Special Commission of Inquiry

into Healthcare Funding

Before: The Commissioner,
Mr Richard Beasley SC

At Dubbo RSL,
Cnr Brisbane Street & Wingewarra Street,
Dubbo, New South Wales

Monday, 13 May 2024 at 11.05am

(Day 025)

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

Also present:

Mr Richard Cheney with Mr Hernan Pintos-Lopez for NSW Health

THE COMMISSIONER: We're going to begin with a welcome to country.

AUNTY MARGARET WALKER:

(Indigenous language spoken. To be inserted once provided)

Good morning, everyone. For those who don't know me, my name's Aunty Margaret Walker. I'm a Wiradjuri Elder from this community. It is a pleasure to be here to offer you a welcome to country today.

The country we're meeting on today is Willow Wiradjuri Country. Willow is the possum, that's our totem for this area, and we're a part of the Wiradjuri Nation.

I would like to acknowledge and pay my respects to elders past, present and future, for they hold our culture, our history and our memories, and also acknowledge the descendants of the eight clan groups within Dubbo.

A warm Wiradjuri welcome to everyone here today. Commissioner, welcome, and everyone, welcome to our country. I will give you our welcome in language, then in English.

(Indigenous language spoken. To be inserted once provided)

Welcome, ladies and gentlemen, to Wiradjuri Country, and Wiradjuri people are glad that you have come. On behalf of all Aboriginal people, our culture, our history and our land, welcome to Willow Wiradjuri Country.

Mandaang Guwu, which is "thank you". Mandaang Guwu.

THE COMMISSIONER: Thank you very much, Aunty Marg. We appreciate it.

MR MUSTON: Given our delayed start, I will endeavour to be brief. The focus this week is on the delivery of health care across the vast Western NSW LHD. Last week the Inquiry was fortunate to have had an opportunity to travel around some of the footprint of the LHD and meet a range of different people involved in the delivery of health care across that area. We visited Dubbo Base Hospital and saw both the new and the old sections of that hospital in operation. It's a busy base hospital with a catchment of something over 100,000 people, spread across a very wide area, and although situated a long way from Sydney, we were shown just how collaboration with metropolitan LHDs has led to the local delivery of what is genuinely world class cancer care to local people in their local area.

We also travelled to Coonamble and were shown around the Coonamble Health Service and then to Nyngan, where we were shown around the Nyngan Health Service. Both are typical examples of the small country hospital adapting to meet the community needs in a changing health landscape.

I should say at the outset that across all of the facilities that we visited, the care being delivered by the dedicated staff at each of them is outstanding. Although operating under extreme pressure, each facility - by which I'm referring to Coonamble and Nyngan - offers limited emergency services, a small number of acute care beds, and increasingly provides a local residential aged care solution for older people living within their communities. Perhaps not the traditional role of a small country hospital but that's a contemporary reality of what we are seeing as we travel around the state.

I mentioned that each of the facilities and in particular those two smaller facilities are operating under extreme pressure. Once again, as we are progressively discovering as we travel around the state, that is also a contemporary reality. The sources of that pressure are varied, but the most significant can be traced to some common themes that we are seeing again and again. The first, and perhaps most significant, being the multifaceted workforce challenges experienced by all of the rural and regional hospitals that we have visited to date. The changing health demographics and increasingly ageing population contribute to those pressures. But that particularly so in combination with the inability of what might be described as the traditional GP VMO model to

deliver adequate and accessible primary care and acute care within these smaller communities.

As one person observed - and I will paraphrase - to the extent that that model, that is, the GP VMO model, was at least in one of these communities able to adequately meet all of the primary and acute care needs of the community that it serves, it was in the rear view mirror and a very long way back at that.

But what we did see was some locally grown solutions which are starting to feed into this theme that in each community, the solution to these problems and the way in which they might best be dealt with will be different and will depend very much on the particular circumstances of the community in question.

So when we were in Nyngan, we had the pleasure of visiting a fantastic multidisciplinary medical centre which has been established by Bogan Shire Council. It is meeting primary health care and other needs within the community in a way that traditional market-based GP-VMO type arrangements weren't. We will hear a little bit more about that today when some members of the council come and give their evidence. I will not delay us further by describing it.

We also had the very great privilege to visit, in Coonamble, the Aboriginal Medical Service located out there which again is providing phenomenal health care not only to our First Nations people but also, increasingly, to the wider community in and around Coonamble and it is expanding in both its operations within the primary health space but also more widely. Again, that's probably something that we might not hear about directly during evidence this week, but will inform some evidence that we will hear at a later stage in the Inquiry.

The other thing that we'll probably hear a little bit about in later stages is some of the evidence that we gathered during the community listening sessions that we held in town last week, where I think it was for six hours we had the great pleasure to listen to a wide range of people involved in the delivery of health care but also as consumers, explaining and telling us about their experiences and ways in which they think changes might be made to improve the way health care is delivered.

But without further ado, I will hand it over to another to take some evidence from Megan Callinan, who is the chief executive officer of Marathon Health.

MR FRASER: Thank you. Commissioner, Ms Callinan is in the witness box.

<MEGAN ANNE CALLINAN, sworn: [11.12am]

<EXAMINATION BY MR FRASER:

MR FRASER: Q. Ms Callinan, could you please give your full name?
A. Megan Anne Callinan.

Q. You are currently the chief executive officer of Marathon Health; is that correct?
A. I am.

Q. And how long have you held that position?
A. Coming up to five years.

Q. Just very briefly by way of professional background prior to taking up that position, could you give us a brief outline?
A. My professional background has been more in community development and regional economic development roles. I have also spent a lot of time working with First Nations communities and organisations.

Q. Ms Callinan, you have prepared a brief outline of some evidence, the evidence you intend to give to the Inquiry. Do you have a copy of that outline with you?
A. I do.

Q. I think it is [SCI.0009.0080.0001]. Have you had an opportunity to read through that prior to giving evidence this morning?
A. Yes, I have.

Q. Is there anything in there that you want to change or is incorrect?
A. I think we've had ample time to update it, thank you.

Q. I will take you to parts of it.

MR FRASER: If I might tender that to the extent that it requires tender. I understand it will form part of the bulk tender in due course.

Q. Can we just start with Marathon itself. We understand that Marathon provides services in a number of rural and regional local health districts in New South Wales; is that right?
A. It does, yes.

Q. Those are the Western NSW LHD, Murrumbidgee, Nepean Blue Mountains LHD, Southern LHD and Far West LHD; is that right?
A. That's right, yes.

Q. And also provides some services within the area that is operated as the Albury Wodonga Health Service?
A. Correct.

Q. Would you just tell me, overall, what's the general focus of Marathon's services?
A. It is a primary health care not for profit. Fifty per cent or a little bit more is focused on mental health services. We're an organisation that currently manages six headspace centres, but we certainly span the spectrum of mental health needs through to severe and persistent mental health and on through to the NDIS.

The other two segments of our services relate to primary health care and preventative health care, and then we are a provider of therapeutic services through the NDIS.

Q. I should have said at the beginning, I understand - and I will use the case of Ms Crothers, the chair of your board - is giving evidence directly after you?
A. She is.

Q. If there is a question that is better suited to her, please don't feel that you have to answer it, if it is more suited to her role.
A. Thank you.

Q. Just let us know. Now, in terms of just overall, in terms of funding, you have a variety of funding sources; is that right?
A. We do. The organisation has an annual turnover of about 34 million in the last financial year. Predominantly

that is funded through the primary health network, which is federally funded initiatives, but we also receive some funding obviously through our fee-for-service arrangements or through NDIS in a retrospective sense, but about 10 per cent of our funding would be received through state government services, predominantly the Department of Community and Justice, around some family preservation programs.

Q. We might just run through your services and just tease out the funding aspects of it as we go. You have already referred to operating six headspace centres?
A. Yes.

Q. Is that a tender arrangement?
A. Yes. So the Commonwealth Department of Health uses the primary health networks to commission those programs, and they are a competitive tender process, and we tender for those in the central west. We deliver five of those services - Lithgow, Bathurst, Orange, Dubbo and Cowra, and we deliver one in Queanbeyan.

Q. So predominantly in this local health district?
A. All bar one. The other headspace centre is in Broken Hill, in the Far West LHD.

Q. In terms of those headspace centres, are you involved in planning for capacity in that regard?
A. Planning for.

Q. Capacity growth or capacity needs in relation to headspace, or is that done by the national umbrella body?
A. It is done at a national level. There has been some recent uplifts through core funding in the last financial year and in forward years but that's done at a national level. We report back through the primary health network on progress.

Q. And in terms of the capacity at those centres, you presumably report back on that as well?
A. Yes.

Q. Are those centres operating at or near capacity?
A. They are certainly operating at capacity. Some have wait lists. It really - I think the key driver to a lot of performance is around workforce. Mental health workforce is very difficult to come by, so attracting and retaining

those staff is an ongoing challenge that I think all services, particularly in rural and remote locations, are faced with, but I'm pleased to say that we do reasonably well in that matter.

Q. Just tell me about the workforce. When you are contracted to operate those services, is it the case that it is up to your organisation to source the workforce?
A. Yes, it is.

Q. And just in terms of that mental health workforce, what are the challenges in that regard that you have experienced?
A. I think we've seen nationally an uplift in the need for people to access mental health services. For us, there is a range of tactics or strategies to attract workforce. Certainly employee benefits - for us it is around providing a really safe clinical governance framework for people to operate within. We do attract a younger workforce or new graduates, but that clinical governance and supervision has been a positive and - has come with good outcomes, with people are being attracted and retained. We also have developed a peer workforce which was an initiative of the national government and national headspace, which is now embedded into the service. So peer workers are very much part of the model and new graduates and early career clinicians underneath senior clinicians is generally how that model works.

Q. Can you explain what you mean by "peer workforce"?
A. People with lived experience. So people that can work with the clientele and offer support from their own practical experience, but that has to be done in a very supervised framework, supported framework, but it has certainly proven to be beneficial.

Q. Lastly, in relation to those headspace centres, have you been able to fill all the vacancies that you have had in recent times?
A. It ebbs and flows. At the moment I would say that we would be almost full, but it is an ongoing challenge. There is a reasonable amount of churn within mental health workforce, simply because of the opportunities that are available. But at the moment, I would say that we are almost full. There would be two or three positions across our footprints that aren't filled in those headspace centres, but it's an ongoing challenge.

Q. Just focusing on mental health, can you just explain the other mental health services that you provide, other than the headspace centres?
A. Yes, so there is a program commissioned for the hard - directed to deliver service to hard-to-reach clients, and that is known as Strong Minds. It is for more that mild to moderate mental health psychological support. We also provide supports for people who experience severe and persistent mental ill health or are in that psychosocial range, and those that are subacute or not on the NDIS. So there certainly is a degree of acuity across the spectrum of care that we provide but it is subacute before a hospital setting.

Q. And in terms of Strong Minds and that subacute service, what is the model of delivery for that service?
A. We operate in the footprint of the primary health network, so it is quite large for Western New South Wales. We would have a substantial workforce ourselves of mental health clinicians. We also subcontract psychological service providers, mental health workforce, across that footprint, predominantly a clinical workforce.

Q. What is the mode of delivery? Is it providing --
A. It can be face-to-face, it could be telehealth, but a large percentage is face-to-face.

Q. In terms of that face-to-face work, is that done at dedicated premises or allied health centres or --
A. We would work with the community and sometimes that is in a GP practice, it could be at an AMS, it could be in a range of places within the community which are prearranged.

Q. We're coming to a few other allied health aspects in a moment, but is that using some of the same premises that some of your other services utilise?
A. Yes. We absolutely rely on strong relationships with other health providers, service providers within the region, and through that, we share resources and we would have arrangements, commercial arrangements of hiring rooms, et cetera, across the region.

Q. And before we move off mental health, those services you have outlined are they also funded through the PHN?
A. Yes, through the Department of Health, the federal government.

Q. Are they just within this local health district in Western New South Wales or --
A. It is across the Western NSW Primary Health Network, so it would be Far West and Western LHDs.

Q. Before we move off mental health, are there any other mental health services, or have we covered them?
A. I think that's predominantly the mental health services. If you were interested in a workforce initiative, I'd be happy to talk to one.

Q. Yes, please do.
A. So in this region, one of the initiatives to try to address mental health workforce, ourselves, the Western NSW Local Health District and two private providers in Orange trialled an attraction program, I think we called it Core Connect, and it was for provisional psychologists who require to do their professional years post graduation. We were successful with some funding to provide their supervision, it can be very expensive and certainly a barrier for mental health clinicians to get that supervision to become registered. It can sometimes take either a year to two years to get that, and there are specific things that you are required to do. We worked together with those organisations successfully to get I think it was 17 provisional psychologists through their accreditations and employed within the region by sharing that workforce, creating a community of practice and supporting one another, and we're looking to continue that with some additional funding, hopefully, because it was the provision of supervision that attracted the clinicians to the region.

THE COMMISSIONER: Q. Who - when you say "successful in getting funding", was the funding from NSW Health, or the LHD, or the Commonwealth?
A. I believe it was bilateral agreements with the state health department used those fundings through the primary health network. That seeded that initiative.

Q. To secure that funding for Core Connect, did you have to put together a business case of some kind?
A. Yes, yes. But it certainly - when we went to market late in the year, in the particular year that we went out, it was certainly those people, those students that had just completed and were needing to do that professional year or

years, were very incentivised by the fact that there was a structured program and a collegial community of practice that they could be part of, which was highly successful.

MR FRASER: Q. When did this run, Core Connect?
A. It is just in its - at the end of the second year, I believe.

Q. In terms of its hopes for it on an ongoing basis?
A. It sounds favourable but I haven't got a full outcome yet, but it sounds favourable to continue.

Q. And that's awaiting something from the PHN in response --
A. Yes, just awaiting a federal commitment. But as I said, I think it sounds favourable.

THE COMMISSIONER: Q. Can I ask, how long is the funding for? Is it a 12-month, or is it longer than that?
A. Generally, it's two years, to match how long it would take someone to complete their professional registration.

THE COMMISSIONER: Thanks.

MR FRASER: Q. And the clinicians that are being supervised and completing their training in this regard, they were what types of clinicians, psychologists?
A. They are provisional psychologists - provisional until they are registered. So there are some restrictions. They can certainly provide services as they are growing in their professional practice.

Q. Was there any input from the professional body for psychologists in planning this program?
A. That's who would register them. So they would meet all of the requirements. We would step through and support them in order to become registered.

Q. But it wasn't a program that was driven or had input from --
A. No, it was a program that Marathon and their partners, the LHD and the two private practices in Orange, came together to work collectively on.

Q. Could I ask you about the area of primary and preventative health care?
A. Yes.

Q. Just give an overview of the work that Marathon does in that regard?
A. Yes, so predominantly, in terms of chronic disease programs that sit within our suite of services, again, we are federally funded through the PHN to provide support for people with chronic illnesses. Specifically we have credentialled diabetes educators and dieticians who provide supports in an outreach setting, again with partners in community, that we deliver those services. And we are also commissioned through the Rural Doctors Network of New South Wales to deliver a range of primary health care and preventative health. There are a range of programs, MOICDP, programs to support better hearing and eye health, as well as the coordination of some specialists that come out to the region that we provide those supports and coordinate them to deliver into community.

Q. I think you just referred to the MOICDP. Is that the Medical Outreach Indigenous Chronic Disease Program?
A. It is.

Q. Can I just ask, in relation to these specific programs, they are being delivered in various locations within Western New South Wales.
A. Yes.

