connected service. But once again, though, if they need
24 support from a medical officer and there's no medical
25 officer in town, that will, you know, definitely impact
26 their abilities to provide services.

27

28 Q. The challenge that you identify in that paragraph of
29 the nature of the location, that being its rurality, would
30 be common; correct?

31 A. Yes.

32

33 Q. Other than the challenges of the remote geographical
34 location and on-call responsibilities, are there any other
35 challenges in particular that you face in your role in
36 attracting medical doctors and graduates to the district?

37 A. Well, there's definitely the risk of professional
38 isolation, you know, if you're the only practitioner in a
39 town, it can be quite lonely and you'll sort of carry the
40 emotional burden of the medical services for that town.

41

42 I think having time off, as Dr Yoosuff discussed
43 previously, time to do, you know, continuous professional
44 development or just have a break, can impact them. Then
45 also, the - you know, the nature of the on-call
46 availability, even though there may not be a lot of
47 presentations, but just being available 24/7, seven days

1 a week, is quite challenging.

2

3 Q. When you refer to the on-call responsibilities, do you
4 have any particular category of medical staff in mind? Has
5 that been a particular feature?

6 A. Well, it's especially for the rural generalists and
7 especially if there's only one doctor in town or even when
8 there's two or three, it does increase, you know, the
9 on-call commitments significantly. But once again, we
10 currently only have one neurologist in Wagga and he is
11 pretty much on call for stroke services. You know, he can
12 have a bit of time off, where we can utilise Telestroke,
13 but it does require availability.

14

15 We have two interventional cardiologists that pretty
16 much do a one in two, and we would have occasional some
17 support from other visiting specialists, but it is, you
18 know, quite a significant requirement.

19

20 Q. That challenge is perhaps linked with professional
21 isolation in the sense of lower numbers in the district?

22 A. That's correct.

23

24 Q. Is the district doing any work to minimise the effect
25 of that feature?

26 A. Well, most definitely. We do support any network
27 arrangement where we try and have our doctors, you know,
28 have structured networks with metropolitan hospitals.
29 That's especially the case in neurology, where we have
30 a strong relationship with the department in St Vincent's
31 Hospital.

32

33 Q. How does that network operate in practice?

34 A. So we essentially have a significant number of
35 visiting neurologists from St Vincent's that provide
36 outpatient services in the neurology practice in Wagga,
37 which is a private practice, which is similar to the bulk
38 of our outpatient services, and they provide specialised
39 services in conjunction with our local neurologist.

40

41 Q. Can we just go to paragraph 5 of the outline, thanks?

42 A. Sure.

43

44 Q. You tell us there that the district has been
45 successful in recruitment. What areas of success are you
46 referring us to there?

47 A. So probably the successful area that I can speak about

1 is in terms of anaesthetics. So I came to Wagga as an area
2 of needs specialist in 2007, where there were only seven
3 specialist anaesthetists providing service to the base
4 hospital. That number has now grown to 23.

5
6 When I started here, we only had three trainees,
7 currently there are 14 positions, and my successor has
8 actually managed to establish a formal rural training
9 scheme where trainees can actually start and complete the
10 bulk of their training in the rural area and only going to
11 metro hospitals to perform specialised procedures that we
12 don't offer rurally.

13
14 Q. Perhaps step us through that. One of the challenges
15 we have heard some evidence about in attracting specialists
16 to the region or retaining those students who may have
17 trained in the region and retaining them in the region is
18 the need for them to travel away to undertake a specialist
19 pathway?

20 A. Correct.

21
22 Q. So can you just describe the initiative that you were
23 referring to in the last answer, so that is a pathway -
24 a training pathway in which specialty?

25 A. So that's in an anaesthesia.

26
27 Q. How has it been structured?

28 A. Well, so essentially, what happens is that facilities
29 are accredited. So Wagga Base is accredited for three out
30 of the five years that is required, but there are certain
31 types of surgical procedures that are not done rurally, the
32 bulk would be things like cardiothoracics and neuro and
33 some specialised paediatric services.

34
35 We've always had rotational trainees from St Vincent's
36 in Sydney and from Canberra Hospital, and all we've really
37 done is essentially engaged a formalised structure so that
38 our trainees can go to them to get the experience of these
39 areas where we don't provide those services, but once
40 again, in return, their trainees come to us and experience,
41 you know, particular procedures. For instance,
42 St Vincent's Hospital in Sydney doesn't do eye procedures.
43 Their registrars come to us and they learn that particular
44 skill.

45
46 Q. I think in your earlier answer you mentioned that
47 under that program, those trainees are able to spend longer

1 in the region than they otherwise might; is that right?
2 A. That's correct. They would pretty much be able to
3 spend most of their time here, apart from the 12 months
4 where they'll need to go to the metro hospital to do
5 cardiothoracics and neuro.

6
7 Q. Is that, to your observation, assisted in those
8 trainees remaining in the region once they've finished
9 their training?

