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

THE COMMISSIONER: Good morning. Yes, Dr Waterhouse?

DR WATERHOUSE: I call Elizabeth Dixon and Anthony Kolbe.

<ELIZABETH DIXON, sworn: [10am]

<ANTHONY KOLBE, affirmed: [10am]

<EXAMINATION BY DR WATERHOUSE:

DR WATERHOUSE: Ms Dixon, could you state your full name for the record, please.

MS DIXON: Elizabeth Ann Dixon.

DR WATERHOUSE: Mr Kolbe, could you also state your full name for the record.

MR KOLBE: Anthony Kolbe.

DR WATERHOUSE: You are both on the board of the Murrumbidgee Local Health District. Is that correct.

MS DIXON: Yes.

MR KOLBE: Yes.

DR WATERHOUSE: How long have you been on the board Ms Dixon?

MS DIXON: Since January 2019.

DR WATERHOUSE: Mr Kolbe?

MR KOLBE: Since January '23.

DR WATERHOUSE: I understand you each chair a subcommittee of the board; is that right?

MS DIXON: Yes.

DR WATERHOUSE: I'm going to go through some questions both in relation to your board position and also your individual subcommittees.

Now, if I could start with you, Ms Dixon. Which subcommittee do you chair?

MS DIXON: Health care safety and quality.

DR WATERHOUSE: Have you chaired that since you joined the board?

MS DIXON: No, I have chaired it for two and a bit years.

DR WATERHOUSE: And Mr Kolbe, the name of your subcommittee?

MR KOLBE: Planning resource and performance.

DR WATERHOUSE: When did you become the chair of that committee?

MR KOLBE: July '23.

DR WATERHOUSE: Ms Dixon, can I start by getting you to outline your professional background and your experience in health and other professional activities?

MS DIXON: So I'm a physiotherapist by background. I spent my early years at Alfred Health in Melbourne where I was a senior ICU nuerotrauma physiotherapist and I participated as a clinician and as a researcher.

I then moved to a sheep station in Carrathool, which is in the western side of our MLHD. I worked in some private and public practices there and then joined the board after studying further business and governance degrees.

DR WATERHOUSE: Have you been on other boards prior to this one?

MS DIXON: No, this was my first.

DR WATERHOUSE: Do you still work in clinical roles?

MS DIXON: Not at the moment.

DR WATERHOUSE: What sorts of work do you do when you're not working for the board?

MS DIXON: Well, I'm in agriculture and raising a young family.

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

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

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

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

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

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

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

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

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

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

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

MR KOLBE: Yes, it would.

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

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

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

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

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

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

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

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

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

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

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

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

DR WATERHOUSE: What is the status of the charter relative to the model by-laws which dictate a lot of the requirements for boards and subcommittees?

MS DIXON: Sorry, could you ask that again?

DR WATERHOUSE: There are model by-laws under the Health Services Act 1997 that provide for a lot of the rules around the subcommittees and the board. What's the status of the charter relative to the by-laws?

MS DIXON: So the charter would acknowledge the model by-laws, obviously, and ensure that we're compliant with them. It would then go further to say what are the processes that the board and the committee will undertake and, in addition, we have additional board subcommittees that are not listed under the regulations.

DR WATERHOUSE: Would you agree with that summary?

MR KOLBE: Yes. Yes, thank you.

DR WATERHOUSE: How does the charter relate to the annual corporate governance attestation statement that's signed by the chair on behalf of the board? Ms Dixon?

MS DIXON: It is a component of the corporate governance attestation statement, as in we have processes that we follow that are based on that - the board charter, but the corporate governance attestation statement is much more comprehensive and significant than just the board charter.

DR WATERHOUSE: Mr Kolbe, would you like to add anything to that?

MR KOLBE: I have nothing to add, thank you.

DR WATERHOUSE: Mr Kolbe, can you talk to me about what types of data the board routinely reviews? Maybe if we start with financial data.

MR KOLBE: Yes, financial data, activity and service data, so in-patient statistics, ED presentations. They may also look at integrated care and allied health information, workforce.

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

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

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

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

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

MR KOLBE: Yes, that's correct.

DR WATERHOUSE: Can you expand on that at all?

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

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

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

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

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

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

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

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

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

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

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

> *Well, health systems generally are very*

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

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

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

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

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

THE COMMISSIONER: Community type setting?

MR KOLBE: Community type setting, yes.

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

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

mutually supporting.

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

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

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

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

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

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

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

THE COMMISSIONER: Thank you.

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

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

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

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

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

MS DIXON: Yes, heavily.

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

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

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

MS DIXON: Yes, I was.

DR WATERHOUSE: What did that involve from your perspective?

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

directors, consultation with the PHN as well, and then formulation of the strategic plan. A lot of consultation with a lot of stakeholders, including within Murrumbidgee Local Health District and externally, and then endorsement of the strategic plan.

DR WATERHOUSE: So that consultation involved members in the community?

MS DIXON: Yes.

DR WATERHOUSE: And involved staff?

MS DIXON: Yes.

DR WATERHOUSE: I'd like to just ask you about some of the reports that come to you as a board, and in particular, I'm interested to know if these are presented to you for noting or whether you actually are required to approve them or endorse them in some way. So clinical services plans - do you see those?

MS DIXON: We do.

DR WATERHOUSE: What role does the board take in relation to clinical services plans?

MS DIXON: So they are required for endorsement before they are submitted to the ministry.

DR WATERHOUSE: What about proposals to address workforce gaps that are impacting on service delivery? Maybe Mr Kolbe, you could answer that?

MR KOLBE: That is - if we take an example over the Christmas period, there were some changes at a particular site because it was unable to be staffed during that short period. Arrangements were put in place and that was endorsed by the board.

DR WATERHOUSE: What about the strategic asset management plan? Is that something that comes to the board? Ms Dixon, would you like to --

THE COMMISSIONER: I think in relation to any question you're asked, whoever is asked it or whoever starts answering it, if the other of you has something you want to

add, just go ahead.

MS DIXON: Thank you. Yes, it does.

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

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

DR WATERHOUSE: What does it contain?

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

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

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

DR WATERHOUSE: What does that plan include?

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

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

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

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

the gap and the issues of Aboriginal health.

DR WATERHOUSE: Thank you.

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

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

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

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

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

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

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

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

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

MS DIXON: Appointments, sorry.

DR WATERHOUSE: So that is something the board is required to establish under the by-laws; is that correct?

MS DIXON: It is, but we don't sit on the committee. We have two nominees, who is our executive director of medical services and our director of clinical governance.

DR WATERHOUSE: So you don't nominate anyone outside the executive to sit on the MDAAC?

MS DIXON: No.

DR WATERHOUSE: How does the board become familiar with the activities of the MDAAC and the information that it's reviewing?

MS DIXON: We receive an annual report.

DR WATERHOUSE: I beg your parton, sorry?

MS DIXON: An annual report.

DR WATERHOUSE: How would the board be aware if there were an issue, say a complaint about a credentialling process or something of that nature, in relation to a senior practitioner?

MS DIXON: So within our clinical governance reporting, there is an opportunity that the director of clinical governance would bring that to the committee and to the board, and I think that would be the process.

DR WATERHOUSE: So it would come separate to the annual report?

MS DIXON: Yes.

DR WATERHOUSE: Mr Kolbe, can I ask you, what does the annual report contain in relation to MDAAC? What sort of information are you presented with about the appointment of senior practitioners throughout the district?

MR KOLBE: I'm sorry, I cannot answer that.

DR WATERHOUSE: Do you recall the content of some of those reports, Ms Dixon?

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

DR WATERHOUSE: What has been your experience on some of

those visits that you've done?

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

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

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

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

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

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

MS DIXON: We would discuss it.

DR WATERHOUSE: I beg your pardon, sorry?

MS DIXON: We would discuss that.

DR WATERHOUSE: Discuss it?

MS DIXON: Yeah.

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

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

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

MS DIXON: Not off the top of my head.

DR WATERHOUSE: What about you, Mr Kolbe?

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

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

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

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

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

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

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

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

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

MS DIXON: Yes.

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

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

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

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

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

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

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

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

improvement in ensuring that our LHACs represent a diversified group of people, not just within the towns but also geographically and - yeah, and that would help to address that problem.

DR WATERHOUSE: Mr Kolbe, did you want to comment on that?

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

DR WATERHOUSE: What about a formal process of engagement with local government, how does that work? Is there such a process to formally engage with local government in relation to health?

MR KOLBE: Not with the board, as I understand. So that engagement would happen between the executive - yes.

DR WATERHOUSE: Are you confident that it does happen with the executive?

MR KOLBE: I would say I'm very confident. They have procedures to follow in regard to consultation and so on, which involves discussions with local government.

DR WATERHOUSE: Ms Dixon, did you want to comment on that?

MS DIXON: Nothing to add.

DR WATERHOUSE: Is this issue of reaching in to these smaller communities without a facility something that the board monitors on a regular basis?

MS DIXON: No, we don't. As I said, you're talking about a substantial number of communities of very small populations. We would hope that within our healthcare services, that that population comes to the health service when it requires hospital services, but equally, there are primary care services there, that the population will be accessing as well.

DR WATERHOUSE: Thank you for that answer. We might go back to the health care quality subcommittee, then. You were starting to explain how you defined the role of the subcommittee. Could I just get you to repeat that from before?

MS DIXON: We're there to ensure that the district carries

out high quality consumer care and optimal consumer experience.