Q. In terms of how those programs came to exist, into planning for the need or identifying the need and putting the program together, could you just give us some --
A. So the Rural Doctors Network is responsible for the needs assessment and coordinating that, and they commission us to provide those services.

Q. And that funding through the Rural Doctors Network --
A. I believe it is sourced federally.

Q. In terms of when you say they are delivered with the assistance of partners, are you again referring to GP practices, Aboriginal Medical Services and --
A. And other health services, yes, maybe RFDS or depending on what's in that community at the time. The LHD rooms could be used as well.

Q. At, say, a multipurpose service or --
A. Could be, yes.

Q. Whatever health facility might be available and --
A. Yes, what ever is appropriate for that kind of setting.

Q. -- who you can work with?
A. Yes.

Q. Am I right, then, in thinking in terms of all of these services, or many of these services that you operate, there is a significant importance in relationships with local providers to work out how to cooperate to be able to deliver these services into local communities?
A. Without a doubt. Relationships is how community health occurs in this region. It is important for us to have those trusted relationships, that we have open dialogue, that we share, you know, our knowledge and our intel and certainly our resources. We currently have two occupational therapists who sit within the Coonamble Aboriginal Health Service and operate in partnership with CAHS, and where we can find opportunities for our clinicians to support others, particularly if they are willing to live in regional settings, we call on our partners to work in partnership.

Q. Just to take that example at Coonamble, how was the need for OTs at Coonamble identified? Did that originate from the Aboriginal Medical Service?
A. It was probably happy coincidence that two graduates coincidentally wanted to be in Coonamble and reached out to us looking for work. We knew that there was work in Coonamble because of our service delivery within NDIS and other early childhood supports, and wanting to accommodate their request to live in Coonamble, we turned to a partner to say, "Would you be able to house these new grads", and we'll provide support and they provide day-to-day supervision.

Q. So a degree of good fortune --
A. Good fortune.

Q. -- from the workforce perspective?
A. Yes.

Q. And then leveraging relationships for mutual benefit I suppose?
A. Absolutely. And I think, you know, wherever we can support somebody, you know, coming to the region, whatever

their circumstances are, we will be working very hard to secure them and to be part of the rural health workforce.

Q. Can I just ask about the funding for these various primary care services that come through the Rural Doctors Network?
A. Yes.

Q. Can I just ask you about the funding cycle. What is the length --
A. It is an annual cycle. I believe that the Commonwealth arrangements are with the RDN, they would need to answer that specifically, but I have a feeling it might be more like a three-year cycle, but our contracts are reviewed annually.

Q. What is your experience about how long before the end of one cycle you have confirmation of renewal for future cycles?
A. For that particular funding cycle, it's - you know relatively in advance, probably within the last quarter of the previous financial year you would have a fair understanding of what would be likely to be provided post that. It's the end of the funding cycle from the Commonwealth where you may have more of a delay. But in the eight years that I've worked with Marathon Health, that program has been running, and I think prior to me.

Q. So in terms of certainty for your clinicians about the service still being --
A. So that particular program, particularly when there are specialists going out into community, that is us coordinating specialists from - so subcontracting arrangements, so it could be an endocrinologist or a rheumatologist from Sydney or Newcastle, and we coordinate them to go out, or a cardiologist, coordinate them to go out into region. So we always have those arrangements in place, maintain I think something up to about 200 subcontracting arrangements for a whole range of specialists, and we would call on them and coordinate that once we had confirmation of funding.

Q. In terms of your perhaps more dedicated staff to the site, who might be there multiple days a week?
A. The administrative side of it is coordinated out of our Dubbo office, so they are ongoing staff, and yes, that's probably where we need to have the confidence that

they can continue to do that facilitation role in order for that to happen. So that's really for us. Once we know the quantum of funds and the frequency, then we are able to ensure that those staff continue those roles.

Q. If you can just tell us, in relation to specialists through your various primary and preventative healthcare service, these are direct subcontracting arrangements with these clinicians; is that right?
A. Yes. So using various networks, we would make contact with people that would be clinicians that would be interested in doing this work, and those staff would have various professional networks that they would go through or professional bodies to seek clinicians that would be willing to deliver that service - some within our local area, some more broader than that. For example, I think we may even access people out of Brisbane, for example, for particular services. But I would have to get further evidence, which could be provided if you were interested in that.

Q. In terms of your allied health staff delivering, say, your OTs, dieticians, diabetes educators, et cetera, in terms of workforce there, have there been any difficulties in securing sufficient staff?
A. Yes. I mean, we could double our workforce and not meet the need for NDIS specifically. We have put a tremendous amount of effort into our workforce development initiatives. That starts with, you know, our student placements. Then we move to new graduate opportunities, but in the last financial year, we've I think had 77 students from 12 different universities across nine different disciplines and that resulted in seven new grads for us across a range of disciplines. That's the amount of work that needs to occur in order to attract that level of staff and, generally, that's not funded. That is what Marathon Health has been doing. There has been a couple of programs we've received some support in in more recent years for, but it is an ongoing focus for us.

But I would say that, you know, it is part of everything from your promotional material, recruitment and marketing, how you run your HR services, how you deliver your students 'experiences and attract people back enticing them to the region - it has been a very large focus for us, but I'm happy to say that, you know, six years ago, seven

years ago, when we were an organisation of about 110, 120, we now have over 300 staff and there are probably more than 100, 120 clinicians that are employed by us, which are professionally recognised clinicians across those allied health services. So it can be done, but it is a lot of very hard work and I think the commitment from the Marathon Health board and its staff to workforce development has seen that occur.

Q. I want to ask you about a couple of workforce initiatives in a moment. Just to round out your service provision, you have referred to it a few times.
A. Yes.

Q. You are an NDIS provider?
A. Yes.

Q. That's throughout those areas in which you operate; is that right?
A. Yes. Predominantly western, southern, through Albury and a little bit of northern Victoria.

Q. In terms of the staff that provide your NDIS --
A. Predominantly it's therapy supports. So the majority is speech and OT, and we also provide positive behaviour support for those that need it. So it's basically therapy. We were in support coordination and we have retracted from that market. We don't provide those services anymore.

Q. I see. You don't provide the service coordination, just the service delivery now?
A. (Witness nods).

Q. In terms of some of those allied health disciplines such as speech therapy, occupational therapy, do those staff operate solely within the NDIS, or are they also providing - do you --
A. There are some other programs.

Q. What are the other programs?
A. The PHN here in Western fund a speech pathology project and we provide early intervention supports to preschools and I think in about 10 communities within Western NSW LHD. We also work across western Murrumbidgee and support some schools. We've also provided some support to Birrang Enterprise Development Corporation who provide services in Bourke, a family-based program where we provide

some assessments and ongoing therapy. So some of it is on a fee for service basis with partners, and some of it is with schools, but the majority of it would be through the NDIS.

Q. I would just like to now ask you about some of your other workforce initiatives. You have already spoken about that in relation to trainee psychologists. There is a service you have referred to in your outline as the learnership program?
A. Yes.

Q. Can you give a quick overview of that and I will ask you some questions about it?
A. We saw an opportunity while we were co-designing a youth outreach program in mental health for western communities, a program funded by the PHN, to develop a workforce initiative for those people living in community who were looking - who eventually we would be looking to recruit to deliver a mental health program. We took the view that if we were to just go straight out to market and advertise, what we would likely do is take resources from existing services and what we're really committed to doing is growing the workforce. So for the 12 months just gone, we decided to work with regional New South Wales, who funded - co-funded, as well as the primary health network, an initiative for 30 trainees. Those First Nations trainees are in three cohorts. The first cohort has just completed. So 15 First Nations people within community started a Cert IV mental health accreditation, delivered by AH&NMRC. Fourteen of those have graduated about six weeks ago and are still working with us waiting for the outreach program to be fully implemented. We have a second cohort that are doing primary health, Indigenous primary health, and a third cohort have just started in community services.

What we see through those opportunities is for people to earn and learn in place, with a living wage, through a collaboration. So it was a single employer model. Marathon Health was the employer. And we supported and coordinated the training with AH&NMRC on CSU's campus here in Dubbo, so people were in community working with their host organisation, learning on the job and being supported and coming into Dubbo on a residential basis. I think they came in four times during the year for a week, and then were supported in community to complete their qualifications.

So I think getting a Cert IV qualification in mental health in this area of those numbers in one cohort probably hasn't happened for a very long time, but it was certainly the first - you know, the start of something that we believe is really worthy of investment because, if we want to keep people healthy and well in their community, those people that are living in that community would be a highly attractive workforce to support the development of, to keep people well in their own communities.

Q. Are those individuals undertaking those three slightly different versions of the program all from different communities throughout Western New South Wales?
A. Yes, there were 10 different communities in that first cohort, and yes, varying communities in the second two cohorts.

Q. And in terms of funding, wholly funded by Marathon; is that right, or through input from others?
A. The funding that we received through the primary health network and regional New South Wales, the Department of Regional NSW, also provided a million dollars' worth of investment into that initiative.

Q. Was that something that was pitched for?
A. Yes, it was something that internally we came up with, a workforce strategy, and pitched that and we were able to get the support of the PHN and regional New South Wales to develop that.

Q. What about plans for it for the future?
A. We have a submission into government at the moment. So the Western NSW Local Health District, ourselves and some partner allied health providers, RFDS and Live Better, have formed an alliance to support workforce initiatives around allied health. We've developed a proposal called the healthcare work force activation hub, that we propose to have based out of Dubbo on CSU's campus, to continue this work. We've been working with our colleagues at TAFE and Health to progress those discussions. So that's a live conversation at the moment.

Q. What is the status of that conversation? There is a submission, you said?
A. Submissions have gone through the government channels and would be sitting with government for consideration.

Q. Which relevant department is that, the Ministry of Health or is it with --
A. It would be through the ministry and it would also be through TAFE as a collaboration.

Q. Effectively, awaiting a response; is that right?
A. Yes, imminent, hopefully.

Q. Just in terms of other workforce strategies, are there any other workforce strategies you wished to touch on?
A. No, I think that's probably the main tactics and strategies.

Q. I wanted to ask you some questions about collaborative commissioning.
A. Yes.

Q. Is that something that has - it is an initiative that has been trialled in the area for some years.
A. (Witness nods).

Q. Can you give an example of collaborative commissioning and your thoughts on it?
A. For me, I think collaborative commissioning in what I understand it to be and how it was implemented in Western, was a missed opportunity. I think there was a large investment of funds to work around supporting people with chronic disease, and I think I've outlined that we have a significant amount of experience and staff who could participate in delivering what I think was meant to be a one-system approach, sort of a joined-up collaborative arrangement.

But I don't believe that it was ever developed outside of the local health district and maybe primary care, being GP practices. It certainly is a bit of a mystery to us as to the outcomes of that initiative, and whilst we were engaged early on in some conversations, we didn't really see what I think collaborative commissioning could have been. I don't think that was realised for us in this context.

Q. In your outline you also have referred to a virtual hub established by the local health district.
A. Yes, I have to say that I don't have any visibility as to what occurred there. I'm not really sure what was

delivered.

Q. Can I just ask you in relation to needs assessments, in some of these areas you have referred to needs assessments being undertaken by Rural Doctors Network. Are you involved in any service planning or needs assessments undertaken on a whole of district level, say with the local health district?
A. Not that I can recall, no. I would say it - there are some needs assessments that are conducted from the primary health network, and there is planning through the local health district, but I do think there is opportunity for service providers that sit outside both of those to contribute to regional planning.

THE COMMISSIONER: Q. Can I just ask you, when you said in your evidence and in your statement that in relation to collaborative commissioning, $13.7 million was allocated to Western New South Wales which aimed to link the 11,000 patients to enhanced diabetes care, do you have any further details about that initiative?
A. I think that that's probably the public-facing comms that would have come out of either a website or media release from health, I would imagine.

Q. And the only thing you know about it is the Rural Doctors Network supporting those 10 people to get diabetes educator accreditation?
A. Yes. We understand that's occurred, yes, but --

Q. That couldn't be the 13.7 million though?
A. No, I don't have any visibility into how those funds were spent.

Q. Have you asked anyone a question at New South Wales LHD?
A. Look, I think, as I said, we had some initial conversations when there was some initial planning, but I don't - we were not part of the implementation model once it was rolled out.

Q. And you don't know anything further than what's in your statement?
A. No, I don't.

THE COMMISSIONER: Thanks.

MR FRASER: Commissioner, those are the questions I had for Ms Callinan.

THE COMMISSIONER: Thank you. Mr Cheney, do you have any questions?

MR CHENEY: No, Commissioner.

THE COMMISSIONER: Thank you very much for your time. We're very grateful. You are excused.

THE WITNESS: Thank you. I appreciate it.

<THE WITNESS WITHDREW

MR FRASER: Commissioner, the next witness is Annette Crothers.

<ANNETTE CROTHERS, affirmed: [11.51am]

<EXAMINATION BY MR FRASER:

MR FRASER: Q. Would you please give your full name?
A. Annette Crothers.

Q. Ms Crothers, you are currently the chair of the board of Marathon Health; is that right?
A. I am.

Q. I believe you are the founding director --
A. I am, yes.

Q. -- of the organisation. You, by way of clinical background, were an occupational therapist; is that right?
A. That's correct, yes.

Q. You are also currently a member of the Western NSW Local Health District board; is that right?
A. That's correct.

Q. Can I ask you, when did you first become a member of the local health district board?
A. Two and a half years ago.

Q. Two and a half years ago?
A. Yes.

Q. Ms Crothers, you have provided an outline of your evidence, [SCI.0009.0090.0001]?
A. That's right.

Q. Have you had an opportunity to read through that before giving evidence today?
A. Yes, I have.

Q. Is there anything in there that's incorrect or requires amendment?
A. No, there is probably a couple of things that are a bit more directive than I would have normally said, but other than that, no.

Q. If there is anything you wish to change, please let me know.
A. Certainly. Really, as much as anything, there is a statement in there saying that NSW Health operates in or delivers service delivery in isolation, and I would actually say that it tends to. There are occasions when it's in partnership.

THE COMMISSIONER: Q. What paragraph are you thinking of there?
A. Paragraph 24.

MR FRASER: Q. I see. It is the last part of that paragraph?
A. The last bit, yes. While I believe that NSW Health tends, because obviously it is the major deliverer of services, those services mostly are in isolation, but there are occasions when it is not absolute isolation all the time.

Q. Would you prefer to remove that part of the sentence?
A. Just that it "tends to", would be more what I would say.

Q. "Currently NSW Health tends to deliver services in isolation." That's what it reads at the moment.
A. Oh, good. Thank you. Maybe I haven't seen the last copy.

Q. Could you tell the Commission when Marathon was formed, came into being? When did Marathon Health come into existence?
A. In 2015.

Q. You have given an overview that it was formed to take over the funding that was held by what was then termed Medicare Local --
A. That's correct, yes.

Q. -- for the Western New South Wales region; is that right?
A. Yes, yes. The Western New South Wales Medicare Local covered much of this area of the LHD, and it was the Medicare local who put up the tender for the primary health - the Western NSW Primary Health Network, which - so that split the staffing for - that were there in the Medicare local.

THE COMMISSIONER: Q. What was Medicare local?
A. Medicare local was a federally funded primary health commissioning service and service delivery, to fill gaps.