10 A. Well, the program is brand new. We have actually been
11 very successful and, you know, from memory, three of the
12 current anaesthetists were my trainees. Most recently
13 I actually interviewed a paediatric anaesthetist, where the
14 last time I interviewed him with was when he was a medical
15 student. So clearly it definitely does work.

16
17 But we need more rural training because that - the
18 period of your life when you complete your vocational
19 training is when you develop personal and professional
20 networks and if you're rural during that time, the chance
21 that you are going to come back rurally is definitely, you
22 know, significantly more.

23
24 Q. Has the arrangement that you've been referring us to
25 required engagement with the college?

26 A. The college actually accredits the site. So they're
27 already accredited. But it was more the collaboration
28 between the different anaesthetic departments, and the
29 current supervisor of training has done a lot of work with
30 his colleagues and they have been very supportive of the
31 model.

32
33 Q. Is there scope for more arrangements of that kind in
34 other specialties within the district?

35 A. Most definitely.

36
37 Q. Any that come to mind in particular?

38 A. Well, one of the other areas where we have been very
39 successful in is psychiatry as well. We can now actually
40 offer end-to-end psychiatry and we actually now have two
41 locally trained psychiatrists in Wagga. So there's
42 definitely opportunities.

43
44 In terms of physician training, there's opportunities
45 as well, because --

46
47 Q. What are they?

1 A. So for doctors who want to do general medicine, we
2 offer most of the sub-specialties, and we have advanced
3 trainees in cardiology, respiratory medicine. We have just
4 been accredited for a trainee in nephrology. We've got
5 neurology trainees. So it really is just allowing the
6 trainees to spend more time with us.

7
8 Q. Are there any barriers that you perceive to that being
9 able to be implemented?

10 A. There are some of the colleges that have certain
11 requirements that you cannot spend more than a certain
12 period of time in a particular facility, and that may, you
13 know, potentially cause barriers.

14
15 Q. Might some of those barriers perhaps be heightened in
16 rural and regional settings?

17 A. Well, it would impact rural settings more because we
18 have fewer trainees, so having access to more trainees
19 would definitely, you know, improve our workforce, and
20 especially senior trainees are a valuable workforce, and it
21 takes the pressure off the consultants.

22
23 Q. I take it from your earlier evidence, particularly
24 trainees who may have commenced their medical training at
25 one of the local facilities?

26 A. Well, that's correct, because they know the context of
27 the area and they've old relationships and they know the
28 other consultants, so definitely benefits.

29
30 Q. In paragraph 5, you note that despite the success that
31 the district has had, there's a degree of natural
32 attrition?

33 A. Yes.

34
35 Q. Is that level of attrition higher than you would
36 expect it to be?

37 A. It's difficult. It's just that we do have people that
38 retire and it then means that we have to recruit, you know,
39 to those vacancies. But probably for us - and in that
40 paragraph, I was probably mostly speaking about
41 anaesthetics, despite the fact that we've got 60 more
42 anaesthetists in town, surgical activity has more than
43 doubled since I started in 2007.

44
45 Q. What's the cause of that?

46 A. It's --

47

1 Q. To the extent you have been able to identify one?

2 A. Well, difficult to say. There has been an increase in
3 the population, once again, not to the extent that the
4 activity has gone up, but - it's probably difficult for me
5 to speculate why the numbers have gone up so much.
6

7 Q. Has there been any work done to attempt to identify
8 the cause of that increased activity?

9 A. No, all we've discovered is that the number of
10 procedures that are booked are still increasing. We
11 expected an increased number of cases post COVID because -
12 where patients would have potentially put off, you know,
13 routine investigations, but we've pretty much completed
14 most of the patients that were delayed during COVID and
15 there is still a steady increase.
16

17 It is definitely an area that we will need to explore.
18 One of the contributing factors will be the ageing
19 population. As, you know, people become older, especially
20 orthopaedic procedures and eye procedures become more
21 common.
22

23 Q. Is it important for planning of services and in
24 particular workforce planing to be able to assess the
25 likely demand on an ongoing basis?

26 A. Most definitely.
27

28 Q. How do you go about doing that?

29 A. So for us, we have a robust data system that will
30 actually tell us, you know, exactly what procedures we do
31 and we actually have that data on a monthly basis, and we
32 can identify trends in particular areas.
33

34 Other factors that we consider is the changing
35 technologies will introduce new procedures, operations, or
36 particular procedures may be done in a different way. But
37 we can definitely do that, as part of our planning and, you
38 know, at the - recently we had a review of emergency
39 surgical procedures and we adapted our theatre schedule to
40 accommodate those particular patients. So that really for
41 us is ongoing work.
42

43 Q. In an earlier answer you said that you had caught up
44 or cleared the patients who were delayed during COVID?

45 A. That's correct.
46

47 Q. What was cause of the delay during COVID?

1 A. So they were periods during the COVID pandemic where
2 non-urgent planned surgical procedures were delayed, and
3 the bulk of the patients that were impacted were the
4 so-called non-urgent patients, which are category 3, so
5 they were orthopaedic procedures, cataract surgery and ENT
6 procedures.