DR WATERHOUSE: What role does it play relative to the board's obligations in relation to safety and quality?

MS DIXON: The board has ultimate responsibility for the safety and quality of the district, but the health care safety committee is there to assist it. It can take the time to look specifically at those issues for its entirety.

DR WATERHOUSE: How often does the subcommittee meet?

MS DIXON: Every two months.

DR WATERHOUSE: What's the sort of membership of the committee?

MS DIXON: So board representatives; the chief executive; many of the leadership team, including the director of clinical governance; and some consumer representatives.

DR WATERHOUSE: And is there some sort of program of work that the subcommittee works through each year or on a cyclical basis?

MS DIXON: There is. So we have a schedule of reports.

DR WATERHOUSE: What sorts of reports do they include?

MS DIXON: They include things such as our accreditation against national standards; our patient safety and quality metrics, which come to every meeting that we have; site visits; service analysis --

DR WATERHOUSE: That's okay, you don't have to remember all of them off by heart. If I can maybe ask you, firstly, in terms of the things you've just raised about accreditation, so what does that involve, accreditation against the national standards?

MS DIXON: Yes, so the national safety and quality healthcare standards are the standards that all hospitals must meet, must be accredited against, and that occurs across our district. Obviously we have many sites, so it occurs in a staged process.

DR WATERHOUSE: Does it include the MPSs, the multi-purpose services?

MS DIXON: Yes, it does.

DR WATERHOUSE: Do they have particular accreditation requirements because of their aged care residents?

MS DIXON: Yes, we do. So we're subject to the national standard accreditation. We're also subject to aged care and to NDIS.

DR WATERHOUSE: How does the district find the process of accreditation? Does it work smoothly? Are there challenges?

MS DIXON: I think it works smoothly. It is a lot for a small facility to have accreditors come on to their site, often in an unannounced fashion, and it can put a lot of pressure on the facility. That's part of the process.

DR WATERHOUSE: Is the intention that people are maintaining quality on a regular basis rather than just getting ready for an accreditation visit?

MS DIXON: That's right, and that is the intent and the shift that it is moving towards, that this is a process of continual improvement rather than a once every few years.

DR WATERHOUSE: Mr Kolbe, did you want to make any comment about that?

MR KOLBE: No, thank you.

DR WATERHOUSE: I might move on to some of the other reports that you have. There's a quality and safety account that is - is that prepared by your subcommittee?

MS DIXON: It's prepared by our director of clinical governance.

DR WATERHOUSE: Is it endorsed by your subcommittee or the board?

MS DIXON: Yes, it is.

DR WATERHOUSE: What does that contain?

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

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

MS DIXON: Yes.

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

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

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

MS DIXON: For the public or --

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

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

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

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

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

DR WATERHOUSE: So was that an initiative of the subcommittee that you chair?

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

DR WATERHOUSE: What does that contain relative to the safety and quality account?

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

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

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

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

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

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

MS DIXON: They do.

DR WATERHOUSE: Where there are criticisms, what is done with that information by your committee?

MS DIXON: So it's one patient story that will be pulled out of many patient stories. All of the information that sits behind that is the sort of information that we're looking at all the time, which may be complaints, compliments, incidents that we are already looking at.

DR WATERHOUSE: So you are looking at clinical incidents as part of this. What about serious adverse events?

MS DIXON: Yes, we look at them.

DR WATERHOUSE: How are they defined?

MS DIXON: So a serious adverse event is where something goes wrong within the healthcare system, so a Harm 1, Harm 2, and we will look at those at every meeting and also then at an annual point, to look at where are the recurring themes.

DR WATERHOUSE: Can you give us an example of what might be a Harm 1, Harm 2 adverse event?

MS DIXON: A Harm 1 might be where something has gone wrong within our healthcare system which has resulted in serious injury or death to a patient.

DR WATERHOUSE: So those are investigated and does the investigation report come to your committee?

MS DIXON: So our committee - they are absolutely investigated, so there is a very vigorous process that the clinical governance team go through with - on their own and also at ministry level.

The reports themselves for each individual case don't come back to our committee but we will look at what are the themes coming out of them? Are there system problems there? Is it a problem with a particular system, with - is this a clinician problem? Is this something that - how can we influence this? How can we learn from it to ensure that it doesn't occur again?

DR WATERHOUSE: And what options are there for your subcommittee to take in terms of directing action?

MS DIXON: The actions are very predefined already on that.

DR WATERHOUSE: Can you tell me about hospital-acquired complications?

MS DIXON: So a hospital-acquired complication could be something such as a fall, a hospital-associated infection, a clot - there are many of them.

DR WATERHOUSE: Are these formally sort of defined as a set that need to be monitored?

MS DIXON: They are. They're in our service level agreement.

DR WATERHOUSE: What role does the committee have in monitoring those?

MS DIXON: We monitor them every month. What we're looking at is what our numbers are, what the New South Wales numbers are, what our specific larger hospital numbers are, and it can be what our peer group is, so that we can monitor how we're tracking against other hospitals.

DR WATERHOUSE: Are there any funding implications associated with levels of hospital-acquired complications?

MS DIXON: They are. We receive a funding penalty if we have a hospital-acquired complication.

DR WATERHOUSE: Did you want to add anything about that?

MR KOLBE: No, thank you.

DR WATERHOUSE: So you've mentioned that you hear patient experiences. Do you hear, as a subcommittee, about staff experiences?

MS DIXON: A lot of the people and culture information comes to the board rather than the health care safety committee.

DR WATERHOUSE: What about cultural issues that may have

an impact on safety?

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

DR WATERHOUSE: Who would take the lead with that?

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

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

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

DR WATERHOUSE: Would you like to give an example?

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

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

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

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

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

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

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

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

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

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

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

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

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

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

MS DIXON: Yes.

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

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

DR WATERHOUSE: Does that sometimes happen?

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

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

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

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

MS DIXON: No.

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 --

DR WATERHOUSE: I might just pause you there because I want to go through a couple of those. So when you say "activity", what do you mean by that?

MR KOLBE: "Activity" refers to inpatient statistics, non-admitted occasions of service, for example, and also - I was going to say something and I've forgotten it now, I'm sorry.

DR WATERHOUSE: That's okay. What about the efficiency and improvement aspect? What do you look at for that?

MR KOLBE: So there is a small team of people within the district who identify and develop efficiency improvement projects. That is a very important initiative and sees savings coming from those projects, and the PRP takes a keen interest in what those EIPs are doing. That has, to my mind, been quite a successful process.

DR WATERHOUSE: Can you give some examples of the efficiency improvement projects that have been successful?

MR KOLBE: I'm not sure that I can think of any off the top of my head. I don't know if Liz can remember an EIP that we could use as an example.

DR WATERHOUSE: Are these initiatives that come from sort of facilities and are filtered back up to the district or do they tend to start at the district level and be rolled out across facilities?

MR KOLBE: No, these are very much localised initiatives. The manager of the unit is in consultation with managers at sites and so on and is active in trying to identify those projects and supports the work of the local site in developing those projects and seeing them through.

DR WATERHOUSE: Are there particular sort of projects that have come out of the pandemic?

MR KOLBE: I can't think of anything that has come out of the pandemic, as such. No. I'm sorry.

DR WATERHOUSE: That's okay. You then mentioned about reports from the director of operations and the director of integrated care. Can you elaborate on those?

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

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

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

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

MR KOLBE: That is correct.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

MR KOLBE: Yes, yeah. So that is detailed information showing inpatient statistics, ED presentations, out of hospital occasions of service, and so on, yes.

DR WATERHOUSE: So would it be fair to say that it is similar data to what the board sees but at a more granular level?

MR KOLBE: That is correct.

DR WATERHOUSE: Do you monitor as a subcommittee against the KPIs in the service agreement?

MR KOLBE: Yes, that's true, that the PRP is involved in monitoring those KPIs. There are some shortcomings with the KPIs and sometimes there is a delay in being able to acquire the data to monitor those KPIs.

DR WATERHOUSE: Can you give me an example of the shortcomings?

MR KOLBE: Well, the delay and the difficulty in accessing some of that information I think is the main concern about that, those KPIs.

DR WATERHOUSE: Is that specific to your district or is that a statewide problem to your knowledge?

MR KOLBE: I would suggest that's a statewide issue, yes.

DR WATERHOUSE: And are you able to give any specific examples of the types of data that are delayed?

MR KOLBE: I cannot, I'm sorry, think of a specific example at the moment.

DR WATERHOUSE: That's okay. How often does the subcommittee meet?

MR KOLBE: That meets every two months.

DR WATERHOUSE: And who are the members?

MR KOLBE: The members are board members, a minimum of three board members attend. That includes, at this stage, the board chairperson and also the board representative on the audit and risk committee, and in addition, members of

the executive.

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

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

DR WATERHOUSE: Thank you.

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

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

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

MR KOLBE: Yes.

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

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

DR WATERHOUSE: So is it a case of highlighting particular

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

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

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

MS DIXON: Yes.

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

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

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

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

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

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

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

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

THE COMMISSIONER: Okay, thank you.

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

MR MUSTON: Yes.

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

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

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

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

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

as the congestive heart failure clinics that Emma spoke of.

DR WATERHOUSE: Mr Kolbe, I know you gave some details about a similar question earlier to the Commissioner. Is there anything you wanted to add at this stage given your population health background?