Q. Was it part of the Commonwealth Government or --
A. Yes, it was --

Q. -- a separate entity?
A. It was funding from the Commonwealth Government and set up - the Medicare Locals were all set up by the Commonwealth Government. Change of government and we had this tendering process for the PHNs, and that left 50-odd staff and some programs and money that were delivering services in the area, and there was a group of the directors, of the Medicare local, who went "Well, we got services, we got money and we've got staff in place, let's keep it going."

Q. Tell me if you don't know, but how long was Medicare local around?
A. Look, I couldn't tell you exactly, but it was probably five years.

Q. And what was the reason for the cessation, if you know?
A. I think it was political. Medicare Locals came out of the general practice divisions that were around, and they were amalgamated into and were given funding to do the service delivery as a Medicare Local.

THE COMMISSIONER: Are we covering that at any stage, that history? Is it necessary?

MR FRASER: We can certainly cover it in a document probably separately, Commissioner, if we need to.

THE COMMISSIONER: Thanks.

MR FRASER: Q. So it is from there that the organisation has grown; is that right?
A. That's correct.

Q. Just in terms of strategic direction and how that has happened, can you give an overview - has it been organic or has it --
A. It's been deliberate but it's also been organic, in that initially we obviously were looking for funds, and our primary focus was about gathering funds, and from a diverse range of funders, so that we were very sure we did not want to have one single funder, we thought sustainability was about diversification as well. We very much stated as a group, a board, that we were going to be rural and remote and we wouldn't be going across to the metro areas, that we felt strongly that there was a very different model of care required in rural and regional areas to those in metro areas. So we targeted funding that was available in areas that were in our area, where we felt that we could offer a service. And it's grown from that and, as Megan was talking about, speaking about the headspace centres that we were funded for quite early on, a lot of the time they have been the introduction of where we have actually gone. Once you get a headspace centre, you get a presence in that community and then from there, you build up the other programs. But it's been largely around taking up funding that is offered in areas where we feel that we could contribute.

Q. You describe in your outline in paragraph 10 initially your strategy focusing on securing funding and providing services related to that funding?
A. That's correct.

Q. And having to manage costs very carefully, but that now, the organisation has sufficient financial security to focus more on fulfilling gaps in service provision using a more holistic approach.
A. (Witness nods).

Q. Could you just expand on that a little, please,

Ms Crothers, first?
A. Certainly. As I say, initially, our funding was around where services were being - or funding was offered for services. We still rely heavily on that, but we do feel that we are financially much more secure than we were, and so we are able to - we are in the market, and a wider market and a more diverse funding market, really. We have our own funds to an extent that we can utilise, if we can do that strategically. But it is about identifying the gaps, and we are therefore going for funding and tenders which come up, which are addressing gaps that we see as something that we may be able to contribute to.

Q. Just in terms of "own funds", is from that from philanthropy or investments or --
A. Investments, mostly. As I say, the funding was still very important.

Q. Particularly in service delivery, I imagine?
A. (Witness nods).

Q. In terms of identifying gaps in service provision, how do you, as an organisation, go about identifying those gaps?
A. Most of those gaps are identified by the operational staff, and Megan has spoken about that to an extent. From the board's perspective, the executive may bring us issues where they see that there are gaps and which are not helpful for the community or for clients or a particular cohort, and we would address that. I mean, mostly, the executive inform us on that and we then make a decision about the way that we might go.

Q. And that often grows out of areas in which you are already providing some services; is that right?
A. That's correct, yes.

Q. Just in terms of various bodies with which you have formed partnerships, you have referred in your outline to partnerships with universities?
A. Yes. Well, that's in terms of the workforce.

Q. That's in terms of workforce and training?
A. As Megan was talking about.

Q. As well as healthcare providers such as the AMSs, GP practices?

A. That's right. Yes.

Q. Again, how does one, as an organisation such as Marathon that now stretches over a number of local health districts, as we have heard - when Marathon has expanded into an area, how does Marathon go about that strategically, about forming those relationships in a new area?
A. You would have to ask the executive.

Q. That's more operational?
A. The operational staff.

Q. I'd just like to ask you some questions about the program you have highlighted in your outline in relation to - that you have undertaken in partnership with Variety?
A. Oh, yes.

Q. Which is a children's charity. That involves flying a subcontracted paediatrician along with allied health, psychologists, speech pathologists and OTs to Walgett on a monthly basis?
A. That's correct.

Q. For diagnostic services to support getting on to the --
A. Assessments.

Q. Assessment for the NDIS?
A. Mmm.

Q. Can I just ask you how that, firstly, came to be? How was that identified?
A. I understand it was identified from the clinicians, but again, that's an operational issue.

Q. In terms of funding, do you know if the local health district has any funding in that or the PHN, or it is solely --
A. Not that I'm aware of.

Q. -- yourselves and Variety?
A. Yes.

Q. You have also, in terms of strategic direction, said in your outline at paragraph 15 that you are about to

launch a second five-year strategic plan?
A. That's correct.

Q. When you say "about to", is that --
A. Later this year.

Q. Later this year?
A. It's just being finalised at this stage.

Q. You have said that you intend that it has a clear focus on collaboration and a focus on elevating the customer voice in service design. If you could just speak a little to how does one achieve that elevation of the customer voice in service design?
A. A lot of it will be with the local communities, as our clinicians work in those communities, they're very definitely involved in having their say in what they - the services that they have delivered. It is about the customer or the client saying what they feel that they need, rather than us dictating to them what they should get. So it's about the collaboration with the actual customer but also with other service providers. We see that there are not enough clinicians to be providing the services in the rural areas, so we need to work together. We do not need to have any duplication or gaps. We certainly don't need duplication.

Q. In terms of identifying, ensuring no duplication, is that - obviously you are part of a number of umbrella organisations, such as the National Rural Health Alliance, Australian Health Care and Hospitals Association, the services for rural and remote allied health?
A. Certainly. There is also - in local communities, there's clearly organisations who provide other services as well, and it is about knowing about those organisations in those communities and working with them as well.

Q. In terms of health services planning for the regions, I'd just like to ask you about that. What you have said is, at least in paragraph 20, "Combined community planning is important", in your view?
A. That's true.

Q. And it would be ideal if you had fewer number of funding sources?
A. It would be - in terms of planning, it would make it easier if we had region-wide planning with all parties at

the same table, so then if the funding was a single funding, it could be disbursed into the agencies who are best to deliver. At the moment, the funding is scattered and as we at Marathon Health have to tender for a number of things, we literally look for opportunities for us to work and locations where we could work, whereas if it all came together and it was a single funding stream, then it certainly would be much easier to coordinate.

Q. I think you make the same point in relation to planning for health services for communities.
A. Yes.

Q. Perhaps you make that even more stridently.
A. (Witness nods).

Q. What's your impression of how health services are planned for, at least in the regions in which Marathon operates?
A. In the past, they have been very fragmented. I think there is certainly at the moment a move between the LHD and the PHN to - we've had one meeting. It's anticipated to plan a lot more closely. And I think that's a really positive move. I think the next part of that move is to include some of the non-government organisations, such as Marathon Health, in that planning process so that we can get all representatives from all parties around the same table to plan for the region.

Q. You have just indicated there was a first planning meeting between the district and the PHN?
A. Mmm.

Q. That's this district, Western New South Wales?
A. Western New South Wales.

Q. And the Western PHN?
A. That's correct.

Q. Western New South Wales. And was that a planning meeting involving the LHD board?
A. Yes. There was a couple of representatives from the LHD board and a couple from the PHN board or the Western Health Alliance board, as the organisation or the company that the PHN works from.

Q. And the focus or the idea behind such meetings is to

coordinate issues of service assessment?
A. That's correct.

Q. Planning?
A. Mmm.

Q. Funding?
A. Mmm.

Q. Is that right?
A. Mmm.

Q. Is there any governance around that meeting or is it --
A. Well, that meeting would be seen to be the governance group for the work that will then be undertaken.

Q. Was the chief executive of the local health district part of that meeting as well?
A. Yes, yes.

Q. As far as you know, is another meeting planned?
A. Oh, yes. We've had one and I think it's a quarterly meeting.

Q. So the intention is that it becomes a quarterly --
A. A regular thing.

Q. How did it come to be? Who drove that, do you know? The district or --
A. I think - I believe it was the PHN requested it. Apparently it has happened in a couple of other PHN areas. But our board was very happy to be part of such a conversation, yes. And then the LHD organised it.

Q. Can I just ask your perspective. Obviously you sit on both Marathon's board and have done since its inception, and now on the local health district board.
A. (Witness nods).

Q. Just in terms of the LHD board, does it assist you, having that interface between the two organisations? Do you think it assists in terms of - well, is it mutually beneficial to the two organisations that there is some crossover?
A. I think so.

Q. Of that nature?
A. Yes. I think so.

Q. To bring different perspectives to the other organisation?
A. I think as much as anything it's about having the whole perspective but from different aspects, for the region. But I also think that there is a benefit in developing the contacts between the organisations as well, that Marathon Health and Megan have been able to introduce to a number of the senior executive in the LHD and I think that that's a worthwhile and positive step as well. But from the board perspective, I think my understanding of what is happening in the region is deepened by that.

Q. By --
A. By being on both.

Q. By being on the local health district board?
A. By being on both, yes.

Q. Just lastly, in relation to how that greater involvement of NGOs and service planning might look like, firstly, is it something that you have been able to raise in any avenue, in any forum or another as of yet?
A. At the meeting with the PHN and the LHD?

Q. Yes.
A. We closed the meeting saying "The next step is to get the non-government organisations on board as well."

Q. And there is a number --
A. We'll wait and see.

Q. Wait and see.

MR FRASER: Those are the questions I have for Ms Crothers.

THE COMMISSIONER: Mr Cheney?

MR CHENEY: Nothing from us, Commissioner.

THE COMMISSIONER: Thank you very much for your time. We're very grateful. You are excused.

THE WITNESS: Thank you for the opportunity.

<THE WITNESS WITHDREW

THE COMMISSIONER: Just before you call the witnesses, I didn't ask at the start what, if anything, you want to do about making up any time?

MR GLOVER: I think the proposal is we will start and finish the next two witnesses, who will be called together, that's Mr Francis and Ms Wood, and then a break for lunch. I think we're tracking okay on that proposal and a short lunch from about 1.30. We must start the witness at 2 o'clock at 2 o'clock. And we must finish the last witness by 4 o'clock.

THE COMMISSIONER: Got it. Okay.

<DEBBORAH ELLEN WOOD, affirmed: **[12.14pm]**

<DEREK ANDREW FRANCIS, affirmed: **[12.14pm]**

<EXAMINATION BY MR GLOVER:

MR GLOVER: Ms Wood, if I can start with you, can you state your full name for the record, please?

MS WOOD: My full name is Debborah Ellen Wood.

MR GLOVER: You are the director of People and Community Services for the Bogan Shire Council; is that correct?

MS WOOD: That is correct.

MR GLOVER: To assist the Inquiry, you have seen and been involved in the preparation of an outline of your evidence for today; is that right?

MS WOOD: Yes, that's correct.

MR GLOVER: We will just have it brought up on the screen [SCI.0009.0078.0001]. You may have a hard copy with you, but I will just get you to look at the one on the screen when it comes up. That's the outline of evidence that you have read before today?

MS WOOD: Yes, that's correct.

MR GLOVER: Is it true and correct to the best of your knowledge and belief?

MS WOOD: Yes, it is.

MR GLOVER: Commissioner, that will be tendered in due course.

Mr Francis, can you state your full name for the record, please?

MR FRANCIS: Derek Andrew Francis.

MR GLOVER: And you are the general manager of Bogan Shire Council, correct?

MR FRANCIS: I am.

MR GLOVER: You have also been involved in the preparation of a statement for today?

MR FRANCIS: Yes.

MR GLOVER: That's [SCI.0009.0079.0001]. If you can see across to that screen, is that the outline of your evidence that you have been involved in the preparation of?

MR FRANCIS: Yes, it is.

MR GLOVER: Have you read it before giving your evidence today?

MR FRANCIS: I have.

MR GLOVER: Is it true and correct to the best of your knowledge and belief?

MR FRANCIS: Yes, it is.

MR GLOVER: Commissioner, that will be tendered also.

Mr Francis, how long have you been the general manager of Bogan Shire Council?

MR FRANCIS: I have been the general manager of Bogan Shire Council 13 years.

MR GLOVER: Prior to assuming that role, have you had any involvement in other roles in local government?

MR FRANCIS: In total, my local government career spans 35 years, yes.

MR GLOVER: Prior to joining Bogan Shire Council, where were you?

MR FRANCIS: I was at Brisbane City Council before that.

MR GLOVER: How long were you there for?

MR FRANCIS: Speaking under correction, nine years.

MR GLOVER: In what roles, generally.

MR FRANCIS: A variety of roles in general management and finance.

MR GLOVER: As general manager of the Bogan Shire Council, is it fair to say that you have ultimate responsibility for the operational side of the council's function?

MR FRANCIS: Yes, I'm accountable to the elected council for the operations of all of Bogan Shire Council, including the medical centre.

MR GLOVER: Generally, or in round terms, how many staff does the council have?

MR FRANCIS: Around 100.

MR GLOVER: Ms Wood, how long have you been at Bogan Shire Council?

MS WOOD: I've been at Bogan Shire Council for 14 years.

MR GLOVER: How long have you been in your current role, that is, director of People and Community Services.

MS WOOD: Since 2016, so seven years.

MR GLOVER: In general terms, what are the day-to-day responsibilities of your role?

MS WOOD: I've overall responsibility for human resources

and community services, and some of those community services involve the operations of the Bogan Shire Medical Centre, the Bogan Shire Early Learning Centre and the youth and community centre.

MR GLOVER: I will come back to some of those in a moment. Mr Francis, can you just tell us a little bit about the shire? What's its population?

MR FRANCIS: Total population of the shire is around 2,500, located 165 kilometres west of Dubbo, so fairly rural. It is a fairly big shire, as most of them are in Western New South Wales. It covers 14,000 square kilometres, three villages within the shire, but Nyngan being the main centre of all of them, and that's where the medical centre and shire offices are located.

THE COMMISSIONER: Tell me if I'm wrong, but is it possible that Bogan has a population of - sorry, Nyngan has a population of 2,500 and the shire has a slightly higher population?

MR FRANCIS: The population of the shire I believe is just short of 2,500. Nyngan itself would probably have nearly 2,000.

MR GLOVER: What are the demographics of the shire? Is it an ageing population, a young population, a mix?

MR FRANCIS: It is a bit of a mix. We do have a fairly young population. Something like 17 or 18 per cent of our population identifies as Aboriginal. It's a mining as well as agricultural area, so we have an operational copper mine within the shire but a lot of agriculture as well.

MR GLOVER: Ms Wood, is there anything you would like to add to that description of your shire?

MS WOOD: No, I don't think so.

MR GLOVER: We have heard some reference already to the medical centre and it is addressed in detail in your outlines. We will come directly to it. Ms Wood, when did the medical centre commence its operation?

MS WOOD: In May 2017.

MR GLOVER: Were you involved in that process?

MS WOOD: Yes, I was.

MR GLOVER: What was the reason for the council electing or deciding to open and operate a medical centre?

MS WOOD: Yes, so Derek may be able to assist in answering some of this, but essentially, we were looking at the two doctors at the time, looking towards imminent retirement, and so the council identified that as potentially being a gap in health care provision, so they looked to establish the medical centre using both federal grant funding as well as council's own funds to construct and operate the medical centre. So essentially, the two doctors who were looking at retirement and no specialist or allied health services within our community, they saw that as a fairly serious need to fill.