7
8 Q. When you say that they've been caught up, have they
9 been caught up wholly within the district's facilities or
10 have there been referrals to other facilities to have that
11 work done?

12 A. No, we did collaborate with private providers in Wagga
13 and also in Griffith.

14
15 Q. And what did that collaboration look like?

16 A. So there were different arrangements. We had what we
17 called a completely outsourced model with one of the day
18 surgery providers where there was a - pretty much a funding
19 arrangement and the patients were sent to that private
20 facility and they provided the service and also the staff.

21
22 Other models we have is what we call a partially
23 outsourced model where, in fact, we rent theatre space and
24 staff from a private facility, but we remunerate the
25 medical officers.

26
27 Q. Is there a process in place to determine which
28 patients may be forming part of that model?

29 A. So clearly the focus for us would be on patients that
30 are overdue, that have waited longer than what is
31 recommended. They would be the highest priority patients.
32 But once again, there's also patients whose clinical
33 condition would make them more suitable to go to the base
34 hospital than a freestanding day surgery.

35
36 Q. Who makes the decision about which cases go where?

37 A. Well, on a clinical basis, it would be a combination
38 of the surgeon and the anaesthetist that review, and also
39 the private facilities have a triaging system to decide if
40 they believe particular patients are suitable. But then
41 for us, it is the patients that really have been delayed
42 the longest, because we want them to have their surgery as
43 soon as practically possible.

44
45 Q. Can you just go to paragraph 6 of the outline, please?

46 A. Yes.

47

1 Q. Just have a read of that paragraph and I will ask you
2 a couple of questions. Let me know when you have finished.

3 A. Yeah, sure. Ready.
4

5 Q. Can you just describe the concept that you are
6 identifying in that paragraph, please?

7 A. Well, for us there's - clearly the demand for medical
8 service is driven by the health needs of the community. So
9 if we had the healthier demographic, you would have less
10 need for medical officers. So that's part of it. So more
11 investment in preventative health care, primary care, and
12 not just medical primary care but really multidisciplinary
13 health promotion, et cetera.
14

15 The other factors that drive demand are historical
16 models of care where all patients have to come to
17 a hospital, they all have to be seen by a doctor, which
18 definitely then increases the demand for medical officers.
19 There's also community expectation, where communities feel
20 that their particular town needs an emergency department
21 with a doctor available 24/7, even though there may only
22 be, you know, one or two presentations per day. So that's
23 probably what's driving demand to an extent.
24

25 The way that we can address supply, clearly, is the
26 rural medical schools, increased vocational training
27 programs, utilisation of telehealth, the utilisation of
28 role substitution and utilising other providers, for
29 instance, nurse practitioners, extended scope paramedics,
30 et cetera. So there's a multitude of different strategies
31 that we can try and employ to balance the supply/demand
32 ratio.
33

34 Q. I'll come back to some of those concepts shortly, but
35 I just want to return to the words at paragraph 6, where
36 you say that the workforce shortage, which is the challenge
37 in keeping up with demand for services that you describe in
38 paragraph 5, needs to be addressed by considering both the
39 demand for services and the supply of doctors to provide
40 those services.

41 A. Yes.
42

43 Q. How is it that the workforce shortage can be addressed
44 by considering the demand for services and the supply of
45 the doctors to provide those services?

46 A. So the workforce shortage is based on the need. So if
47 we need fewer doctors, the workforce shortage won't be as

1 severe. So that's the one. And in terms of the - if we
2 can address the supply, then we won't have a rural
3 workforce shortage in Murrumbidgee.

4
5 Q. So what you are describing is - this is my language,
6 tell me if you agree with it or not - a two-pronged attack?

7 A. That's correct.

8
9 Q. One focused on reducing the demand by perhaps some
10 preventative health and access to primary health care on
11 the one hand; correct?

12 A. That's correct.

13
14 Q. And increasing the supply, on the other, through
15 a range of training initiatives, including things that have
16 been labelled "grow your own" type initiatives; correct.

17 A. That's correct.

18
19 MR GLOVER: Commissioner, I note the time. I am told we
20 have to rise now to depart the building on time. I'm
21 certainly not going to finish Professor Bruce this
22 afternoon.

23
24 THE COMMISSIONER: My apologies, Professor, but we will
25 have to get you to come back tomorrow morning.

26
27 THE WITNESS: Sure, that's no problem.

28
29 THE COMMISSIONER: Is 10 o'clock all right to start
30 tomorrow morning or would you prefer to start at 9.30?

31
32 MR GLOVER: 10 o'clock is fine.

33
34 THE COMMISSIONER: Okay. We will adjourn until 10 o'clock
35 tomorrow, then.

36
37 **AT 4.12PM THE COMMISSION OF INQUIRY WAS ADJOURNED TO**
38 **FRIDAY, 22 MARCH 2024 AT 10AM**

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