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

DR WATERHOUSE: Just one last question --

THE COMMISSIONER: Can I just - "Emma", is Emma Field?

MS DIXON: Yes.

THE COMMISSIONER: It's fine to call her "Emma"; it's just that if someone did a transcript search, they might use "Field" and we wouldn't pick that up.

MS DIXON: Our director of integrated care and allied health.

THE COMMISSIONER: Yes.

DR WATERHOUSE: Just one final question. Is there any change you would like to see at the state level that would enhance the way the district can deliver services to the community?

MR KOLBE: Well, I think if we are going to move to new models of care, then this is not something that is going to happen easily, it's going to be a complex process, so some work to be done on how that is to be achieved, what is are the - what's the pipeline of shifting that model of service and what are the resources and what are the workforce needs? There's a lot of working-up of that to be done, I think I would say.

DR WATERHOUSE: Ms Dixon?

MS DIXON: I think that looking at how we deliver value based care is going to be part of that, how we incentivise and fund better outcomes for patients as opposed to a traditional model which has been more about volume of patients.

DR WATERHOUSE: Commissioner, I have no further questions.

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

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

THE COMMISSIONER: So data is important?

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

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

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

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

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

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

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

MR CHIU: No questions, thank you, Commissioner.

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

<THE WITNESSES WITHDREW

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

MR MUSTON: Yes.

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

LUNCHEON ADJOURNMENT

THE COMMISSIONER: Good afternoon.

Mr Muston?

MR MUSTON: I call Dr Alam Yoosuff.

THE COMMISSIONER: Come forward, sir.

<ALAM YOOSUFF, affirmed: [1.01pm]

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

<EXAMINATION BY MR MUSTON:

MR MUSTON: Q. Dr Yoosuff, you are a board member of the Murrumbidgee LHD?
A. Yes.

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

the reporting.

Q. So to the extent that you as a subcommittee have identified those issues that you think require some attention, what's the mechanism by which those views ultimately find their way through to the people on the ground who should be --
A. We do ask questions from the executives and then we do ask for feedback on how things progress, and then sometimes we might put on the calendar, say in three months or six months and 12 months, a timely manner of reevaluating what the process is. So that's the normal process that we've been keeping track on.

Q. So in terms of the engagement between you and the executive, is it the case that you, as a subcommittee, identify a problem and come up with a recommended solution, or that you identify the problem, bring that to the attention of the executive and ask the executive to come up with a solution to the problem?
A. Correct. Going into solution by us is a bit operational, hence we would stick to the level of asking the right questions and probing the right pathway to get to an answer. So our focus would be to see what would be the feedback or response and outcome of our questioning.

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

Q. Until January 2024, I think you were also the director of primary care at the MLHD?
A. That's correct.

Q. Could you just explain to us what that role involved?
A. That is a very innovative role. I don't think that role is there in any other local health district. It is one of its first kind, where the chief executive and our executive director of medical services created this position, had a recruitment process and I became the successful candidate for it.

THE COMMISSIONER: Q. When was that?
A. Just before COVID - September 2019.

THE COMMISSIONER: Thank you.

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

MR MUSTON: Q. So it was an innovative role which, to your understanding, is unique to this LHD. What were the functions that you had in that role? What was it that you were retained to do?
A. My main focus was to connect and communicate and network better with primary care, particularly the GP VMOs in the district. Given our general practitioners who are spread wide across the whole district, it is quite a task to, you know, keep all of them up to date with what's happening with the LHD and the LHD then to have a person to, you know, talk and become the conduit or bridge of getting solutions through LHD.

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

THE COMMISSIONER: Q. Was that what you were told when the role was created - you've applied for the position. Was that better connection with primary care what you were told was the purpose of management or the chief executive creating the role?
A. Yes, correct. There were two main things told while the interview process and the recruitment, but one is that exactly what you said. The second one is that we wanted to get our single employer model, Murrumbidgee model, up and going, and as part of that, we really need a significant primary care focus, and the other one was that.

THE COMMISSIONER: Thank you.

MR MUSTON: Q. In that role, did you have any particular projects or objectives that you were required to deliver, other than improving connectivity between primary care and the LHD in a general sense?
A. Yes, I had a significant role in getting the Murrumbidgee model, single employment model, up and running, because I had quite a bit of a networking and collaborating approach with the federal government and the Ministry of Health in Sydney and the PHN and local GP

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

Q. So in terms of all of those various moving parts that you needed to bring together in order to get the single employer model going, are you able to indicate, at least in broad terms, what it was that you needed to get from each of them in order to get that project up and running?
A. You know, the single employment model is a very new version, of such, where the local health district or state run local health district employs a GP registrar under a salaried version of an employment contract, which is not a thing that Australia did, and for that to happen industrially you need to have AMA and a few other people on board, and all the GP registrars will need to complete their fellowship with the college of rural/remote medicine or Royal Australian College of General Practitioners in a fellowship pathway, so those colleges need to be in line with what we are doing.

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

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

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

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

Q. So that's the training organisation. Which other organisations? You mentioned HETI was one of them?
A. Yes. HETI was --

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

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

Q. Which enables them to do, for example, obstetrics?
A. That's correct.

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

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

Q. Does HETI have a role to play in deciding where these trainee positions are located?
A. Correct. HETI will accredit a place so that that place can be an advanced skill position, and then once you accredit, the colleges will allow the registrar to go there and complete the required placement, so then there can be first and final exam and given the diploma or the status of completed advanced skill.

Q. So that's for the advanced skill training. In relation to the GP training, or the rural generalist training, perhaps without the specialisation, who makes a decision about where those employed general practitioners or GP registrars get sent within your district?
A. At the moment it's called a WPP program, where the PHN is the manager of it, but Royal Australian College of General Practitioners, or ACRRM, Australian College of Rural and Remote Medicine, they are the ones who decide where the registrar would go. So their divisions in New South Wales are different to our divisions. So PHN borders are different, LHD borders are different. Similarly, registrar allocating borders are different. So Murrumbidgee, Far West, Western, Southern and Canberra will come under one jurisdiction of where registrars get allocated.

Q. So to the extent that, for example, the RACGP is making decisions about where a particular GP registrar employed under the single employer model might be able to go to train, they are making decisions which have to take into account, or take into account in some way, a much wider geographical footprint than just the Murrumbidgee LHD?
A. No, RACGP will make decisions on what the registrar needs to do to fulfil fellowship. RACGP will make the decision on which GP practice is accredited to keep a registrar. We, as MLHD, will make the decision on where our single employment model registrar will go. We can't send our single employment model registrar to a place where the RACGP hasn't accredited saying that this is a place where you can or can't send, they'll tell us. Then we will decide to send. So our decision has been based on MMM4 and above towns, so it's not towns like Wagga or Griffith, we're talking about towns like Young, Cootamundra, Finley, West Wyalong, type of place.

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

Q. Employed, sorry, as a registrar by the MLHD?
A. Yes, correct.

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

A. Correct.

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

Q. Is that right?
A. No. RACG and ACRRM are both in parallel. They decide where the registrars can be accredited and be sent, so --

Q. So you, as the LHD, get told, "Here are the practices within your LHD which have been accredited by the colleges as accredited training locations"?
A. Yes. And then we can work with them in the - beforehand. We can actually work with the practices and the colleges and get practices accredited to send the registrars if we want to. Say we have a town X we want to send the registrar, but if the practice is not accredited, we can go through the process of accrediting them so that we can send the registrar there too.

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

Q. Those decisions about where best to deploy a registrar under the scheme are based on what sort of considerations?
A. Number one, it's based on the rurality. Number two it's --

Q. So rurality, I think you said --
A. MMM4 and above. Number two, it's based on need - for example, you know, we need to send an obstetric registrar in Young. We might need to send a GP anaesthetic registrar to Temora, things like that.

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

I was involved.

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

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

Q. To make sure I have understood it correctly, the advanced training positions which HETI decides are available, they are facilitated through here, the Wagga Base Hospital?
A. They fund - they fund the position.

Q. And are those positions delivered, in your LHD, through the Wagga Base Hospital?
A. Mmm, and we have some advanced skill positions in Griffith Base Hospital too, for anaesthetics.

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

Q. -- that performs --
A. You need to have a level of supervision, level of credentialling and all those things in place to be able to afford that.

Q. We might come back to some of those issues a little bit later.
A. Sure.

Q. You're also the board director of the Murrumbidgee Primary Health Network?
A. Yes.

Q. How long have you held that role?
A. I've been MPHN board director since 2017, October.

Q. Do you think there are real advantages in having the overlap between the LHD board position and the PHN board position in a role like yours?
A. Reciprocal, yes, it's very good for both sides, my understanding. I do understand the primary care patch a lot better by being on the PHN side, and I do understand the running of NSW Health and LHD process better, being on the LHD.

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

Q. Do you feel that it enhances the --
A. It enhances the collaboration.

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

Q. So to your observation, having worked - your involvement in both organisations, at least in this LHD, there is a strong level of connection and collaboration between the PHN and the LHD?
A. Yes. I think in this organisation, knowing my colleagues around rural New South Wales and stuff, I guess MLHD has a strong primary care focus.

Q. Can I ask, other than the geographic convenience of having the two offices 100 metres apart, is there anything else about this LHD that you think explains the high level, higher, perhaps, than other LHD, level of collaboration?
A. Few things. Number one is that close proximity of office, I don't think it's the main reason, but one of the biggest reasons is our geographical border and the PHN's border is the same. It's not the same in other places. If you go to the Western PHN, that includes Far West and Western LHD and there are certain LHDs where they have two PHNs sometimes. So it allows us - it gives us a lot more credibility in how we can do things, given that we have the same jurisdiction.