MR GLOVER: Mr Francis, is there anything you would wish to add to that answer? .

MR FRANCIS: I think so. In general terms, with the impending retirement of those two GPs, I believe our community faced a situation where we would be without a doctor. There was no full-time doctor at the hospital, at the MPS at that point, and our understanding has been that not many GPs these days want to come into a place and start their own practice and be responsible for the running of the practice themselves. So we saw a need to construct a building and set up the operations of a medical centre so that the GP could come in and do the doctoring, which is what they are there for, rather than the administrative side of things.

MR GLOVER: So the council owns the building?

MR FRANCIS: Council owns the building, yes. We constructed the building ourselves.

MR GLOVER: And fitted it out?

MR FRANCIS: Yes.

MR GLOVER: Including all the equipment?

MR FRANCIS: Yes.

MR GLOVER: In an earlier answer you mentioned an understanding that GPs are reluctant to come to an area like your shire and open a practice. How did you form that understanding?

MR FRANCIS: Just through discussions that we've had over the last seven to 10 years with individual GPs themselves, but also with the likes of the PHN, Rural Doctors Network, people within the industry that we've spoken to.

MR GLOVER: Including, I take it, attempts to attract and retain GPs within the area; is that fair?

MR FRANCIS: Yes, we have been involved in a number of efforts over the last few years to attract and retain doctors.

MR GLOVER: We will come back to that issue in a moment. Ms Wood, I think you said earlier, as part of your day-to-day responsibilities, it includes oversight of the management of the medical centre; is that right?

MS WOOD: Yes, that's correct.

MR GLOVER: Can you just tell the Commissioner in general terms the nature of the services that are provided out of the centre?

MS WOOD: Yes, certainly. We have obviously GP services, and that's two full -time equivalents of GPs. We also have a registered nurse and an enrolled nurse, so providing support services to the GPs in that space. We also have sonography or ultrasound, podiatry operates from the medical centre, as does physiotherapy. We also have pathology on site within the practice, and then there is a number of other allied and professional specialist services that visit the medical centre on a sort of, you know, weekly, monthly, quarterly type basis, as well as telehealth services to some specialists.

MR GLOVER: Are all the staff that work in the centre council employees?

MS WOOD: No, the doctors - one is on a contract. The other GP is employed through locum agencies at the moment. Our nurses, support staff, administrative staff,

sonography, are all employed under the local government award, which is through council, and then we have a number of service agreements with some of the allied health services, and then we lease out rooms to the pathology.

MR GLOVER: Have there been particular challenges in recruiting and retaining staff to work in the medical centre?

MS WOOD: In terms of the provision of the allied health services, a lot of our arrangements have come through the government-funded services like through Marathon Health, such as diabetes educator, psychologists, et cetera. So from time to time, depending on their availability and whether they are able to come to Nyngan, there are some challenges in that space, but with regard to nurses and our administrative staff, we've had no issues in retaining staff locally. All of our staff are actual locals who we've employed locally.

MR GLOVER: When you referred in that answer to services being provided by Marathon Health, are they services delivered within the walls of the medical centre but being delivered by Marathon Health as opposed to the council?

MS WOOD: Yes, that's correct.

MR GLOVER: What about attracting and retaining doctors?

MS WOOD: That has been an ongoing challenge for us for the entire time that we've opened the medical centre. We've had a number of GPs who we have contracted on sort of, you know, a term basis, anywhere from 12 months to two or three years. But generally, the second GP position has always been through locum agencies purely because we've not been able to attract and retain two permanent GPs on contract.

MR GLOVER: Mr Francis, do you wish to add anything to those answers?

MR FRANCIS: I think one of the strengths of our model and the way we operate is the ability to employ local people, so people like the podiatrist, the physiotherapist and the nurses are local people, so it is pleasing to see us being able to provide employment to those qualified individuals who might not otherwise be able to access employment in a

remote location. The other thing is that the support and administrative staff have gained skills with us that they wouldn't otherwise have had. We've been able to train them and skill them up. So that's a good part of the equation.

MR GLOVER: Is the council's medical centre the only facility of its type in the shire?

MR FRANCIS: Yes, it is. There is at least one other doctor practising part-time, but it's very much on a part-time basis.

MR GLOVER: There is a NSW Health facility also within the shire; is that right?

MR FRANCIS: Yes, there is.

MR GLOVER: In terms of funding the operations of the medical centre, Mr Francis, how does the council fund its operations?

MR FRANCIS: Well, taking into account the Medicare billings and other moneys that come in to the centre, there is a funding gap or shortfall of around $500,000 or $600,000 on an annual basis, and the council has seen fit to cover that itself through its own resources, its own revenue, which is essentially ratepayer funding or funding that we get from the federal government, general grant funding that all local councils get.

MR GLOVER: Ms Wood, in that answer, Mr Francis referred to Medicare billings. Is it a bulk bill practice?

MS WOOD: Yes, we are 100 per cent bulk billed.

MR GLOVER: Has the council looked at options in terms of its billing practices to narrow the shortfall, if I can put it that way?

MS WOOD: Yes, in this 2024/2025 budget, we have looked at potentially implementing a gap payment, but looking at the demographics of our patients, around 30 per cent of our patients would be affected by that. The other 70 per cent wouldn't be affected by gap fees because they are either under the age of 16 or hold a Commonwealth concession card, so the gap fees wouldn't apply to them. So basing that on the 30 per cent of our patients, we would only be looking

at attracting potentially an additional $98,000 in revenue per annum, if we were to introduce gap fees.

MR GLOVER: So not enough to make up the shortfall?

MS WOOD: Not the entire shortfall, no.

MR GLOVER: Looking at the operations of the medical centre - I will direct this to Ms Wood first and then perhaps to Mr Francis - are there any particular expenses which you can identify as perhaps contributing to the shortfall that Mr Francis has identified?

MS WOOD: I guess the main operating expense is the cost of the GPs. So in our budget for 2024/2025, the cost of the GPs is $1 million, and then the rest of our staff and other operating expenses make up the rest of the expenses in that space there. So, you know, they are a large portion of our expenses.

MR GLOVER: When you refer to the cost of the GPs, that's the contracted GP as well as the locum staff?

MS WOOD: Correct, that's both.

MR GLOVER: Does the council provide additional support by way of accommodation or vehicles to those doctors?

MS WOOD: Yes. The council has its own stock of housing and supplies housing free of charge to the GP, both locum and contracted, as well as providing them with vehicles. They also cover all of the costs of travel for any locums attending the practice.

MR GLOVER: Mr Francis, is there anything you would wish to add to those answers?

MR FRANCIS: I think the cost of locums can be considerable, bearing in mind that we have had them from as far away as Perth, so there is a fair bit of travel cost that goes into that equation as well as the accommodation and locum agency fees. So it all adds up.

MR GLOVER: To your observation, has the cost of engaging locums to work in the medical centre been on an increasing trend over recent years?

MR FRANCIS: I would say it got more expensive during COVID and shortly after COVID. It's probably come down a little since then, but it's higher than it was when we started the practice, yes.

MR GLOVER: I take it that the council would prefer to not have to engage locums; is that right?

MR FRANCIS: Of course. From a cost point of view as well as from a continuity of care point of view, people like to be able to see the same doctor when they have a repeat visit, so our ideal is to have two more or less permanent contracted doctors rather than make use of locum agencies. Having said that, we have good working relationships with the locum agencies that we use and they support us pretty well. We've probably got a core of half a dozen locums that come back to us, so it's not like it's a strange face every time.

MR GLOVER: In an earlier answer, reference was made to some grant funding in addition to what the council receives from the MBS payments. What grant funding has the council been able to obtain for the purposes of operating the medical centre?

MR FRANCIS: Many councils within New South Wales used to receive the New South Wales Government resources for regions funding, which was specifically directed at mining impacted councils. That program has since finished. But we did receive funding from that program for a couple of years and the council took the decision to use some of that funding to put towards medical services, the sonography, the Aboriginal health worker that we are looking at employing shortly, and the diabetes educator as well. So council set aside some of that funding which it could have used for other things, like road construction, for example, but the council took the decision to put that money into those health programs.

MR GLOVER: And those grants, I think you said, are now ceasing?

MR FRANCIS: They have ceased. So we are using funding that we had already received.

MR GLOVER: Those grants that were available to all of local government, I think you said?

MR FRANCIS: All local governments in Australia fund their operations partly from rates income, which I'm sure everyone's familiar with, but also get a financial assistance grant from the federal government. So depending on their circumstances, each local government in Australia will get that extra funding directly from the federal government, and that's used to fund the range of normal council operations.

THE COMMISSIONER: You mentioned funding for mining impacted councils.

MR FRANCIS: Just to clarify, yes, that's two different types of funding. So the Resources for Regions grant, which is for mining-impacted councils, we used to fund those three particular positions. Every council in New South Wales has got, for a number of years, and continues to receive, the financial assistance grant, which is a block funding direct from federal government, which helps pay for the cost of council operations.

MR GLOVER: Is there similar grant funding available from the New South Wales Government?

MR FRANCIS: No, there isn't.

MR GLOVER: While we're on the topic of rates, do you have a view about whether council stepping in to the provision of medical services is something that falls within the ordinary business of local government?

MR FRANCIS: It certainly doesn't fall within the ordinary business of local government, but I believe our council took the decision to become involved purely because of market failure in our particular region. If we hadn't stepped in and established the medical centre, no-one else was going to. I believe the residents and ratepayers of the Bogan shire value having the centre there and, from that point of view, the issue of council running it and contributing funding towards it I think is acceptable to the majority of our population.

However, looking at it in another way, something like - the shortfall in the medical centre constitutes something like 15 per cent of our annual rates, and from that point of view, it is inequitable to be expecting

a small rural council to contribute that much money towards a function that most other councils wouldn't dream of doing. Certainly none of the metropolitan councils would be requiring their ratepayers to pay towards the cost of primary health care.

MR GLOVER: You see that as inequitable because the burden falls on a rural council like yours but wouldn't fall, perhaps, on the Willoughby council in Sydney?

MR FRANCIS: No, that's quite right, and that's partly to do with our demographics and the ability to attract and retain GPs.

MR GLOVER: What about the ability the of council to fund the operation through rate revenue? I take it the rate revenue doesn't necessarily contemplate the fact that the council is having to step into this area?

MR FRANCIS: No, it is unusual for any council to be operating a medical centre.

MR GLOVER: Are you aware of other of your rural colleagues having to step into this space?

MR FRANCIS: There are a number of rural shires within New South Wales that I'm aware of who own a building that houses medical practices, but I'm not aware of any others within New South Wales who actually operate a medical centre.

MR GLOVER: Are you aware of whether the issue of councils having to step in to the provision of healthcare services, whether directly like your shire or by the provision of the infrastructure, has been raised with whichever the relevant department of the New South Wales Government might be?

MR FRANCIS: We've had discussions with NSW Health over the years, in terms of working together with them on solutions for visiting medical officers. We've not raised the question of funding directly with the New South Wales Government. That's partly because we see the issue of funding for primary health care as a federal government responsibility. We have taken it up with the local federal member and one or two other people in the federal government space, and have been working with the National Rural Health Alliance over the last few years to bring this

situation to the attention of people in Canberra. But, so far, there are no solutions for us.

MR GLOVER: Is there any additional support that you perceive could be given to your council and others in the similar position by New South Wales Government?

MR FRANCIS: Well, I think one of the things is that running the operation like we do, we hopefully, through preventative medicine and education, are keeping people out of the hospital system - the role of primary health care. I think there are ways of working together more closely with NSW Health in terms of funding at least one of the GP positions. I'm not sure whether there are any mechanisms for NSW Health to directly fund a practice like ours. I'm not aware of any.

MR GLOVER: Ms Wood, is there anything you would wish to add to those answers?

MS WOOD: I wonder, could you just clarify, are you asking whether we have any solutions to how we may fund ourselves moving forward or what recommendations we might want to put forward?

MR GLOVER: I will ask you that question, if I haven't, but what I was exploring with Mr Francis is whether you would - or your shire council would - benefit from additional support, whether that be through funding or support in kind from the New South Wales Government. Mr Francis has told us that issues have been raised through the federal member, with the federal government, but I'm directing attention to support that might be coming from the New South Wales Government, but if you see a funding opportunity from the New South Wales Government, feel free to share it.

MS WOOD: Yes, well, I suppose there is the potential for maybe some type of block funding. You know, this is an essential community service that our council is providing and I'm aware that block funding specifically is to address community needs in that space, but I would agree with Derek in that I think that potentially some solutions through NSW Health and some type of agreement with them about provision of GP services, and if it was one of our GPs that was funded through the state government, that would be fantastic, because, you know, we do look at the rates of

hospitalisation for those people who are not treated in the primary health space. We have higher rates of hospitalisation and high cost burden for health conditions in our particular area, and if we can educate and treat before it gets to hospitalisation rates, then we believe that we're keeping those patients out of the state government health system.

MR GLOVER: What might that model look like?

MS WOOD: I would suggest potentially a shared employment model may be something that could work.

MR GLOVER: By "shared employment", so the GP would work in the medical centre but also provide VMO services into the local Nyngan health service; is that right?

MS WOOD: Yes, that would be correct.

MR GLOVER: Have there been any discussions between the council and the local health district to pursue that sort of concept?

MS WOOD: Yes. Last year we were looking at the potential for a shared employer model with the LHD and one of the concerns that we had was having support for those registrars within our space, to be able to have professional support and professional mentoring available to them in our location.

MR GLOVER: What was the concern that you have identified?

MS WOOD: So having access for the registrars here to have a mentor locally for them. Obviously Nyngan is 165 kilometres from Dubbo, so ensuring that they've got the professional support and mentoring available to them in their space is very important.

MR GLOVER: So the concern from the council was that that may not necessarily be something that could be provided within the operations of the medical centre; have I understood you correctly?

MS WOOD: That's correct at this time, but there is potential for that in the future.

MR GLOVER: Have there been any other discussions between

the council and the local health district in terms of collaboration to provide services, both through the medical centre and through the local health service?

MS WOOD: Yes, there has, but I feel that Derek is probably more suited to answer that question.

MR GLOVER: Yes, Mr Francis, can you tell the Commissioner about those, please?

MR FRANCIS: A number of years ago we did explore the option of employing a GP and entering into an arrangement with the local health district whereby they would pay us an amount for us to take on the VMO services at the hospital. Unfortunately, at that time, the GP that we had on board with us decided that he didn't want to do VMO work, and that's a personal choice and one must respect that. So that fell flat and we weren't able to recruit a GP, after that, who was interested in doing both the GP work for ourselves and the VMO work at the hospital.

MR GLOVER: I think - tell me if I've got this wrong - at one point it was the policy or at least the preference of the council that those GPs who would be employed in the medical centre would provide VMO services into the local health service; is that right?

MR FRANCIS: That's entirely correct. When the practice was first opened, it was a formal resolution of the council and policy, that any doctor that was employed to work at the medical centre would also do VMO work, but that proved very hard to translate into practice, purely and simply because not every GP wants to be a VMO, we discovered, so that policy got changed so as not to jeopardise our chances of employing a GP at the practice.

MR GLOVER: By that last answer, do I understand it that by recruiting on the basis that the GP in question would be expected to provide VMO services put the council at somewhat of a competitive disadvantage?

MR FRANCIS: Well, purely I believe it limits your pool of prospective GPs to those who are willing to do VMO work, which we didn't want to do, and it has proved easier to recruit GPs who don't want to do VMO work than to wait out and try and find one that does.

MR GLOVER: Tell me if you don't know, but are you aware of the reasons why the council resolved, when it did, to require that GPs employed in the medical centre also provide services as VMOs?

MR FRANCIS: I believe that came out of an understanding of community expectation that people would be able to see their own GP for routine things and then, when they had to attend the hospital for whatever reason, they would be able to see the same GP, so it was a bit of continuity. That was the case for many years with one of our local doctors, who was also the VMO, but also out of a concern that our council believed that the MPS, to give it its proper name - not "hospital", the MPS - there needed to be a doctor at the MPS on call. So it was to try to fill that community need that they made that policy decision originally.

MR GLOVER: Aside from the issue of whether the council and the LHD might be able to come together in at least aligning the operations of the medical centre with the MPS, does the council engage in any consultation with the LHD on other issues relevant to the delivery of healthcare services within the shire and the region more generally?

MR FRANCIS: Well, we are in constant contact with the LHD at a local level, in Nyngan, purely because there is a residential aged care facility attached to the MPS and most of the patients of that facility are patients of the practice. So our GP and our nurse attend the residential aged care facility on a weekly basis and obviously have interactions with the staff and management of the MPS.

MR GLOVER: What about in relation to service planning or a needs analysis of the residents within the region? Is that something that the council and the LHD --

MR FRANCIS: I don't believe we've ever had any discussions about planning, no.

MR GLOVER: Ms Wood, do you want to add anything to those answers?

MS WOOD: No.

MR GLOVER: Ms Wood, is there any aspect of the engagement in collaboration between the council and the LHD that you consider could be improved for the benefits of the

residents of the shire?

MS WOOD: Not that I can think of, no.

MR GLOVER: Mr Francis, do you have a view about that issue?

MR FRANCIS: No, not beyond what we've already spoken about, the provision of GP services, as such.

MR GLOVER: Thank you, Commissioner. I have no further questions of these witnesses.

THE COMMISSIONER: Mr Cheney?

MR CHENEY: No questions, Commissioner.

THE COMMISSIONER: I guess at some stage we'll hear from NSW Health about their views about a local council like this having to fund healthcare services from ratepayers.

MR CHENEY: Yes, most likely Thursday, I think, with Mr Spittal, Commissioner.

THE COMMISSIONER: I guess we will hear from the Commonwealth at some stage - maybe? I'm talking to someone that's not here. Does anything arise out of that?

MR GLOVER: No, Commissioner.

THE COMMISSIONER: Thank you both very much for coming. We are very grateful for your time. You are excused.

<THE WITNESSES WITHDREW

THE COMMISSIONER: Is that lunch?

MR GLOVER: We have caught up, that's lunch.

THE COMMISSIONER: What time do you want to make it?

MR GLOVER: It will be 2 o'clock. The next witness is, as I understand it, stepping out of a surgical list to make himself available at 2.

THE COMMISSIONER: The witness after that we have to finish at 4?

MR GLOVER: Correct.

THE COMMISSIONER: All right. We will adjourn until 2 o'clock.

MR GLOVER: Thank you, Commissioner.

LUNCHEON ADJOURNMENT

THE COMMISSIONER: Dr Harfield, you can hear me?

DR HARFIELD: Yes, I can.

<MICHAEL PATRICK HARFIELD, affirmed: [2.00pm]

<EXAMINATION BY MR MUSTON:

MR MUSTON: Q. Could you please state your full name for the record?
A. My full name is Dr Michael Patrick Harfield.

Q. You are currently the director of medical services at Mudgee Hospital?
A. I am.

Q. You are a rural generalist by qualification?
A. I am.

Q. And you are the acting rural health director of medical services for four procedural hospitals within the district?
A. That is correct.

Q. Have you had an opportunity to review a document which is headed "Outline of evidence of Dr Michael Harfield"?
A. Yes.

Q. Are you satisfied that the content of that document is, to the best of your knowledge, true and correct?
A. Yes.

MR MUSTON: In due course, Commissioner, that will form part of the bulk tender.

Q. Now, can I ask you some questions about your role as acting rural health director for medical services in the

procedural hospitals. First of all, for those of us who are not in the medical profession, what is a procedural hospital?
A. So a procedural hospital is a hospital that is large enough to carry out operative procedures, so for us, the biggest operation probably is caesarean section. As well as that we have regular surgical lists which we also do. I guess it's fair to distinguish us from smaller sites where they don't do any procedural services, such as birth units, elective surgical lists, that sort of thing, and it sort of places us below what we would consider a base hospital, which is where I think the service provision changes by scale. So it's generally related to a number of patients through the door in a given year. Don't ask me for the exact number but I believe 20,000, for instance, through the emergency department is something they often talk about, but it's probably a bit more complex than that. And a base hospital would indicate that now you are looking at more specialist care, so specialist surgeons, specialist physicians, more specialist sort of care, if that makes sense.

Q. So the procedural hospitals in the district that you deal with are Mudgee, Cowra, Parkes and Forbes?
A. That is correct.

Q. And I think you have already told us you are based at Mudgee Hospital?
A. That is correct. I am one of - yes. So I am the director of medical services at Mudgee hospital but I'm also one of the clinicians here, in anaesthetics emergency and on the ward.

Q. Just in relation to your role as rural health director medical services, what does that role involve?
A. So it's a relatively new position for me, but the idea of it, I believe, is to provide support to the procedural hospitals insofar as support for their medical staff to carry out their functioning and support them through that, and hopefully provide a bit of guidance, although that sounds a bit paternalistic, around I guess their future plans and how we're going about navigating the current situation we're in, would be the simplistic way of looking at it.

Q. And so does each of those other procedural hospitals have its own director of medical services?

A. Some of them do, some of them don't. So Parkes and Forbes have someone in a part-time position. Cowra doesn't have anyone at all at the moment.

Q. And in terms of Parkes and Forbes, the people who are sitting in that role in a part-time position, are they staff specialists or are they GP VMOs, or something else?
A. I believe - as far as I can recall I believe they are employed as a staff specialist is how it was advertised.

Q. Can I take you back? Your professional background before you took on the roles that you have, you qualified in medicine where?
A. In Queensland.

Q. And after qualification, where did you do your initial training?
A. So I finished my medical degree at University of Queensland in Brisbane. I did my initial training in Mackay. I then did some training for my more rural-based work in Proserpine, which is in the Whitsundays there, spent a good sort of eight years there, from memory, doing my anaesthetic training, some obstetric training, some emergency training, my GP training, got my qualification with the College of Rural - sorry, College of General Practice. Then I moved down to Mudgee. That would have been about 12 years ago now.

Q. So at that point you moved to Mudgee and you were a fellow of the Royal Australian College of GPs?
A. Yes. Correct.

Q. With additional training in anaesthetics and obstetrics?
A. I didn't continue with the obstetrics, but definitely continued with the anaesthetics and did some emergency work as well. So I moved to Mudgee about 12 years ago now, continued in a role where I was in primary care, working primarily as a general practitioner who also did emergency medicine, anaesthetics and inpatient care.

Q. So that role, was that within a private practice within Mudgee?
A. Correct.

Q. Sorry, I interrupted?
A. Oh, shared - sorry, just to be a hundred per cent

clear, yes, the general practice was in a private GP practice; the anaesthetics and emergency and inpatient stuff was done at the hospital.

Q. Yes. At that time, what was the rough split between the period of time that you would spend during any given week in general practice and the period of time that you would be up at the hospital dealing with anaesthetics and emergency?
A. Obviously variable, but if we're going a rough split, I would say at that stage three to four days primarily in general practice, one day of anaesthetics, and at that stage we were doing, the way the roster was working, the emergency work was done in the evenings. So if I was working in the emergency department, I would finish in primary care, say, at 6pm and then start a six-hour shift in the emergency department, and one in four weeks I would be on call for anaesthetics, which meant if there was any kind of anaesthetic requirement or an emergency, it was pretty much drop whatever I was doing at that stage and attend. Some weeks were busier than others, a bit hard to sort of quantify that one. Busy, shall we say. But that would be the split.

Q. Sorry, I interrupted you. You were working split between general practice and I assume you were working as a VMO when you were delivering the anaesthetic and emergency services?
A. Correct.

Q. As a VMO, were you on a sessional arrangement, or was it fee for service arrangement?
A. It was the fee for service arrangement.

Q. When did you transition from that role as a GP VMO into the role that you currently have?
A. It was a gradual process. So about three years ago, COVID time, so we already sort of decided that the hospital required at that stage a medical superintendent or a director of medical services, and we had developed a PD or a position description for that, to that effect, and we were going to advertise for that externally. That was before COVID. Then COVID hit, at which point we realised we weren't going to be getting anyone applying for that role at all. No-one was moving at that stage, anywhere, and we also realised that we needed someone in that role. It was now actually fairly urgent that we had someone in

there.

Q. Just pausing there, what was it about the role that led you to think that it was important that someone was filling it? What was the gap that that role was filling that was not otherwise being provided by the GP VMO model at that time?
A. So there was no-one at that stage in a leadership role within the hospital set-up. So I guess without a medical practitioner or doctor in that role, we really had no-one to talk to at that stage, and at that stage, we were being asked a lot of questions around medical stuff - again, to make it all sound a bit simplistic. So we required some sort of leadership role going forward to try and, I guess, optimise what we were doing. At that stage, in those days, especially in COVID, there was a lot of - I don't want to sound too harsh, but there was a lot of unproductive talking and acting, and none of it was particularly focused on where it needed to be. There was a lot of talk around a bunch of different things.

It needed someone to sort of step into the role of trying to collect, I guess, the group sort of knowledge base and try and aim it somewhere. I think that was what we were hoping for even before COVID, but then, like I said, we weren't going to get anyone. So someone needed to step into the role at that point.

Q. When you say "we" in that context, that's you and your colleagues who were working with you at the hospital at that time?
A. Yes. A number of colleagues, either at the hospital and in private practice as well, so from the medical community as well, so within the town.

Q. So you obviously chose to apply for the job?
A. Yes. I think I was the only one who was really interested at that stage, so we put it out, but there wasn't really much interest at that point. Again, it was the middle of COVID. It required someone who was clinical as well, so the number - and at that point in time, there was only really me and several other doctors who did the majority of the hospital work on a regular basis. Don't get me wrong, there were many other doctors who do do work in the hospital, but between me and maybe two others, we did the majority of it. Had a lot of planning around --

Q. At that time, what was it, if there were any particular factors, that led you to make a move from general practice/VMO into the salaried position that you have now taken up?
A. Well, at that point I didn't choose. I did both. So I was working both still as a GP in the community, as well as doing the VMO hospital work, but now I was doing this work on top of that. So these were extra duties at that stage.

Q. At the time that you initially took the position, you were continuing to practise primary health care as a GP in rooms in town?
A. Yes.

Q. You were continuing to deliver services on a fee for service basis as a VMO into the hospital?
A. Yes.

Q. And in addition to that, you had taken on the role of the director of medical services at the hospital?
A. That is correct.

Q. In relation to the last bit, was that a salaried position, or was it just part of your VMO service?
A. That was a salaried position at that stage.

Q. Do you still provide - you mentioned that the role that you picked up, the salaried role, involved some clinical work. Did that overlap with the VMO work you were doing, or do you continue to operate as both a VMO and a director of medical services?
A. So the way we have been doing it here, which has been approved, is to - I guess it's hard because, as rural generalists, we have many different hats on, so I guess I'm not doing VMO fee for service in the emergency department as well as the salaried job there. My VMO work is strictly for my anaesthetic work, which is done completely separate from all of that. The staff specialist role is for the director of medical services job, which, when we did the position description, it's a 50:50 clinical/non-clinical role, by design, so it was to be 50 per cent of my shifts' hours would be performed in the emergency department, and the other 50 per cent would be done as a non-clinical managerial role.

Q. What about primary care, have you continued to deliver

primary care as a GP into the community?
A. No, I stopped that about two years ago now.

Q. Why was that?
A. The workload. It was getting to the point where I couldn't do - there were multiple - actually, there were multiple reasons for it, but one, and the more sensible reason for me to stop, was because it was turning into a rather large amount of work. So I was only really getting to do two days a week of general practice, maybe one and a half if I'm being honest, and that sort of doesn't equate to being able to do as good a job in GP as I was wanting to do at the time. You find yourself chasing a lot of stuff after hours as well, when you are not there, which I think probably led to me becoming somewhat burnt out. Like I said, there was just not enough hours in the week for me to be doing that many jobs, whilst still having a young family of four children, so made the decision, looking at it, which one - which work I preferred and, to be honest, it was the hospital job at that point held more interest for me, and I also felt it was more important at that stage for the community to have someone continue trying to improve the model here.

Q. In terms of the model --
A. It's not an easy thing, yes.

Q. In terms of the model you have there at Mudgee Hospital, I will come back to that, but I want to ask you some questions that are directed really at the situation as it exists in the other procedural hospitals and as it existed at Mudgee before this current trial was introduced?
A. Yes, understood.

Q. Understand?
A. Understood.

Q. You have identified in your outline a number of challenges that you see as existing in the provision of health care within the Western NSW LHD, at paragraph 4 and following?
A. Mmm-hmm.

Q. Could I ask you, those challenges that you have identified presumably are based on your experience both as a GP and in the role that you have held - roles that you have held at the hospital?

A. Yes.

Q. In relation to them, can I ask, the first one that you point out as a main challenge is a reduction in primary care services.
A. That is correct.

Q. Could you just expand on what you think some of the reasons - well, let's take it step by step. First of all, in saying that, are we to infer that you mean a reduction in the number of GPs practising privately relative to the number of people within the population that they serve?
A. I would believe that's true. Certainly in Mudgee, we've seen a reduction in the number of qualified senior GPs compared to the population, which is increasing. That would probably be the main issue. We see that sort of translating into wait times for seeing a GP around the three to four week mark.

Q. Before you go on, can I ask, do you have a view about what's led to that reduction in the number of GPs choosing to deliver primary care within communities like Mudgee, for example?
A. I think it's multifactorial. I think one is there are fewer people going into general practice as a whole now, and that's not a New South Wales unique problem, that's a national problem at the moment. So we're seeing fewer people - fewer trainees going into general practice. Certainly in my near 20 years as a doctor, the majority of that time spent teaching students and junior doctors, we see fewer and fewer talking about going into general practice, and now we're starting to see that translate to fewer and fewer numbers. So certainly there are not enough GPs to go around. Then, when you add in especially rural, they are going to have to leave the major metro centres to do it, again, we find it's harder and harder to attract candidates.

The job itself, dare I say it, is harder. You are operating more at the edge of your scope of practice when you go rural. Insofar as that, we don't have the services that metro doctors have - access to specialists, access to investigations, access to larger hospitals are just things that we do not have. So you are required to do a lot more. Any number of examples I can come up with, even simple things like skin cancer surgery, a lot of doctors in the city, for instance, would just refer on to dermatologist

surgeons, other skin cancer doctors, whereas we have to kind of do it ourselves, which is fine, that's part of the training, and that's part of what attracts us to it, but it's not for everyone, and I wouldn't even say it is for the majority, and so candidates will sort of see that sort of thing as a negative. Very much there are some who see it as a positive and are attracted to that, but we're not seeing as many of those as we used to.