Q. I understand the credibility point, but in terms of the practicalities of it, what is it about having the same border between the LHD and the PHN, which enhances --
A. We can have the same data sources; we can have the same health need assessments; we can do very similar community consultations; we can have collaborations when working with communities in lots of projects together, and,

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

Q. Is that because or is one of the reasons for that because, within the Murrumbidgee LHD, it is only the Murrumbidgee LHD which is making a claim to or seeking to have access to moneys available through the PHN for the delivery of these projects, whereas a PHN that might cross multiple LHD boundaries would have multiple LHDs each competing for the funding that's available through the PHN to deliver projects?
A. Possible. You could frame it that way but in the way that, you know, this competition for the funding wouldn't be a big issue in the way how PHN works,because the PHNs work in identifying gaps and funding the gaps, or commissioning services to cover the gaps, right? And there isn't a significant proportion of funding coming from the PHN to the LHD, as such, I'm aware of.

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

Q. The PHN has a limited budget to deliver its gap-filling role?
A. Mmm-hmm, yeah.

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

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

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

filled are filled?
A. Correct.

Q. And in that sense, is it possible that there might be some competition, perhaps not the right word, but at least a desire on the part of each LHD to have as many of their gaps filled as is practicable from the limited resources of the PHN?
A. Possible. If there is that competition, it's good, because we will have better productivity, I would say. But what we see is PHNs and LHDs, if they are working well together, we see better performance or better outcomes.

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

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

Q. -- critically important for that to be --
A. Very correct. It is not only PHN/LHD business. Anything to do with health, I believe it is quite political, and personalities and connectors and lead people in the organisation are key and significant in getting better outcomes for our people.

Q. Is it your view, as someone who observes it from both sides of the collaboration in this district, that the people who are doing it are extremely well suited to that role?
A. That's correct. That's correct.

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

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

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

A. Yes.

Q. -- might cross over the boundary?
A. It is very important, because continuation of care is the hallmark of primary care - continuity. For better continuity, we need to communicate between systems better.

Q. We've heard some evidence about discharge summaries which come from the hospitals to primary health care when a patient is discharged from an acute setting. Do you have experience of those discharge summaries?
A. Yes.

Q. What experience do you have there?
A. I create discharge summaries every day and I read discharge summaries from others every day.

Q. So perhaps we should just clear that up before we get into the issue. You are creating discharge summaries in your capacity as a VMO --
A. The VMO in the Finley Hospital.

Q. -- in the Finley Hospital?
A. And when I go and see patients in my general practice as a GP I read discharge summaries of others who have written and sent it to me.

Q. So to the extent that you happen to be the doctor at Finley Hospital who treated, in an acute setting, the patient who then walked through your door, no issue --
A. I write a letter to myself, yes. I write a letter to myself and it goes to the cloud and the cloud sends it to my computer on the other side.

Q. To the extent that you are treating patients who have been seen by other doctors in an acute setting, what has your experience of discharge summaries been - starting first, say, with Finley Hospital?
A. Yes. I think it is a lot better now compared to where we were. When we didn't have this eHealth system and, you know, the electronic way of communicating discharge summaries, it was quite disorganised. You know, I'm talking about in 2008 when I started my practice in Finley to what it is now. If I do a discharge summary now electronically, I get it on my other computer within a few seconds, sometimes. It goes straightaway.

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

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

Q. So coming from where?
A. Wagga Base Hospital or Sydney hospitals, kind of.

Q. Yes?
A. Yeah.

Q. So issue one with the discharge summaries for those colleagues, is it that they've told you that the timeliness of the discharge summary is a problem - that is --
A. Timeliness is an issue sometimes. Sometimes the content might be an issue. Sometimes trying to trace and get stuff, going through the process of getting through the medical admin and medical records - sorry, not medical admin, medical record systems, might be a process that will - you know, a challenge.

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

Q. What about the experiences you have with Victorian based health services? If you have a patient who walks through your door and says, "I was in Albury hospital last week", you haven't been provided with a discharge summary, how do you deal with that information --
A. I have to ask them to sign a release of information form and get the medical records, "You need to send it across." The vast majority of the time it's a lot more

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

Q. Is that a useful function of the Melbourne system?
A. Very good function, because no matter what time you go and hit the hospital there, I get the automated notification saying, "You are here."

Q. And that is in addition to the discharge summary?
A. Yeah.

Q. Which hopefully will follow soon?
A. That's in addition to discharge summary.

Q. What happened while they were there?
A. Correct.

Q. Are you familiar with the single digital patient record project --
A. Yes.

Q. -- that's being rolled out by NSW Health?
A. Yes.

Q. Do you have a familiarity with what it will involve in terms of communication between the acute care setting and the primary care setting?
A. Basic understanding, yes. I don't think communicating between primary care and the acute care setting was the main focus in that single digital patient record system. It could improve into it, because the software that they are going to purchase does that in US. I mean, it can do it.

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

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

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

Q. Do you think it should be a priority in the development of the single digital patient record that each of those silos of information are connected up?
A. Difficult to say that yes for that, though, because single digital patient record is a New South Wales initiative to how to manage state related health services. When you look at primary care data, it's more Commonwealth or PHN related stuff. How do we get that together needs a bit more work on it.

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

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

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

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

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

Q. What sort of challenges does that present?
A. It is quite a dispersed population, small population all over the place.

Q. What sort of challenges does that really manifest?
A. Because you need to treat everyone equitably. You need to be able to keep services available for every corner of the district, right? So Murrumbidgee is twice as big as Tasmania, with 250,000 people, and with 508 towns, 33-odd local health districts - local government areas, but 32 health posts. So to keep track with all those and doing the right thing by everyone is a challenge. It's a quite complex task as a local health district.

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

Q. I will come back to workforce in a minute because I understand that's the challenge. In terms of the population that's spread across that wide geography, we hear repeatedly that rural areas have an ageing population; that's the case in the Murrumbidgee LHD?
A. Yes, correct. If you look at our ageing data, you know, breakdown, profile, it's very similar - what our current profile is, what Melbourne and suburbs is predicting in another seven to eight years time. Their profile is going to be very similar to what ours is like now. So we understand that as a significant challenge.

Q. What are the particular challenges presented by a widely dispersed and increasingly ageing population?
A. More home care needs; more people needing services at home; more spots for aged care residential situation.

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

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

Q. Just pausing there, I assume that the prospect of staying in a caravan makes recruiting people into programs like the single employer model challenging?
A. Yes, that's correct. Look, if the system is supportive, they will stay with us, they have stayed with us, and we've done everything we could do to get there. But if there isn't any housing in the market to rent, then that's quite a challenge. We have that problem a lot in many places in Murrumbidgee and around Albury-Wodonga.

Q. Can I ask you, to the extent that the population is dispersed across I think you said 503 towns --
A. I think 508, yeah, somewhere there.

Q. 508 towns and communities, and was it just over 30 of them have a health delivery facility in them?
A. Yes, mmm-hmm.

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

Q. Those facilities have an LHAC attached to them?
A. Yes.

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

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

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

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

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

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

Q. What about the local councils? Is there a formal form of engagement between the LHD and local councils within the LHD boundaries?
A. Yeah. I think the councils are part of LHACs. Every council - sorry, every LHAC has a council member in it, and that is kind of the accepted model, and the - we do go to the country, rural - Country Mayors' Association gatherings and listen to what they've got to tell us and communicate

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

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

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

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

Q. Is there any formal mechanism by which the views of councils are picked up by the PHN?
A. Yeah. I think the councils do - councils are part of their clinical advisory committee and council is part of - some of the council representatives are part of the clinical councils that the PHNs have. Like, we have one district clinical council, like that, the PHN has four clinical council - one for Wagga, one for Riverina, the other one for western and the other one for border, so those councils do have council representation in some instances. So I think there is quite good interconnected relationship.

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

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 --

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

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

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

Q. So in order to provide that training program, it would need to be delivered through a larger hospital than, say, Finley?
A. That's - Finley could do it. I think Finley is not the ideal place for that type of thing. I think Griffith or Wagga or Deniliquin, Young, type of place would be the idea type of place, because you need to have an onsite doctor all the time to be able to supervise such an international graduate for us to fulfil the criteria for the Medical Board.

Q. Is it your view that by running a program like that through facilities based in Murrumbidgee LHD, you would have a greater capacity to fill --
A. We will have a better pool to recruit, and we will have a better opportunity to send GPs into smaller towns such as Berrigan, Batlow, where they will work in the hospital, aged care as well as the community.

Q. You mentioned a moment ago the fact that doctors in this day and age like to take time off, not unreasonably. Is that something that the community's expectation has not quite caught up with?
A. Not quite. I know there are certain parts of the community who think that, in Finley, in 1985 they had their appendix out, they had their knee done, they had their hip done, they had their babies born, "And now you guys are talking about that you can't even run an emergency department", you know? There is that notion in the community. But the vast majority of the community do understand the context is different and the circumstances are different, and they want better care, too.