Or they are sort of being put off of it as well by their time in larger hospitals, anecdotally, but it is a strong body of anecdotal evidence, where we have junior doctors - my feeling is most doctors in their sort of first four years spend it in a larger hospital, they have no exposure at all to general practice or rural medicine, so they will go through the first four years of their career in a large hospital, cared for, trained for by specialists, who also don't really know what we're doing out here and don't really have any experience, and so time and again we do hear about it, you know, where junior doctors who might have been keen on rural or general practice, but in the first four years of their career, the people they role model are specialists who say "Oh, look, you are really good, you should become a cardiologist or an orthopaedic surgeon", you know, so they get wooed over to that sort of side. We never really get a chance. A lot of the time what we get are the people who don't necessarily get that system.

So we get a lot of people who have either burned out or failed through their training, which short changes us a little bit, but that's kind of the set-up we have had. We don't get access to junior doctors in their first couple of years and I think that's what we're certainly trying to change. I assume you will talk to me later on about that in a way, but that's one of the major problems as I see it, so fewer doctors coming through wanting to do it and junior doctors being almost steered away from it.

Senior GPs have to take some of the blame for this too. A lot of senior GPs will be telling junior doctors "Don't do this. The money's not good enough. The stress is too much. The work is too hard. If I had my time over again, I would go and do X, Y, Z specialty instead of this one." So there is a bit of that that also happens. Obviously that's going to kill it for most junior doctors, if they meet sort of senior GPs who are telling them not to

do it as well - not all of them, but I know that that's there. So it is hard.

Q. In terms of that reduction in the availability of primary care through a reduction in the number of GPs, is that having an impact on services which are able to be provided in smaller procedural hospitals within the LHD?
A. Yes. So --

Q. What is that effect?
A. -- I think what we were seeing is fewer GPs wanting to be involved in the hospital due to a number of reasons, but time pressure being one of them. I know a few of the GPs here who were initially providing services in the emergency department have had to pull back because, again, there's only so many hours in the day and if they want to keep doing primary care, they can't do it as well as what was happening at the hospital.

Q. So time pressure is one of those reasons. What are the others, perhaps if we could list them and then maybe we can explore them a bit? Time pressure is one?
A. Yes. Emergency medicine is stressful, and if you are not an actual emergency trained doctor, then it's really stressful. So we've had a lot of - well, not a lot, but I have had multiple GPs who aren't that strongly trained in emergency care, who were almost forced to work in the hospital as part of their, I guess, agreement to come work here initially, and that has sort of led to more stress and burnout, and in one or two instances I know of where there are doctors who probably would have stayed had we not forced the whole "You must work in the emergency department" thing. They have left.

We've now recognised that, so we don't push that anymore, because it was just causing too many doctors to leave, but certainly there was a period --

Q. When you say "we", who was it who was insisting on doctors working into the hospitals?
A. Oh, the private practices, because obviously the services were provided by the private practices. So if you are a doctor who is providing that sort of care as well, and you are getting new doctors, you kind of want them to get involved with the emergency department because otherwise your roster starts looking a lot like a one in three roster, whereas if you have got more doctors who can

do it, it provides an easier way of, I guess, coping with the demands. We weren't finding that.

Q. That's the second on our list, that is, maybe doctors who are temperamentally not well suited to work in the hospital don't want to. Are there other reasons why there has been a drop-off in service by GPs as VMOs in hospitals?
A. I think - they are the main ones that I have seen in my town. Now, I haven't got the best knowledge around the surrounding towns, but I do understand there have been some issues previously with how they felt they were treated by the LHD, but I can't really speak to that. I haven't sort of had the opportunity to talk to those parties yet to find out, but I have been here for 12 years in a medical capacity, not necessarily in this role but you hear things, you go to conferences, but there was definite dissatisfaction with some of the previous, I guess, management set-ups, which have passed by now, if that makes sense. People change jobs, people move on, and those people aren't here anymore, but the hangover from what happened back then certainly - it's palpable.

I've spoken to doctors, for instance, in Lachlan region who are still very wary of even engaging with the hospital because of how they felt they were treated. So there is a bit of that that is still hanging around, so obviously when new doctors come, they warn them against working at the hospital. Again, that's --

Q. Sorry to interrupt you, but in terms of the reduction in the availability of primary care, it's had a knock-on effect in terms of the number of people who are willing to practice into the hospitals as VMOs. You tell us in your outline that it's also led to increased wait times for GPs. I think you told us a moment ago that it was up to three to four weeks?
A. Correct.

Q. You also tell us in your outline that it's led, in your view, at least at your hospital, to an increase in category 3 and 4 presentations within the emergency departments?
A. (Witness nods). Yes, yes.

Q. Is that something which, insofar as you are aware, is replicated in the other procedural hospitals that you have a responsibility for in your role?

A. Insofar as I know. I was looking at some numbers, again mainly Mudgee based because I haven't had a chance to look at the ones from Parkes, which would be the next busiest facility, but we've increased the number - when you look at the number of presentations through the emergency department, it appears to go up by about 1,000 every year for the last three or four years now, and we have seen a decline in the number of GPs and, as a result, we're seeing patients come through the ED, I feel, but the majority of those are the category 3s and 4s, and consistently we see that going up as well. So lack of GPs are obviously going to lead to people coming to the emergency department, and we do have an increasing population, there is no two ways around that.

Q. Do you have a sense of whether that increase in category 3 and 4 presentations in the emergency departments is happening outside of hours when GPs might otherwise have been closed anyway, or is it something which is happening more consistently during the periods when GPs, which would once have been serving the community, would have been open?
A. The vast majority of my presentations occur at about 9 or 10am. It's quite a significant spike at 9 to 10am, and then it slowly drops off again until 4 or 5pm, so --

Q. Do you have a view about why the 9 to 10am peak hour occurs in your emergency department?
A. I would suggest because they go to the GP to try to get an appointment, find out that they can't, and that's something we know of. We hear it, again anecdotally, of course, but patients will say that. It is not uncommon for a staff member to ask them, "Why didn't you go to the GP with this?" At least it was a common thing to ask several years ago, but now we don't bother. But really it is that sort of - the doors open at 8.30, I believe, patients go there to try to get an appointment and they can't, so then they go to the next available, which would be us in the emergency department, which is fair enough, essentially.

Q. To the extent that those patients need care of any sort, whether it be a prescription or whatever it might be, the emergency department is meeting those immediate needs for them; is that right?
A. Yes. We don't turn people away, unfortunately, so we can't really say "That's a GP problem, go away and make an appointment with your GP". We may not give you, for instance, the full six months that you are after on your

script, but by the same token, we're not heartless enough to say "Go away". We will give you a script for four weeks worth and hopefully get you through, if it is appropriate.

But we know that because we're mostly GPs ourselves so we understand the pressures and we also know what happens if you don't do it, which is the patient will get sicker and become, dare I say it - suffer more. So we're not in for that, so we do what we can, whilst trying not to encourage it.

Q. That brings me to my next question, which is whilst the immediate healthcare needs might be being met by emergency, do you have a view on the longer term impact on patients' health outcomes caused by this more episodic care that's being delivered to them in an emergency setting rather than in a more traditional primary health setting?
A. It's suboptimal. It's definitely suboptimal, I think.

Q. When you say "suboptimal", in what way?
A. Yes, so there are a lot of studies that show outcomes are better when you can engage with a regular GP who can carry all of your chronic care needs. Emergency departments are not set up for chronic care. They are an acute care service. In a pinch, sure, we can do the chronic stuff if we had to, but it is not ideal and there is no real follow-up that we would be happy with. You wouldn't be happy with following things up in the way that we can do in a hospital, as opposed to a general practice, where there are better systems in place to ensure results are followed up, patients are seen to and followed through with and, you know, checking the effects of medications - all those sorts of things. So from our point of view, it's definitely better to see a GP for those presentations than an emergency department.

Q. So while I understand the situation is at least in the process of being corrected in Mudgee, another issue that you raise, or challenge that you raise, is the heavy reliance on premium labour.
A. We're referring to locum workforce, yes. Yes. Again, we're not unique at all. There seems to have become an incredible surge on the use of locums. Ever since I've been in Mudgee, there's been locums in the emergency department. So ever since I got here 12 years ago, the day - the majority of the day was looked after by a locum workforce because the GPs were sort of doing the primary

care thing in their practices, as one would, but the hospital didn't have any real, I guess, hospital based workforce, didn't appear to be, I guess, considered important at that time, so they would use doctors who were on locum wages, which they were happy with, but I believe once COVID came through, the cost of locums sky rocketted and it became more widespread, so premiums went up.

Q. You have expressed the view that the cost of using locums as the standard form of care in hospitals is not sustainable.
A. Not at all, and it's suboptimal. I mean, there is no cap on what they ask for. There is no actual answering to anyone as far as performance goes. I mean, there is some sort of feeling that they can be held into line, but realistically, they just leave and will go to another job with no real repercussions at all.

Q. Is the increased reliance on --
A. The cost is --

Q. Is the increased reliance on locums something which is yet another symptom of the drop-off in the number of GP VMOs providing primary accommodation and primary and acute care in communities?
A. I would suggest that's got a bit to do with it. I'm not sure I could blame it entirely on that, but certainly - I mean, a lot of locums we see are GPs, so a lot of the locums that have been hired previously have been GPs, who have just decided they didn't want to be GPs anymore, and then they are being paid this rather large sum of money and they have continued along that line.

Then they have attracted other GPs to that sort of, dare I say it, career path, and so again, there are fewer GPs in the community. Maybe not my community exactly, but someone's community lost a GP because they wanted to be a locum, and now what we're seeing is younger doctors are sort of forgoing training pathways to become locums.

They still use locums, mainly for night shifts, but you come across them and there is no desire to sort of continue on with a training program because they kind of feel why should they, they're going to take a steady wage of $2,000 per day, so why should they? And I think that's part of the problem as well.

Q. You tell us in paragraph 4(b) of your outline that the VMO fee for service model being the traditional model for GPs in public hospitals doesn't encourage GP involvement with non-clinical services such as teaching, quality assurance projects and clinical audits. Can I just get you to explain, first of all, why, and then the impact that that has on the operation of the hospitals, as you see it?
A. The fee for service model is really geared up to get them in to see patients, do a service and then go again, which is good for some instances but certain things don't lend itself to that. So quality assurance projects and audits, for instance, which are necessary things to be done, aren't getting done because the combination of things - the fee for service model, there is no particularly good item number for that sort of work. I feel it allows senior management in various forms, maybe not necessarily mine, but to not value it, and so when they get lumped with a bill for X number of dollars for it, they are not willing to pay it and so they don't encourage it, whereas the current model with staff specialist sort of employment, the non-clinical stuff is baked in to it, so it is already paid for, and so it is a lot easier to sort of organise it.

So it's a lot of the things that need to happen that don't, if you know well, I mean, the rostering, teaching of students - yes, don't get me wrong, VMOs still teach and I would never suggest they do not, but a lot of it is unpaid for, which, when you - you can sort of try and tell yourself that, "I'm doing this for the good of everyone but I'm not really getting paid for it", but that only goes so far before people start "Well, I don't have time for that anymore so I don't really want to teach", or it limits the amount you teach.

Q. In terms of the impact on the operation of hospitals that is caused by this reduction in the delivery of non-clinical services, what are they? What impact does it have on the hospital?
A. As far as this one goes, this hospital, for instance, a fee for service during the day doesn't pay all that well, so it pays significantly less than the evening, and the rate was always a bit low compared to even bulk billing, so it discouraged GP VMOs from wanting to work in the day. So we, for the longest period of time, couldn't really achieve that. That has been rectified in a variety of --

Q. I might not have been clear in my question. In terms of those hospitals where the GP VMOs on a fee for service model are not delivering those extra clinical services, what impact is that having on the way in which those hospitals operate, say some of the other ones that you have responsibility for?
A. So I understand what you are asking, I really do, and it's one of these ones I'm trying to quantify in my head, because that's the obvious thing I need to do. But it's just more - how do I say it? There are a multitude of problems that need to get sorted out in a hospital on a day-to-day, and a lot of those don't get done when there is no-one around. So now we sort of have people around who can attend to all these sort of smaller problems, which isn't really a great answer for your question. There is more responsibility for junior doctors. So if we have a junior doctor, for instance, who is present in the hospital grounds, I will have someone who is actually here, on site, to be able to sort of support them, whereas other sites, what they have is remote supervision, so you might have a second- or a third-year doctor who is working on the ward on their own with, you know, the presumed supervision being someone who is in another facility, who is there apparently on the phone, but it is again quite different if you are the junior doctor, knowing there is someone there, versus someone who you have got to call in.

I guess other parts to it, there is a lot of projects within the actual, for instance, the theatre unit, sort of having someone go through the equipment lists and keeping them up to date, trying to sort of come up with new - what's the word I'm after, just trying to keep up to date with all of the stuff that needs to be kept up to date isn't done when there's not someone here, so I'm just trying to pick out a few examples. What's the word I'm after - ambulatory care, we're looking at different models of care there, but with things like more - sorry, I know this is sounding all wishy-washy all of a sudden.

Running theatres, for instance, we need to sort of have various things booked and sort of looked after, and it is easier to do when someone is here as opposed to somewhere else. I guess that's the problem. With the VMOs, they are just not on site, so if they are not on site, they can't really deal with it and they don't really want to deal with it while they are doing other stuff. While the staff doctor's here - we're still working, don't

get me wrong, we will either be in the emergency department seeing patients or I will be in the operating theatre doing things there, but if there is a sudden need for us to deal with something, we can deal with it in a timely contemporaneous fashion, which leads to a smoother running hospital. Sorry, that sounded really ordinary, but - yeah.

Q. The locums who get used in other hospitals are on site, but are they doing any of that extra clinical work, such as teaching, quality assurance projects and clinical audits?
A. Not at all. Not at all. I guess the other part to them is, if you ask them to do something even vaguely outside of the scope of what they were employed to do, they will not do it, whereas the staff we have here, I might be working in the emergency department, but if someone needs something done in the ambulatory care unit or - I will do my best to get over there and sort it out at the same time, whereas with locums, that just doesn't happen.

Q. That probably brings us nicely to the trial that's running at Mudgee Hospital. The staff you have got there are rural generalists who are GPs who have been employed as staff specialists within the hospital?
A. Correct.

Q. Can I just ask, you have indicated in your statement that the alternative and usual way in which a generalist or GP would be employed within a hospital setting is as a CMO?
A. So CMO is the only award in New South Wales that they were using, yes.

Q. And what's --
A. Previously.

Q. In terms of the difference between a staff specialist and a CMO, there is a salary difference?
A. Yes.

Q. That is, the CMO is paid less than staff specialists?
A. Significantly less.

Q. And are there any other differences between the two which would disincentivise someone taking up a role as a CMO, where a staff specialist position might be an alternative possibility?
A. It is essentially a dollar difference value, yes.

It's all financial, as far as I'm aware. There may be some better benefits, you know, from the staff specialist award, but it really comes down to financial.

Q. So the trial that you are running at Mudgee Hospital has the hospital staffed by GPs/rural generalists, employed as staff specialists. How many do you have employed in that capacity at the moment?
A. We have three, with a fourth about to be employed.

Q. Those staff specialists who are employed in the hospital in that capacity are not currently involved in the delivery, at least in their employed capacity, of primary care within Mudgee; is that right?
A. That is correct.

Q. Are any of them doing a little bit of primary care on the side, practising in rooms in town on days when they are not working in the hospital?
A. Not strictly speaking - no. No is the answer. I do have another regular doctor who I'm confident will be moving across to it, but he is currently still a VMO here and he does one week at a time of general practice, but we know he's making his mind up, but he will be moving across to it. So that would actually take me to five staff specialists, but I can't call him that yet, because he's not.

Q. So in terms of the results insofar as you have been able to see them so far of having this more stable group of staff specialists employed in Mudgee Hospital, you have told us that there have been some improvements in the emergency department services?
A. (Witness nods). Yes.

Q. Could you just explain to us what those improvements are?
A. So I think we're still managing to cope with the increasing number of presentations every year, still maintaining a high standard. Most of the Bureau of Health Information stats that come through show a very high patient satisfaction when it comes to Mudgee. Our ED was nominated or won the best emergency department in Australia at the recent emergency nurses conference, which was a national sort of conference.

We have a fully staffed - the number of no-shows for

our shifts is non-existent. They are always staffed.

We are dealing with an increasing workload and we are managing it, whereas a lot of other sites are just now fully reliant upon locum workforce. And I've still managed to engage multiple GPs in the community to still work there in the emergency department, where I think previously we were on a slippery slope away from that, but by getting a core group of hospital-based doctors who can ensure that it continues to run in a stable fashion, the GPs are able to come in and help out sort of on a smaller time basis, on a reduced amount of time, whereas before, the entire reliance upon the GPs was sort of burning them out. So we've been able to keep a few people on that sort of roster now.

Q. I think you tell us that you have reduced your reliance on locums and now only use them for night shifts?
A. That's correct. Previously we were using three locums - two a day and occasionally three, and now we're sort of only using a night shift locum, and the plan is, once we get a few more staff specialists, we will be able to eliminate the night shift locum as well, and that is in the plan.

Q. I think you also tell us that you have now got at least one registrar training for the ACRRM fellowship.
A. Mmm-hmm.

Q. Could you just explain to us what that training pathway is and how it is that the current model that you have put in place enables that to operate?
A. Yes. So ACRRM is the College of Rural and Remote Medicine. It's the second primary care qualification in Australia. So if you want to do primary care, you've got to do either RACGP or ACRRM. Now, we have got our own - we've been accredited through ACRRM, so we've done some work to get the hospital itself accredited. So we're now allowed to have a registrar to come through and be based entirely at this hospital, whereas previously, again, it was - you would - if you were a registrar, you had to go through a GP practice.

The advantage here is that we're able to give them a lot more training in regards to the hospital side of things. So the emergency, anaesthetics, obstetrics, inpatient unit - they get a more in-depth sort of

experience there, with the idea that they will go into GP later on, it's just a later part of their training curriculum, so we're now able to get them at an earlier stage. We can do that now because we've got onsite doctors that aren't locums, and you need that to be able to supervise registrars.

You know, the college really do insist upon that sort of training model. What we're hoping is that by them getting a good experience and some good learning from here, that they will want to continue on staying rural and, more importantly, hopefully, in turn convince other people to sort of go rural as well.

Q. Do you get the sense that a salaried model like the one you are running there at Mudgee might be more attractive to young doctors than, say, traditional general practice?
A. I think from what I have seen, it seems fairly clear that is what junior doctors want. I mean, I've been involved in other things as well, like single employer models, so I was involved in the roll-out of that in Western LHD, and talking to registrars there as well, it is a common thing that they do want a more secure work pay cheque, really, at the end of the day. Fee for service doesn't appeal to them as much as previous generations. They like that stability. They like the ability to not have to worry about things like tax, which can be quite complicated when you are a VMO, where you get 100 per cent of your pay and you've got to then try to figure out how that all gets paid, whilst also deciding where you put your super. Things like that, the current generation aren't particularly keen on that.

General practice, that is entirely how it is done. So your small business owners and all the stress that goes with that. You know, I think the current generation, certainly not all of them, I don't think I could label a whole generation as wanting to avoid it, but I think what we've done previously is rule out those that don't want to do it, essentially, when you are told "This is the only way it can be done."

Q. Can I ask, we've been dealing with the medical workforce. What about the nursing workforce at Mudgee Hospital, has the trial that you've had running had any impact on workforce issues in terms of nursing staff?

A. Besides satisfaction, I know the nursing staff prefer having someone on site all the time. They do feel safer. They feel they can approach us more. It's a lot easier for them to find one of us physically and ask us for help, as opposed to having to ring a GP rooms, get through to the secretary, get on to the doctor there, that sort of approach.

I don't believe I've increased their numbers or anything like that. There's a few other initiatives which we had to put into place which have helped with certain things, but I wouldn't suggest those are my - the medical model we have here, that's more along the lines of having a night doctor who is on site now rather than on call. So that's also over the last three years where we've had to put that in, but that's enabled them to put a wider range of nursing staff on at night. So less senior nursing staff can be now put on to a night shift because there is a doctor there 24/7, but no, I haven't - I wouldn't lay claim to increasing nursing numbers, as much as I would love to.

Q. In terms of model, the employed model that you have running there at Mudgee, do you see any opportunities for it to be expanded in a way which might enable it to fill some of the gaps in primary care within your community?
A. There are potential ways in which it could help. I mean --

Q. How might that help?
A. -- the first obvious one would be - I will go through those. I think the first and obvious one is if we get enough doctors interested in it who may not want to come out to do solely GP, if we get enough of us, then eventually I suspect we would all do a smaller amount, certainly not enough to, you know, fill every space, but it's certainly - we would take some of the load off the local mainstay GPs, if that makes sense. If there are more of us here and we don't all work one FTE within the hospital, we can then branch out, do more.

I guess other ways - and these are still very much in the infancy of planning, even, but certainly a hub-and-spoke approach to smaller sites. Like I think I have said it previously, Gulgong, we look at Gulgong and think potentially, if I've got enough doctors, then we could have a setup where they go out to Gulgong for two or

three days at a time and actually cover the hospital there and primary care, whereas, at the moment, no-one's going to want to go and do that at the moment.

Q. So just looking at --
A. But it relies on --

Q. Looking at Gulgong, what is currently available at Gulgong in terms of primary care?
A. So I believe Gulgong's got one GP and they have space for two and they have an MPS, which has a bit of an outpatient department and some of the inpatients in a RAC facility. I believe they are about to lose the current GP there, and so they will be going to no GPs at all. So they are essentially going to be fee for service.

Q. So the expansion of your model would potentially see one of the salaried doctors from Mudgee going, I think you said, to two days a week, say, perhaps on a roster, to cover the needs of that small MPS, provide primary care to the aged care residents, and provide primary care services to members of the community of Gulgong through some sort of a clinic?
A. Yeah, that would be the way that model could potentially work. Like I said, it's a very early thought, and it is reliant upon numbers of staffing, but like I said, it could certainly - I could see a way in which we could organise something where we could cover that. It would not be - and compared to a traditional GP practice type model, it wouldn't be as good, but given that I think chances of actually filling that are very hard, it may be the best option for a site like Gulgong which will struggle to sort of attract doctors to their sort of town.

Of course, like I said, if they could find two GPs who wanted to set up shop in town, stay there forever and just see everyone, that would be better, but the reality is it's just not looking like that's an option, especially with fewer GPs coming through. So we've got to do something, and that could be potentially one way of managing it.

Q. Any other ways that you see your model there at Mudgee potentially expanding or being adapted to meet primary care needs in communities like yours?
A. There's always the talk about running clinics within the hospital, but again, that's the sort of thing you do when you've got no-one left out there in the community to

do it, because it's not as good. It's not as good.

If we got to the point where we had no GPs in town and we needed to cover that shortfall, then - because currently, at the moment, what's happening a lot of is coming through the ED - we could sort of look to arrange some sort of clinic that might be able to cover that, but again, it would not be as good as the traditional GP model, as long as the traditional GP model can keep attracting people to do GP, and I think that's the crux of the issue, is that they are struggling to do that.

THE COMMISSIONER: Q. Can I just ask you, doctor, in terms of what you have said about reduction in primary care and GP shortages, there is several big mining operations near Mudgee. Do they supply their own health services, do you know, or do the workers there use private primary care in the region?
A. They absolutely use private primary care. So that has been one of the reasons, I suspect, why we've been seeing the numbers increase. So the mines have been here since I got here 12 years ago. The latest problem is - well, not "problem", the latest issue is the renewable energy projects, solar farms, wind farms, that sort of thing. We're seeing more and more workers coming from that, and a lot of those guys are transient, so they don't necessarily look to want to get a new GP, because they're only here for six weeks, eight weeks, and so don't want to start a new relationship.

So we do see a few of those come to the hospital in the hopes of just getting that thing sorted out, you know, problem A - "I would like to get problem A sorted out because I'm only here for six weeks and I don't want to wait three weeks to get in and do all that." We're seeing more and more of that.

Q. Is that the same for the mining workforce, too?
A. I think we're lucky in Mudgee, the mining workforce seems to be more stable. We get a lot of families related to mining, so I find that they are living in Mudgee long term. They have moved their families here. We don't have the FIFO workforce. I'm from Queensland initially and I worked in Mackay and Proserpine and there was a lot of FIFO around there for those surrounding towns, so quite a different population.

THE COMMISSIONER: Thanks.

MR MUSTON: Q. Can I ask you some very quick questions about the trial that you have got running at Mudgee? The first is, how long is it to run for, or what is the duration of the funding that you have got to run that trial?
A. Unclear at this stage. It's - I won't say open-ended. It's a hard one. I mean, there is no - it is not officially in the budget so to speak, which sounds strange, but we've been allowed a bit of freedom to employ people how we would like in this model, and the LHD has been really good in allowing us to do that. So there is no hard end date to it, and a lot of the people we're hiring, these are permanent contracts, so that's not like they're going to cut those off in two years or something like that.

So I think the LHD is happy for me to continue with this as long as we keep showing some results and demonstrating that we're able to attract and keep doctors and provide that service. I think they are happy with the fact that I'm reducing locum usage. I think that - you know, in a very immediate sense, that shows that we're at least being somewhat financially responsible and then they see the other sort of things like the improvements in patient satisfaction and other KPIs, which I think again goes a long way for allowing us to continue doing what we're doing here and, honestly, if we weren't doing those things, I think we'd very quickly find that the funding would dry up and we would be told that. But no, there is no hard end date. It's just --

Q. In terms of the permanent appointments that you have made, I think you have told us they are either a rural generalist like yourself or GPs. How have you managed to employ them as staff specialists under the current award arrangements?
A. Now, my understanding of that, when you go through the award, part of the issue is when you read the award, it says the staff specialist award applies to anyone from the colleges of - and then they list every single college except the College of GP and ACRRM, but then there is an extra paragraph in there, can't remember off the top of my head but it is definitely there, where it says the LHD is then allowed to hire anyone into that role at that award that they deem is qualified to do the job. And so the LHD and people in administrative health who I have also spoken

to about this all feel that that's allowed us to do this, because that was initially one of the, I guess, hurdles, was this perceived thought that we don't deserve to be paid a staff specialist award. But it is definitely in there, in that paragraph, I've highlighted it. It's everywhere. So that's how we got around that one.

Again, it's the support from the LHD. I can't stress that enough. Western have been really good in this regard. I imagine there are other LHDs who just wouldn't even have a bar of this. But Western have enabled us to sort of get a start on it and so we're quite keen to show that this can work for us, at least.

Q. At least to the extent that you have been able to assess its success to date, you are satisfied that by retaining this core group of staff specialists into the hospital, and the stability that that brings with it, you have produced fiscal savings in terms of a reduction in locum expenses?
A. Yes.

Q. And produced better outcomes in terms of the care that has been delivered to patients within the hospital setting?
A. I'm very confident of that.

MR MUSTON: I've got no further questions for this witness, Commissioner.

THE COMMISSIONER: Thank you. Mr Cheney?

MR CHENEY: Nothing, Commissioner.

THE COMMISSIONER: Doctor, thank you very much for your time. We're very grateful. You are excused.

THE WITNESS: Thank you very much. I appreciate the opportunity.

<THE WITNESS WITHDREW

MR GLOVER: The next witness is Mr Greg Tory.

<GREGORY PHILIP TORY, sworn: [3.04pm]

<EXAMINATION BY MR GLOVER:

MR GLOVER: Q. Mr Tory, could you state your full name for the record, please?
A. Gregory Philip Tory.

Q. And you are the general manager of the Lachlan Shire Council?
A. That's correct.

Q. And prior to giving your evidence today, have you been involved in the preparation of a document headed "Outline of anticipated evidence"?
A. Yes, I have.

Q. Do you have a copy of it there with you today?
A. Yes, I do.

Q. Have you read it before giving your evidence?
A. Only briefly.

Q. Only briefly today?
A. Yes.

Q. Or you have read it from cover to cover, as it were, at another time before this morning; is that right?
A. Yes, I went through it on Friday and I read it very briefly this morning so I agreed with the changes.

Q. Are there any changes you would wish to make to that document?
A. No.

Q. Are you satisfied that it is true and correct?
A. Yes.

MR GLOVER: Commissioner, this is relatively hot off the press. I think for the moment we might just mark it. Oh, I'm grateful to my learned friend. Mr Cheney has just informed me that he is happy for it to be tendered, so it will be tendered. NSW Health are happy for it to be tendered so it will form part of the bulk tender. For the benefit of the transcript, it has been allocated a number which has not yet been physically applied to the document but it will be [SCI.0009.0089.0001].

THE COMMISSIONER: That number is on the screen. Things are ahead of you.

MR GLOVER: I should not have doubted it for one moment.

Q. Mr Tory, how long have you been the general manager of the council?
A. All but seven years.

Q. Prior to that, had you held any other roles with the council?
A. Yes, I was the director of environment and projects.

Q. When was that?
A. From early 2017 through until I was appointed as the general manager.

Q. Can you tell us a little bit about the Lachlan shire?
A. Its comprised of about 6,100 people or 6,090 I think it says in my affidavit, just under 15,000 square kilometres in area, it is comprised of the townships of Lake Cargelligo, Condobolin and Tottenham; we have four villages, Albert, Derriwong, Bircher, and Tullibigeal. The service by hospitals in Lake Cargelligo, Condobolin and Tottenham. The Lake Cargelligo facility falls under the Murrumbidgee Local Health District. Condobolin and Tottenham fall under the Western NSW Local Health District. Tottenham was part of the Four Ts trial in conjunction with Trundle, Tullamore and Trangie, where they shared GP services for primary care, provided through the LHD. At Lake Cargelligo, that township is serviced by a general practice practitioner who also provides VMO at the hospital. He's been there for quite some time and he also employs another doctor to work with him providing medical services at the town and in the hospital.

Q. We'll break some of that up a little.
A. Okay.

Q. Do you have a copy of the outline of evidence there with you?
A. Yes, I do.

Q. In paragraph 7, you tell us, and you have mentioned in your last answer, that the towns of Tottenham, Tullamore and Trundle are part of the 4Ts program. Are you generally

familiar with that program?
A. I was, but I wasn't intimately involved. Our mayor was, but I understand the principles behind it and how it was funded.

Q. What's your understanding firstly of the operation of that program and then we'll come to funding in a moment?
A. It was one of a number of trial programs that was established to try and provide primary care to each of those small communities after withdrawal of general practice in those towns. It was conducted with GPs offering primary care services out of the local hospitals and they were also supported - when there was no GP physically on site, it was provided through a telehealth service, supported through a telehealth service.