Q. There is presumably more to that shift than just the fact that doctors working in small communities like to have a reasonable work/life balance. Have there been changes in medicine that have occurred over the last several decades which mean getting all of those procedures done in a hospital like Finley is no longer realistic?
A. That's correct. I don't think I'd want my appendix taken out in a smaller hospital where there is no operating theatres or standards maintained to the level of what Wagga would do. If I don't want it, then I don't want my patients to have it, too. That's a simple as that. You know, I think that time has gone. We know that. But people know it too, but they do point out - when something is getting lost, they do point it out, to say, "Look, this is what the situation was."

Q. Is there more to it than the facilities and the standards or accreditations within facilities? Is there also the fact that the surgeon who might be taking out an appendix in a small facility might do one or two a year whereas someone in Wagga might do one every morning?
A. Exactly. Exactly. It's more the fact that there isn't the workforce to do it anymore. You might have had it in the past but there isn't the workforce to even employ emergency trained nurses in smaller hospitals like mine, and let alone doctors. So I think the necessity or, rather, the situation is such, we just don't have the people to do it.

Q. Can I ask - and this might be a bit circular - to the extent that there are procedures that could safely be done in smaller hospitals, would doing them in those hospitals act as an incentive to GP VMOs with advanced training to head out to those areas?
A. Correct. Very correct. Very correct. I might just pick up some numbers, but they're not exact numbers.

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

If there is a mechanism that we can utilise the

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

Q. And it's the case, is it, that a proceduralist who came to work as a GP in a small rural community would almost necessarily also have to work as a VMO in the hospital, if they wanted to perform that procedure?
A. Yes, mmm-hmm. That's correct.

Q. Is it your view that that would be advantageous in terms of assisting with workforce challenges in those smaller hospitals and smaller communities that are around them?
A. One, yes. Most importantly, continuity of care. If you are - if you have an obstetrician in the town, that means that's the only surgeon you have in the town. If you are in trouble, that person will be there to do a lot of stuff. Not only will they be delivering babies, they can do a lot of stuff to help. If you have an obstetrician in the town, the town will have an anaesthetist. If you have an anaesthetist in the town, you are not going to only anaesthetise procedural stuff in your theatre, you will have an anaesthetist who can help you when there is a significant life-threatening emergency. You have an anaesthetist who can help the existing doctor who is in trouble with a complex situation. So a proceduralist in town is not only about doing the procedural stuff on the theatre, but they are a significant asset to a lot of other things.

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

Q. Doing a higher turnover of procedures at the moment?
A. We do it in Murrumbidgee, quite often.

Q. How does it work?
A. In Murrumbidgee, some places deliver only, what, 40 to 50 babies per year, and if those obstetricians want some

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

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

Q. Other than workforce challenges, which need to be overcome, and maybe overcoming them is - more procedures in smaller hospitals is part of that challenge, but is there anything else which is disincentivising the LHD from delivering more procedures in smaller hospitals?
A. I think proceduralists - procedures done out of base hospital is not measured as a key performance indicator. If you had an inpatient in the emergency department in Griffith Base ED for more than 24 hours, that will alert, and it is a reportable thing to the CE, and it will even get alerted at the state level.

THE COMMISSIONER: Q. Can I just ask, procedures in smaller hospitals - what are we talking about?
A. Endoscopies, minor surgeries, cholecystectomy type of thing, lump, bump, skin cancer excisions, that sort of thing and --

Q. That's the sort of thing we were told was being done at Tumut, for example?
A. Correct, yes, caesarean sections.

MR MUSTON: Q. Uncomplicated obstetrics?
A. And I think we do certain things like cataracts and some joint replacements and things like that, too, in some of the --

THE COMMISSIONER: Q. Not in Tumut because I remember

asking that. But maybe there are other small hospitals that do joint replacements, are there?
A. Correct. I think - I don't think in Murrumbidgee - I don't know, I need to check that. I know in --

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

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

MR MUSTON: Q. So you started mentioning that procedures performed in the smaller hospitals didn't trigger any KPIs?
A. Mmm-hmm.

Q. Do you think it would be useful to have KPIs which incentivised the delivery of procedures through smaller hospitals?
A. I think yes.

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

Q. Do you have a view about what the nature of block funding might mean in terms of an incentive or disincentive to perform procedures in smaller hospitals, block funded hospitals?
A. I don't know a lot about it. I know except for Griffith, Wagga and Deniliquin, everything else is block funded. I think block funding is kind of one spoon measure to everyone. That is not the best deal for us if we are looking at better performance. That's my broader understanding about it. The intricacies of whether that would be better than this is beyond my capacity to answer.

Q. Let's move on to another little issue which is associated with the dispersed population and large geography. Access to specialist services to patients across the LHD - what are your observations of that?
A. I deal with many LHDs, given my position in the border. I deal with Albury-Wodonga, I deal with Murrumbidgee, I deal with the Victorian sector in the sense Shepparton and Melbourne. The significant problem I see in Murrumbidgee's context is not having public outpatient

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

Q. So is that a workforce issue? Is that the absence of the public clinics or is it a --
A. It's a historical way of how we work and system issue, I would say, because in Albury-Wodonga and Murrumbidgee historically, the practitioners are seeing patients in their own private practices, and then if they need any procedures, they book them through the base hospital allocations for theatre list.

Q. So do I take it from that that the historical system prevents or creates a blockage in terms of wide access to specialist services by people within the LHD?
A. Could be said that, yes, in the sense if we had public outpatient clinics, we could have - some of our patients who have had difficulty in getting to different places or paying the out of pocket costs could have had better and quicker care than they would have otherwise had. So that would make a difference.

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

Q. You're not suggesting that within the LHD there should be public clinics for each of these various sub-specialties of which they're no doubt almost infinite in number?
A. No, I wasn't suggesting anything in that line. What I was suggesting is that if I have a patient who needs to see a cardiologist, example, I can send them to Goulburn Valley Health outpatient clinic where they will get triaged and get seen by a physician or cardiologist, and what needs to be done will be done, there will be no cost.

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

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

Q. Is that a common occurrence, sending a patient to Melbourne for a neurologist?
A. In my place, yes. Not in Wagga. Wagga has two neurologists here. There's quite a lot of backlog to wait and see, despite the out of pocket cost, but in certain regions going to Canberra or going to Melbourne would be the quickest option, if you want to see someone quickly.

Q. So we've got cardiologist, ophthalmologist, orthopaedic surgeon?
A. And paediatrics for autism spectrum disorder or behavioural problems - very difficult to get in to one.

Q. Are you aware of public clinics for any of these areas of specialisation being available in other LHDs within New South Wales through your other roles?
A. Yes. I think there is public clinics in Sydney. Many LHDs do have, if I'm not mistaken. I know - I was involved with the ACI in consultation for how to formalise and make a referral system so that - how to refer to public health clinics. So that was kind of a dreamy situation for me in Murrumbidgee's context, when I had a look at it.

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

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

Q. In what way?
A. People who need specialist care, vast majority of them are the complex ones, and vast majority of them are the ones from lower socioeconomic situations, and the more rural you go, the more difficulty that you see.

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

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

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

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

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

Q. You've told us a little bit about the cross-border challenges that you face in terms of getting patient records from Victorian hospitals where patients that you see in a primary care setting go into those facilities. Are there any other cross-border issues that you think impact on the way in which you and the LHD respectively are able to deliver health care to the communities that you respectively serve?
A. It was a big problem during COVID time because of border issues, and other cross-border things are

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

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

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

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

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

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

Q. Putting your LHD hat on, to the extent that you're trying to make an assessment of communities' needs within the LHD and perhaps also the PHN, is there a good information flow between the Victorian health service and either the LHD or the PHN in terms of services which might be being accessed by local LHD, Murrumbidgee LHD patients across the border in Victoria?
A. I think yes, with Albury-Wodonga. I'm not sure with the other places, because Albury-Wodonga and our executives have regular catch-ups and there is a process of working together.

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

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

Q. What was the AMA's role in relation to that negotiation?
A. I think my - if my memory is correct, AMA was involved in ratifying or, rather, endorsing our industrial relations component of our contract. We had to devise a new contract for these registrars, state employees, and AMA was involved in giving feedback for that.

Q. The other issue we have heard a lot about is the state/federal funding divide.
A. Yes.

Q. Does that present any particular challenges, as you see it, to the delivery of health care in Finley and also the wider LHD?
A. I think it is a significant problem.

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

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

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

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

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

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

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

15 minutes?

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

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

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

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

MR MUSTON: We'll say 10 minutes.

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

SHORT ADJOURNMENT

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

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

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

Should I understand that to be, for better or worse, in Australia, we tend to define primary care as the first service you go to outside of a hospital or a specialist setting, whereas I think I'm right, the World Health Organization has a different view about what primary care is, where it's a much more integrated series of services that are to meet the health needs of the person? Is that what you were talking about when you were talking about the way that primary care is defined and that lack of integration?
A. Yes. I think yes, in a way what I was trying to say is, in the Australian context of general practice, we are shackled with the Medicare billings and it is more GP-centric. 95 per cent of our consults are seeing or

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

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

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

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

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

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

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

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

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

MR MUSTON: Q. Do you think that the salary model would operate as a greater incentive to rural generalists and/or GPs with advanced skills to go into rural areas than the market-based model currently does?
A. I would say yes, but I would want to make the focus a bit beyond just merely the salary model.

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

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

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

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

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

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

Q. -- to determine the way in which primary health care and acute health care and aged care are going to be delivered within a community?
A. Yes. I think you're right on the target, yeah.

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

Q. And it should be supported in as many ways as it needs to be supported to maintain viability - yes?
A. Yes. That's correct.

Q. Work should be done as between the market based deliverer of primary health care and the acute setting to make sure integration between the two is maximised?
A. Yes, correct. I might rephrase it this way.

Q. Yes, please do.
A. Blacktown, Parramatta type of place, whether you do it

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

Q. So in those areas where a market may not be able to sustain the adequate delivery of primary health care to its community, or to that community, do you see scope for the state to step in and provide, in an integrated manner, the delivery of that primary health care and thereafter enter into whatever negotiations it needs to with the Commonwealth about how collectively the state and the Commonwealth might go about funding that endeavour?
A. I should say yes for that, but with a qualification, though.

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

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

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

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

Q. So a GP much like yourself but employed by the state, delivering primary health care through rooms in a small town, with an obligation to, as required, provide what is the equivalent of the VMO type services through the small local hospital?
A. Correct, yes. I think --

Q. Would a scheme like that help some communities?
A. Yes, it will help some communities.

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

Q. Which will take into account the needs of the community?
A. That's correct.

Q. The viability of the market?
A. Yes.

Q. As it exists, and could potentially exist?
A. That's right. Look, that type of model will work in some smaller towns - example, you know, Barham, Batlow type of smaller towns. If you tried to do that in Cootamundra or Tumut type of town, it will upset the existing market of how things are happening.

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

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

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

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

Q. What is it that the locals are doing to make it work well, first?
A. I think one is community focus, and both places, in Temora and Finley, the council, the LHACs, many other stakeholders came to one party in having one objective, and in both places, making a viable, profitable general practice wasn't the sole purpose of the business of it, and in both places, our vision was the clinicians should be able to do community general practice as well as the hospital care and the aged care - that's the only way you can have a place-based solution.

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

Q. Is there anything you think the system could do, or any changes that could be made to the system, which would enable that sort of success to be revisited in other communities that aren't lucky enough to have the right people?
A. Yeah. I think system is not growing the right people to do that. You know, you need to forcefully become the right person to do it in this current trend - my feeling is.

Q. How would the system go about growing the right people?
A. If we had a GP VMO leadership in a lot of other towns, other than Temora and what, Cootamundra, we would have had better international medical graduates being trained and got into hospital system and then we wouldn't have had the

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

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

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

Q. How could the system be rewarding it, do you think? Or how should the system be rewarding it?
A. I think that's what I'm coming up to. I'm trying to say that we're not incentivising the leadership roles. We are not, you know, recruiting or, rather, growing the leaders to come to that position. We're just waiting and seeing if somebody is popping up, then, okay, let's go with that kind of situation.

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

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

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

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

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

Q. In terms of that workforce and perhaps the classroom that we're dealing with within the LHD, what's the impact of locums and agency staff on the composition of that classroom, as you said?
A. Locums are necessary. You can't exist without locums, because locums are going to be an integral part, no matter what.

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

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

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

patients per day.

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

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

Q. Is there anything that the system could do to try and arrest that loss of senior people to the agency or locum market?
A. Standardising prices and, you know, blocking where LHDs could compete with each other with, you know, pricing, and looking at issues, such as when there is a locum who wants to come and work, tell them "Look, don't apply for it right now, just leave it, leave it till the last moment, then you will get emergency rates. That's better rates than the rates that you would get now", that kind of, you know, gouging, gaming the system. You can identify them. They can be worked on.

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

Q. Is it your view that a more centralised approach to the contractual arrangements between agencies and the state would potentially enable some of that change to be done?
A. Yes and no, though. I think centralised version would be good in a way with pricing and reducing competition and making use of things. No, is it'll add a lot of bureaucratic process, and one of the main things about locum, getting locum into gaps, is that you can get them without going through a whole heap of bureaucratic process that has to go through normal recruitment pathways. So if you add that up, then you end up, you know, stagnating the process. So I think if there is a way that you can get

good off both sides, yes.

Q. We've spoken a lot about the single employer model. As it's currently rolled out one the Murrumbidgee LHD, do you think it is sufficient to meet the demand or the needs of the community in the primary health space?
A. No.

Q. How much bigger do you think it would need to be in order to better meet the needs of the community?
A. I wouldn't know to answer how much, but I'm aware that it is certainly not, because we embarked in Murrumbidgee model as a pilot of five. We weren't, deciding that number of five based on - based on a need basis; it was just a picked up number, five, right? So that's how it was designed, because that's the only way we could get to the next step: okay, we will do it and show it, it can work.

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

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

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

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

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

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

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

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

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

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

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

Q. So we've probably already covered this, but in terms of your knowledge of the candidates who have been through the model, and particularly those who you have suggested might prefer a salaried model, at least conceptually, do you think the existence of a salaried model might enable them to be placed in areas where - communities where the market based model is simply not functioning?
A. I would say yes, but if you asked the same question from the registrars and the new generation, they would have a very resounding yes.

Q. In terms of collaboration that various entities do, can I ask, does the collaboration within the LHD and PHN, as you experience it, draw in the Aboriginal community controlled health organisations, like RIVMED?
A. Yes. I think our LHD has a significant focus on Indigenous health. We work very closely with RIVMED and GAMS in Griffith, and we - GAMS is supporting the Hay Aboriginal health service, and we have been working very closely with the community in Brungle, in Tumut, so our dealings and, you know, negotiations are very strong and have been happening for quite a long time.

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

Q. What about the collaboration with aged care and the private aged care sector?
A. Private aged care sector had a lot to do with us during COVID time, because they had issues with, you know, infection control, public health related stuff. Our dealings have strengthened and got a lot better.

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

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

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

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

Q. Do you see that the different conditions and awards are an impediment to collaboration between the private aged care sector and the state to try and deal with some of the workforce crises in relation to nursing staff?
A. Yes, in a way, because --

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

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

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,

because that's a carrot and stick approach.

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

Q. And that would be to the benefit of patients living in your region in your little area in what way?
A. In the way of better life expectancy; better involvement in decision-making and better care; access to otherwise not available medication through routine, standard process; access to more regular intensive investigations sometimes.

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

Q. That's the patients. In terms of recruitment of a medical workforce to regional areas, do you think a greater reach of that medical research and trials into the regions would have any impact on the recruitment of the medical workforce to your areas?
A. Yes. I think more than medical workforce, when you talk about research and clinical trial, if there is an expert on this, they will tell you better, but from what I heard from my oncologist colleague in Albury, is that what actually matters is administrative support and clinical trial expertise, research and funding related support. More than the medical workforce by itself, other accessories in place to make the existing medical workforce do clinical trials and provide better care for patients is what - what matters, than getting more oncologists or more clinicians to do it.

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

THE COMMISSIONER: Yes, Mr Chiu?

<EXAMINATION BY MR CHIU:

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

Q. Coordinating what is there, but also to bring things that are new to meet those gaps; is that correct?
A. That's correct.

Q. Facilitating that coordination so that it works better together and continues to work into the future?
A. That's correct.

Q. And potentially stepping in to train, to bring in workforce, to fill in those gaps as well? Those sorts of things?
A. Yes. I would say - I would say NSW Health facilities such as in Murrumbidgee and certain places has no other alternative, other than providing primary care through the acute care settings in places where there is certain market failure. We've got no option.

Q. But you see that as a last resort when all of those other steps fail?
A. At the moment, the way how it works is it becomes the last resort. But what I see is that it is inevitably going to happen and it is on the horizon that it will happen, so we might as well get ready to do it properly rather than becoming a last-resort situation. That's my feeling.

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

wouldn't be anything else exist possible.

Q. So other than in those situations, though, I think you gave some evidence earlier that that is actually not the most efficient way to provide primary care, if it can be avoided?
A. That's correct. I think hospitalists providing primary care is not the best deal, from what I can see. I might be wrong, but I don't see that is going to be cost-effective.

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

MR CHIU: Yes.

Q. But in a sense, the models that you have provided, such as the single employer model and the collaborative commissioning process in Murrumbidgee are ways of trying to facilitate what's already there to avoid a situation where you do have to step in?
A. Correct. Yes. They are, you know, initiatives that try to get many people collaborating, yes.

Q. So in an ideal world, you would see the district and NSW Health's role more as one of leadership rather than ownership of primary care?
A. In market failure situations, yes. Say NSW Health can't be - my opinion - my opinion - NSW Health can't be the primary care leadership role in Blacktown or Campbelltown.

Q. But in a regional area?
A. But in Hillston or Lake Cargelligo, yes.

Q. It needs to take a leadership role?
A. Yes.

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

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

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

commissioning and single employer model. You understand those to be what I mean by a leadership role?
A. I think they're innovative approaches, my understanding is.

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

THE COMMISSIONER: Q. I mean, if there is market failure of primary care and the state does nothing and the Commonwealth does nothing, what happens?
A. You will see more people in hospital. And whoever comes to our door, we'll have to provide.

MR CHIU: Q. Ultimately the question that we all face is how do we avoid that failure or how do we solve that failure? Do you agree with that?
A. That's right. Look, that's a complex question. There's no one answer for it. But, you know, being cognisant of that is happening is an important thing too. I don't really think we are 100 per cent there. We're not realising that this is happening and this needs attention. You don't need a lot - information on that, for example - I'll give you an example, you know, out of 250,000 people in Murrumbidgee, 150,000 people come to the emergency department, right?

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

THE COMMISSIONER: Q. Because the Sydney LHD has a competitive general practice market; right?
A. That's right, yeah. So what I'm trying to point out is we already are providing primary health care service in the name of ED care or hospital care in our smaller towns, non base hospital towns, and we've got to recognise that this is a problem and it is going to only grow and then --

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

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

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

Q. An expensive way of providing primary care?
A. That's correct. It is expensive, yes.

MR CHIU: No further questions.

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

MR MUSTON: Just very quickly.

<EXAMINATION BY MR MUSTON:

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

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

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

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

THE COMMISSIONER: Thank you.

MR MUSTON: Q. Your answer was:

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

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

A. Correct.

Q. That's the last resort?
A. Correct, yes.

Q. So dealing with it, to use your terminology, as a last resort measure, you wait until it's failed and people have been denied or unable to access the health care they need, and then you step in and try and fix it?
A. Yes. If you - look, I think --

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

Q. Is your suggestion that we should actually be planning, aimed at saying we should be looking at providing solutions to this problem before we endure a period where people are unable to access the primary health care that they need, rather than sitting back and waiting until it's going to happen, or until it happens, I should say?
A. Yeah, look, I think it is a complex question. I don't think I have a right answer for it. But what I'm trying to get to is what you said is correct, we do wait till market failure happens and then see the burden on us and then pick up on it, and it's a two-way process, though.

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

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

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

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

<THE WITNESS WITHDREW

MR GLOVER: I call Professor Lenert Bruce.

<LENERT DESMOND BRUCE, sworn: [3.44pm]

<EXAMINATION BY MR GLOVER:

MR GLOVER: Q. State your full name for the record, please?
A. Lenert Desmond Bruce.

Q. You are the executive director for medical services for the Murrumbidgee Local Health District; correct?
A. That is correct.

Q. You've held that role since 2020?
A. That's correct.

Q. You're also the general manager of the Wagga Wagga Base Hospital; is that right?
A. That's correct.

Q. And you assumed that role in about April 2023; correct?
A. That's correct.

Q. Are you affiliated with an educational institution?
A. Yes. So I hold an academic appoint with the Charles Sturt University for their rural medical school.

Q. What role do you perform in that appointment?
A. So I'm the head of the Riverina campus, which is the Wagga based campus.

Q. And in your role at that campus, do you oversee the delivery of training?
A. Yes, I do support education of medical students but I also teach for UNSW as well.

Q. Just dealing with the Riverina campus, what training and education is delivered on that campus?
A. So we have medical students that start off at Orange, so they do normally their first and second year in Orange

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

Q. And are these students able to complete their entire training in rural and regional settings?
A. They can, yes.

Q. That's prior to moving on to specialist pathways; is that correct?
A. Yes.

Q. And you mentioned you do some teaching for UNSW?
A. That's correct, yes.

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

Q. Can you just describe in general terms your day-to-day responsibilities as the executive director for medical services of the district, please?
A. Yes, so as the executive director of medical services, my role is to provide strategic advice to the chief executive, the other members of the executive and also to the directors of medical services at Wagga Base and Griffith Base Hospital.

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

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

Q. Let's just break that up a little. When you say you that your role is to provide strategic advice to the chief executive and other members of the executive, what sort of topics are you providing that advice on?
A. Well, it really depends. There would be industrial matters, which is probably the bulk of the work we do. Part of it is also service needs analysis, what type of medical staff do we need, the numbers of staff we need, what is the best way to engage them, you know, what instrument is most appropriate.

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

Q. This is all in the workforce space; correct?
A. That's correct, yes.

Q. You mentioned in your earlier answer credentialling and scope of practice for medical practitioners?
A. That's correct, yes.

Q. What is your role in the credentialling process?
A. So I'm a member of the credentials committee and I chair the appointments committee.

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

Q. So this is a process that identifies the particular functions that particular specialists can perform within the district's facilities; correct?
A. That's right. And it's also determined by the site where they practise.

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

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

Q. Because of the nature and --
A. And the resources required to do the particular procedure. It's a bit of a extreme example but, you know, it is just the - it's not that the doctor cannot do it but it's probably not appropriate at that particular site.

Q. And you mentioned in your earlier answer scope of practice for medical practitioners. What is your role in that process?
A. So I'm part of the credentials committee and we're very lucky that NSW Health now has a model scope of practice document that we utilise as the basis, and that's normally something that's discussed during the interview process, but it really determines what particular procedures or type of work a clinician can conduct in Murrumbidgee.

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

Q. Is it conceivable that a particular specialist might be credentialled to do a certain type of procedure in your district but may not be credentialled to do that in another district?
A. It would be difficult. It really would depend on if the facilities are like for like. You know, I expect that if we felt that a doctor can do a procedure at Wagga Base, if you had an equivalent hospital, they should be able to do it. Sometimes, though, having procedures has got other impact in terms of funding the cost of procedures, so a particular health service may decide not to do a particular procedure.

Q. So there might be all sorts of influences on the credentialling decision that is in addition to the particular qualifications and skill of the individual specialist?
A. That's correct, yes.

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

A. Yes, that's correct.

Q. Do you have a copy of that with you?
A. No, but I'm happy to --

Q. I can give you one.
A. Thank you.

Q. You've seen that document before?
A. I have, yes.

Q. Have you read it before giving evidence this afternoon?
A. I have.

Q. Is it true and correct?
A. Yes. It looks - let me have a look --

THE COMMISSIONER: Q. You have read it before, Professor?
A. Yes.

MR GLOVER: Q. It accurately reflects the evidence you're prepared to give to the Commission; correct?
A. Yes.

MR GLOVER: Commissioner, I propose to tender it in due course. Perhaps it can be MFI 2 for the moment and we'll wrap it up.

THE COMMISSIONER: Certainly thanks.

MFI #2 OUTLINE OF EVIDENCE PREPARED BY PROFESSOR BRUCE

MR GLOVER: Q. Go to paragraph 4, Professor Bruce, of this outline.
A. Mmm-hmm.

Q. There you describe a number of challenges, or you identify that the district experiences a number of challenges in attracting medical doctors and graduates; do you see that?
A. Yes.

Q. I take it you refer in that paragraph to "medical doctors and graduates" because that is the focus of your work; correct?

A. That's correct.

Q. And are you aware whether similar challenges are experienced in relation to nursing staff and allied health?
A. We definitely face challenges in the context of nursing staff and allied health. In my other role as the general manager of Wagga Base Hospital, we do experience challenges in recruiting especially specialised nursing staff, so nursing staff experienced in intensive or critical care, perioperative nursing staff, and particularly - some particular allied health professions is also challenging for us.

Q. Are those challenges similar or different to the challenges that you refer to in attracting medical doctors and graduates to the district?
A. I think some of the challenges can be similar but it would depend on individual circumstances. I think in terms of medical practitioners, there's a larger risk of being a sole practitioner in a very stressful and complex situation, while for allied health staff, they would normally be part of a slightly larger group or even a connected service. But once again, though, if they need support from a medical officer and there's no medical officer in town, that will, you know, definitely impact their abilities to provide services.

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

Q. Other than the challenges of the remote geographical location and on-call responsibilities, are there any other challenges in particular that you face in your role in attracting medical doctors and graduates to the district?
A. Well, there's definitely the risk of professional isolation, you know, if you're the only practitioner in a town, it can be quite lonely and you'll sort of carry the emotional burden of the medical services for that town.

I think having time off, as Dr Yoosuff discussed previously, time to do, you know, continuous professional development or just have a break, can impact them. Then also, the - you know, the nature of the on-call availability, even though there may not be a lot of presentations, but just being available 24/7, seven days

a week, is quite challenging.

Q. When you refer to the on-call responsibilities, do you have any particular category of medical staff in mind? Has that been a particular feature?
A. Well, it's especially for the rural generalists and especially if there's only one doctor in town or even when there's two or three, it does increase, you know, the on-call commitments significantly. But once again, we currently only have one neurologist in Wagga and he is pretty much on call for stroke services. You know, he can have a bit of time off, where we can utilise Telestroke, but it does require availability.

We have two interventional cardiologists that pretty much do a one in two, and we would have occasional some support from other visiting specialists, but it is, you know, quite a significant requirement.

Q. That challenge is perhaps linked with professional isolation in the sense of lower numbers in the district?
A. That's correct.

Q. Is the district doing any work to minimise the effect of that feature?
A. Well, most definitely. We do support any network arrangement where we try and have our doctors, you know, have structured networks with metropolitan hospitals. That's especially the case in neurology, where we have a strong relationship with the department in St Vincent's Hospital.

Q. How does that network operate in practice?
A. So we essentially have a significant number of visiting neurologists from St Vincent's that provide outpatient services in the neurology practice in Wagga, which is a private practice, which is similar to the bulk of our outpatient services, and they provide specialised services in conjunction with our local neurologist.

Q. Can we just go to paragraph 5 of the outline, thanks?
A. Sure.

Q. You tell us there that the district has been successful in recruitment. What areas of success are you referring us to there?
A. So probably the successful area that I can speak about

is in terms of anaesthetics. So I came to Wagga as an area of needs specialist in 2007, where there were only seven specialist anaesthetists providing service to the base hospital. That number has now grown to 23.

When I started here, we only had three trainees, currently there are 14 positions, and my successor has actually managed to establish a formal rural training scheme where trainees can actually start and complete the bulk of their training in the rural area and only going to metro hospitals to perform specialised procedures that we don't offer rurally.

Q. Perhaps step us through that. One of the challenges we have heard some evidence about in attracting specialists to the region or retaining those students who may have trained in the region and retaining them in the region is the need for them to travel away to undertake a specialist pathway?
A. Correct.

Q. So can you just describe the initiative that you were referring to in the last answer, so that is a pathway - a training pathway in which specialty?
A. So that's in an anaesthesia.

Q. How has it been structured?
A. Well, so essentially, what happens is that facilities are accredited. So Wagga Base is accredited for three out of the five years that is required, but there are certain types of surgical procedures that are not done rurally, the bulk would be things like cardiothoracics and neuro and some specialised paediatric services.

We've always had rotational trainees from St Vincent's in Sydney and from Canberra Hospital, and all we've really done is essentially engaged a formalised structure so that our trainees can go to them to get the experience of these areas where we don't provide those services, but once again, in return, their trainees come to us and experience, you know, particular procedures. For instance, St Vincent's Hospital in Sydney doesn't do eye procedures. Their registrars come to us and they learn that particular skill.

Q. I think in your earlier answer you mentioned that under that program, those trainees are able to spend longer

in the region than they otherwise might; is that right?
A. That's correct. They would pretty much be able to spend most of their time here, apart from the 12 months where they'll need to go to the metro hospital to do cardiothoracics and neuro.

Q. Is that, to your observation, assisted in those trainees remaining in the region once they've finished their training?
A. Well, the program is brand new. We have actually been very successful and, you know, from memory, three of the current anaesthetists were my trainees. Most recently I actually interviewed a paediatric anaesthetist, where the last time I interviewed him with was when he was a medical student. So clearly it definitely does work.

But we need more rural training because that - the period of your life when you complete your vocational training is when you develop personal and professional networks and if you're rural during that time, the chance that you are going to come back rurally is definitely, you know, significantly more.

Q. Has the arrangement that you've been referring us to required engagement with the college?
A. The college actually accredits the site. So they're already accredited. But it was more the collaboration between the different anaesthetic departments, and the current supervisor of training has done a lot of work with his colleagues and they have been very supportive of the model.

Q. Is there scope for more arrangements of that kind in other specialties within the district?
A. Most definitely.

Q. Any that come to mind in particular?
A. Well, one of the other areas where we have been very successful in is psychiatry as well. We can now actually offer end-to-end psychiatry and we actually now have two locally trained psychiatrists in Wagga. So there's definitely opportunities.

In terms of physician training, there's opportunities as well, because --

Q. What are they?

A. So for doctors who want to do general medicine, we offer most of the sub-specialties, and we have advanced trainees in cardiology, respiratory medicine. We have just been accredited for a trainee in nephrology. We've got neurology trainees. So it really is just allowing the trainees to spend more time with us.

Q. Are there any barriers that you perceive to that being able to be implemented?
A. There are some of the colleges that have certain requirements that you cannot spend more than a certain period of time in a particular facility, and that may, you know, potentially cause barriers.

Q. Might some of those barriers perhaps be heightened in rural and regional settings?
A. Well, it would impact rural settings more because we have fewer trainees, so having access to more trainees would definitely, you know, improve our workforce, and especially senior trainees are a valuable workforce, and it takes the pressure off the consultants.

Q. I take it from your earlier evidence, particularly trainees who may have commenced their medical training at one of the local facilities?
A. Well, that's correct, because they know the context of the area and they've old relationships and they know the other consultants, so definitely benefits.

Q. In paragraph 5, you note that despite the success that the district has had, there's a degree of natural attrition?
A. Yes.

Q. Is that level of attrition higher than you would expect it to be?
A. It's difficult. It's just that we do have people that retire and it then means that we have to recruit, you know, to those vacancies. But probably for us - and in that paragraph, I was probably mostly speaking about anaesthetics, despite the fact that we've got 60 more anaesthetists in town, surgical activity has more than doubled since I started in 2007.

Q. What's the cause of that?
A. It's --

Q. To the extent you have been able to identify one?
A. Well, difficult to say. There has been an increase in the population, once again, not to the extent that the activity has gone up, but - it's probably difficult for me to speculate why the numbers have gone up so much.

Q. Has there been any work done to attempt to identify the cause of that increased activity?
A. No, all we've discovered is that the number of procedures that are booked are still increasing. We expected an increased number of cases post COVID because - where patients would have potentially put off, you know, routine investigations, but we've pretty much completed most of the patients that were delayed during COVID and there is still a steady increase.

It is definitely an area that we will need to explore. One of the contributing factors will be the ageing population. As, you know, people become older, especially orthopaedic procedures and eye procedures become more common.

Q. Is it important for planning of services and in particular workforce planing to be able to assess the likely demand on an ongoing basis?
A. Most definitely.

Q. How do you go about doing that?
A. So for us, we have a robust data system that will actually tell us, you know, exactly what procedures we do and we actually have that data on a monthly basis, and we can identify trends in particular areas.

Other factors that we consider is the changing technologies will introduce new procedures, operations, or particular procedures may be done in a different way. But we can definitely do that, as part of our planning and, you know, at the - recently we had a review of emergency surgical procedures and we adapted our theatre schedule to accommodate those particular patients. So that really for us is ongoing work.

Q. In an earlier answer you said that you had caught up or cleared the patients who were delayed during COVID?
A. That's correct.

Q. What was cause of the delay during COVID?

A. So they were periods during the COVID pandemic where non-urgent planned surgical procedures were delayed, and the bulk of the patients that were impacted were the so-called non-urgent patients, which are category 3, so they were orthopaedic procedures, cataract surgery and ENT procedures.

Q. When you say that they've been caught up, have they been caught up wholly within the district's facilities or have there been referrals to other facilities to have that work done?
A. No, we did collaborate with private providers in Wagga and also in Griffith.

Q. And what did that collaboration look like?
A. So there were different arrangements. We had what we called a completely outsourced model with one of the day surgery providers where there was a - pretty much a funding arrangement and the patients were sent to that private facility and they provided the service and also the staff.

Other models we have is what we call a partially outsourced model where, in fact, we rent theatre space and staff from a private facility, but we remunerate the medical officers.

Q. Is there a process in place to determine which patients may be forming part of that model?
A. So clearly the focus for us would be on patients that are overdue, that have waited longer than what is recommended. They would be the highest priority patients. But once again, there's also patients whose clinical condition would make them more suitable to go to the base hospital than a freestanding day surgery.

Q. Who makes the decision about which cases go where?
A. Well, on a clinical basis, it would be a combination of the surgeon and the anaesthetist that review, and also the private facilities have a triaging system to decide if they believe particular patients are suitable. But then for us, it is the patients that really have been delayed the longest, because we want them to have their surgery as soon as practically possible.

Q. Can you just go to paragraph 6 of the outline, please?
A. Yes.

Q. Just have a read of that paragraph and I will ask you a couple of questions. Let me know when you have finished.
A. Yeah, sure. Ready.

Q. Can you just describe the concept that you are identifying in that paragraph, please?
A. Well, for us there's - clearly the demand for medical service is driven by the health needs of the community. So if we had the healthier demographic, you would have less need for medical officers. So that's part of it. So more investment in preventative health care, primary care, and not just medical primary care but really multidisciplinary health promotion, et cetera.

The other factors that drive demand are historical models of care where all patients have to come to a hospital, they all have to be seen by a doctor, which definitely then increases the demand for medical officers. There's also community expectation, where communities feel that their particular town needs an emergency department with a doctor available 24/7, even though there may only be, you know, one or two presentations per day. So that's probably what's driving demand to an extent.

The way that we can address supply, clearly, is the rural medical schools, increased vocational training programs, utilisation of telehealth, the utilisation of role substitution and utilising other providers, for instance, nurse practitioners, extended scope paramedics, et cetera. So there's a multitude of different strategies that we can try and employ to balance the supply/demand ratio.

Q. I'll come back to some of those concepts shortly, but I just want to return to the words at paragraph 6, where you say that the workforce shortage, which is the challenge in keeping up with demand for services that you describe in paragraph 5, needs to be addressed by considering both the demand for services and the supply of doctors to provide those services.
A. Yes.

Q. How is it that the workforce shortage can be addressed by considering the demand for services and the supply of the doctors to provide those services?
A. So the workforce shortage is based on the need. So if we need fewer doctors, the workforce shortage won't be as

severe. So that's the one. And in terms of the - if we can address the supply, then we won't have a rural workforce shortage in Murrumbidgee.

Q. So what you are describing is - this is my language, tell me if you agree with it or not - a two-pronged attack?
A. That's correct.

Q. One focused on reducing the demand by perhaps some preventative health and access to primary health care on the one hand; correct?
A. That's correct.

Q. And increasing the supply, on the other, through a range of training initiatives, including things that have been labelled "grow your own" type initiatives; correct.
A. That's correct.

MR GLOVER: Commissioner, I note the time. I am told we have to rise now to depart the building on time. I'm certainly not going to finish Professor Bruce this afternoon.

THE COMMISSIONER: My apologies, Professor, but we will have to get you to come back tomorrow morning.

THE WITNESS: Sure, that's no problem.

THE COMMISSIONER: Is 10 o'clock all right to start tomorrow morning or would you prefer to start at 9.30?

MR GLOVER: 10 o'clock is fine.

THE COMMISSIONER: Okay. We will adjourn until 10 o'clock tomorrow, then.

AT 4.12PM THE COMMISSION OF INQUIRY WAS ADJOURNED TO FRIDAY, 22 MARCH 2024 AT 10AM

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