Q. And who delivered the program?
A. Western NSW LHD.

Q. And did you observe the benefits of that program in the community within your shire?
A. Not personally. I didn't receive any service, but I did receive feedback that the community were benefited by the fact that there was a doctor in town and it didn't require them to travel as regularly as they had been when the local GP left the town.

THE COMMISSIONER: Q. And the GPs were employed by the LHD, were they?
A. No, there was a GP servicing the town in private practice that left the town and moved away, and the LHD put a GP into the hospital, shared with the other three towns, to provide primary care.

MR GLOVER: Q. The GP that was put into the hospital, as you said in your last answer, to your understanding was that a GP engaged by the district to provide those services through the hospitals?
A. That's correct, as I understand it, yes.

Q. Do I take it from that answer that, to your understanding, the program was funded by the LHD; is that right?
A. It was funded by a grant from the federal government, but coordinated by the LHD.

Q. In your earlier answer, you mentioned the Condobolin

Health Service. That includes a hospital; is that right?
A. That's right.

Q. Do you have an understanding of the services that are available at the Condobolin hospital?
A. I know they have inpatient services, they have an emergency department, they have some palliative care beds, they have a radiology department. They are the services that I'm aware of.

Q. Are you aware whether there are any visiting medical officers providing services into that facility?
A. There are, but not regularly. And I haven't had any recent conversations with the local health district, but the last conversation I had, several months ago, was that they had a locum doctor providing VMO services about once a fortnight, and supported by telehealth services in the other week. I was also asked - at that time I was negotiating for the Royal Flying Doctor Service to establish a private practice in Condobolin and I was encouraged by the LHD to ask the RFDS if they would consider also providing VMO services to support the hospital, if they took up the option of the private practice.

Q. We may as well deal with that now. If you have your outline there, can you turn to paragraph 13. There you tell us that the council has had to take action to address a gap in service, and then in the introduction to paragraph 14, it entered into an agreement with the Royal Flying Doctor Service to take over the previously vacant general medical practice in the council-owned building, et cetera; do you see that?
A. Yes.

Q. Firstly, what is the council-owned building that you have referred to in paragraph 14?
A. It's a purpose-built medical facility in Melrose Street.

Q. What does it comprise?
A. Five treatment rooms, a nurse practitioner's office, administration office, kitchen, storeroom, toilet facilities. It's, as I said, a purpose-built medical practice.

Q. It was built by the council?

A. Yes. I'm not aware of the funding arrangements. I think there were some contributions. It was approximately 20 years ago that it was constructed.

Q. Since it was constructed, are you aware of who has been operating out of it from time to time?
A. I'm aware of the operators since 2017. When I moved to the area, Ochre Health were providing medical services out of it. They withdrew their services in 2019, I would think that it was, and then Brenshaw Medical started to provide medical services out of the facility. They endeavoured to operate a practice there until April 2023, when council terminated their lease because they were getting into or they had ongoing financial problems and they weren't providing doctors to support the town, and we commenced negotiations with the Royal Flying Doctor Service, who have now gone into the facility.

Q. Just dealing with the arrangements with Ochre and then Brenshaw, did you say?
A. Yes.

Q. Were those arrangements whereby those operators rented the space in the council-owned facility and then delivered the services through their own practice?
A. That's correct.

Q. And is that arrangement similar or different to the one that the council has entered into with the Royal Flying Doctor Service?
A. Very similar.

Q. In renting space in that facility to the Royal Flying Doctor Service, is that done at market rent or a subsidised rent?
A. They are currently on a six-month rent holiday, with the rent to commence - sorry, the rent will have just started, I think it commenced in April this year, and it's done at a market rate.

Q. Aside from the services operated out of the council-operated facilities by those various providers and now the Royal Flying Doctor Service, are there any other primary care services available in Condobolin?
A. Sorry, can you repeat that? If I could just go back to the previous question.

Q. Of course you can.
A. Done at market rent, it was on the basis of the rental arrangements that were put in place with the previous tenant, and their rent was determined by the income they were receiving from a sub-lease to a pathology provider. So that was how our rent was established for the facility, and it was offered to the Royal Flying Doctor Service under the same terms.

Q. On those same terms which had been entered into some years earlier; is that right?
A. Yes.

Q. So is the point that although it was market at that stage, it may not necessarily be full market as of today?
A. That's correct.

Q. Whilst we are on that topic, in an earlier answer you said that the council ultimately had to terminate the lease of the earlier provider. In paragraph 16 of the outline, you tell us about some assistance that was provided to that operator to attempt to maintain the services at the facility?
A. Yes. The figure that's mentioned there wasn't in the form of assistance to the provider. The provider was offered a rent-free holiday and then were given multiple opportunities in which to enter into payment arrangements to catch up on arrears for rent that had then become due. Over a period of, thinking back, 18 months to two years, there were a number of different agreements reached with that provider that they failed to honour, and ultimately council took the decision to terminate the lease.

Q. In attempting to enter into arrangements or provide rent holidays, as you have described it, what was the motivation of the council in doing so?
A. To retain GP services, primary healthcare services, for our community.

Q. Why did the council seek to do that?
A. Because there are limited service providers in town. We have the Aboriginal health service and we have the hospital, and there is a considerable amount of pressure brought on council from the community to actively support the retention or provision of medical services in the town.

Q. How, to your observation, does that pressure manifest

itself on the council?
A. Yes, it has.

Q. How?
A. How? Telephone calls, letters, people calling in to the counter to talk to me.

Q. Is it fair to say in rural communities, people in your position and that of the elected councillors are well known to the community?
A. Yes, certainly they are well known to the community.

Q. And the community is not backwards in coming forwards about their concerns; is that fair?
A. That's fair. I think it's also fair to say that the community is generally not very well aware of what council's role and responsibilities are. Council is often approached about providing services for a whole raft of different areas that state and federal governments normally provide but the community presume it's council.

Q. In paragraph 10 of the outline you tell us that you have observed that there's been a diversion of services from local delivery to larger regional centres. Do you see that?
A. Yes.

Q. Firstly, what type of services have you observed being diverted from locally to those major centres?
A. Dialysis is the most pressing one, but there's been maternity services. I haven't - "observed" is not the right word there, but I have been made aware that there used to be minor surgery offered - stitches, things like that; ingrown toenails, those types of services - that were provided in a short stay ward at the hospital, but they are no longer provided.

Q. You said earlier in that answer that dialysis is the most pressing issue?
A. Yes.

Q. Why is that?
A. At any one time, there are 12 to 15 residents in town that need regular dialysis treatment. There was a dialysis chair at the hospital that was funded from, I'm told, community raising the funds to buy the chair, and it was withdrawn prior to my arrival in 2017 and not supported.

I've been told that it had been withdrawn because there was no trained nurse to operate the chair, but I've also been told that that wasn't correct, it was a contraction of services, and people now have to travel to Forbes to obtain that dialysis treatment. Forbes is 100 kilometres away from Condobolin.

Q. So the decision to move the service away from Condobolin happened before you assumed the role of general manager or returned to employment at the council?
A. Yes, it occurred before I started in the role of general manager.

Q. But I take it from the answer you gave that the community has provided you some feedback as to their views on that decision; is that right?
A. They have, and as has several long-term councillors, and it's actually a specific action in council's community strategic plan, which is a document produced through consultation with the community about what their priority issues are for councils to work towards and advocate on, and the provision of dialysis services is a specific item in the plan, and has been since prior to 2017.

Q. And through the provision of that feedback, have you become aware of the impact on those community members of them not being able to access that service within the shire?
A. Yes, not directly, indirectly, through being advised that residents can't obtain community transport to attend for regular treatment; that there are people who have opted not to seek treatment as regularly as it is required; and that that, in itself, has led to adverse health outcomes for those individuals.

Q. Other than dialysis, maternity services and some procedural services that you described earlier, are there any other services that have been, to your understanding, diverted to larger regional centres?
A. No, not being a long-term resident I'm not aware of what services other than the ones that I've mentioned were provided in the past.

Q. Has the council raised these issues with the local health district during your time as general manager?
A. Yes.

Q. Have you been involved in those discussions?
A. Yes, I was.

Q. What has been the outcome of them?
A. Again, it was principally around the dialysis chair, and we were informed that we won't be getting a chair back, that the services will remain being delivered in Forbes.

Q. Were you informed why that was the case?
A. I understand it was to do with cost, but that's the only reason I can say.

Q. How did you come to that understanding?
A. Through the conversation.

Q. Something you were told by the LHD?
A. Yeah.

Q. Did you raise --
A. Sorry, it was along the lines that we couldn't afford to provide every service in every community, which we understand.

Q. When you say "we understand", the council understands?
A. Myself and the mayor at the time, yes.

Q. And is that something that you perceive to be also understood by the community at large?
A. No, I don't think the community do well understand it.

Q. Understand the decision to remove the service; is that what you mean?
A. Yeah, they don't understand the decision to remove the service.

Q. Does the community, to your observation, have an expectation, though, that every service will be available to them, say, at the Condobolin hospital, or do they understand that some services need to be delivered through major centres?
A. I think collectively the community would understand that. I think individually, when a person needs a service, that understanding is diminished and they don't quite know why they can't get the treatment they want in the town that they live.

THE COMMISSIONER: Q. Is your understanding - when you

used the words "collectively the community", is that based on conversations you have had with residents?
A. Yes, my opinion of my community.

Q. Sorry, your opinion?
A. My opinion of my community.

Q. But is that opinion, then, based on conversations with members of the community?
A. Members of the community and councillors, yes.

MR GLOVER: Q. In addition to the council-owned practice building that you have described earlier, does the council provide any other support to the delivery of medical services within the shire?
A. Yes, we do. So in Lake Cargelligo, council owns a home which it rents at a subsidised rental to the resident GP out there. He has his own home, but he then houses his employed GPs in that facility.

Council has two townhouses in Condobolin which we furnish and rent to the Royal Flying Doctor Service, for the housing of their employees; and in Tottenham we have a four-bedroom, modern four-bedroom home that's rented by the LHD for the use of the local doctors, and I understand some nurses that come to town, and that's also at a considerably subsidised rental.

Q. Why does the council take the steps of offering that support to medical practitioners within the community?
A. When I first started with the council, council were providing the house free of charge and a motor vehicle free of charge to the doctor in Tottenham, and council made the decision that they couldn't afford to continue to provide that level of support to GPs. The decision to ask the doctor to pay a fairly modest rental and the withdrawal of a fully fuelled motor vehicle from offer led to him leaving the town and left that community without a doctor.

Through the Four Ts trial, council were asked to make a contribution towards the cost of that project through the provision of a house, and council provided the house free of charge at the commencement of the trial. The trial went on longer than expected and the period of agreement where it would be provided rent free expired. The community then funded the rent for a further six-month period, and at the conclusion of the trial, the LHD agreed to rent the

property from council. As I said, it is a very heavily subsidised rent. It is $100 a week and council do all of the grounds maintenance and building maintenance in the property as well as pay the water and electricity bills, so it doesn't cover the cost to the community there.

Q. I take it from that answer that the council has taken that step as a measure to attract and retain medical practitioners within the shire for the wider benefit of the community; is that fair?
A. Council's taken that step because they want to ensure that there is medical facilities provided for the community, but it's a reluctant decision to do it.

Q. Why do you say it is a reluctant decision to do it?
A. Because it is a cost that council is incurring that they are not funded to provide. It's not a service that is included in the local government charter, and I am afraid that it's the thin end of the wedge as to levels of support that they may be expected to provide for any number of other state or federal government services that we want to retain in our area, for instance, police, teachers. Where else might it extend to if we need to attract those types of professionals into our region.

Q. When you say the council is not funded to provide, do you mean that it's not part of the rate revenue or other grant revenue that would be available to the council?
A. That's right. It's not part - it's not a business of council under the Local Government Act in the charter for council services, and there is not - it is not part of the make-up when - that IPART consider, for instance, when they are determining rate peg for the amount that councils can increase their rates and charges. The cost in the provision of housing for medical services isn't something that's taken into consideration there.

Q. Just on this issue, in paragraph 23 of the outline you tell us that there is increasing discussion, which was apparent during the trial of the Four Ts, about health being the responsibility of three tiers of government. Do you see that?
A. Yes.

Q. What was the discussion?
A. There were a number of meetings that I sat in where the LHD representatives were saying that this is

a responsibility of all levels of government and we all need to contribute to solve the problem.

Q. And do I take it from your earlier answer, you disagree that it is the responsibility of local government?
A. That's right.

Q. Are you aware of other of your colleagues having to provide support or step in to the space of delivering medical services?
A. I'm aware that many rural councils have to do that in order to attract medical services into their communities.

Q. That's the position that your council has found itself in as well; correct?
A. Yes, it is.

Q. To the extent that that has become somewhat of a reality for your council, is there any additional support that you would like to see from, let's just take the New South Wales Government, firstly?
A. I would like to see whatever employment arrangements are necessary in order for the health service to be able to attract and retain staff in these communities provided by their employing body.

Q. To the extent, though, that local councils, including yours, are finding themselves in a position where they feel that they have to provide support or even enter into the delivery of medical services themselves, is there anything that you see could be done to better support councils to do so?
A. I think that the cost of providing or supporting these types of services should be a consideration when the state government is determining increases to rates and charges. In saying that, though, a lot of the - you know, the community that I work for is a fairly low socioeconomic community, and their capacity to pay increased rates and charges is limited, so it's a double-edged sword. The cost of supporting or supplementing the provision of those services isn't something that is expected or required of larger councils, so whether it be Dubbo or Orange or Bathurst, Tamworth, or even into Sydney, those councils who share the same rate peg or who obtain the same rate peg as smaller rural communities aren't necessarily incurring the costs of providing homes, because they have doctors and services and are a more attractive community to live in,

and they don't need to have those types of incentives to get people into their communities.

Q. So the point being that there is a burden being placed on rural communities like yours, which is not being felt by metropolitan counterparts; is that right?
A. Yes.

Q. Does the council engage in discussions or consultations with the LHD relating to, firstly, the availability of health services within the shire, and the region more generally?
A. Not specifically in the engagement of health services, but they come up in discussions. Through Tottenham, for instance, there's a welfare council community, and the deputy mayor is a representative on that, and that committee regularly meets and then provides feedback to the council. At Lake Cargelligo, the Murrumbidgee health district have a bi-monthly meeting that myself and the mayor are invited to, that we participate in, to hear of issues and emerging issues that might be impacting that community.

It's not something that happens in Condobolin. We don't have a health council or a health community. There is another councillor, Councillor Peter Harris or Dr Peter Harris, who is a dentist, that I have encouraged to speak to the hearing. He was on the Condobolin health council when it did exist and he has had a long involvement with the provision of health services in Condobolin. Unfortunately, he wasn't available to come today, but I'm sure that he has got some valuable information.

Q. Just in that answer, you mentioned a bi-monthly meeting that happens within Lake Cargelligo, which is part of the Murrumbidgee Local Health District?
A. Yes, that's correct.

Q. And what sort of things are discussed at that meeting?
A. The provision of services, the purchase of new equipment, the distribution of section 19 funds, funds collected from Medicare when the GP provides services at the hospital, so the distribution of those funds and the use of those funds for the welfare of the community; staffing levels, those types of issues.

Q. And is that an opportunity for the council, through

you and the mayor, to raise issues in relation to the community at least in that part of the shire?
A. It is. However, because of the arrangements there with the existing doctor in town and he is a long-term doctor and the services that are provided, we don't have many ongoing issues to raise in that community.

Q. But there is a forum there, should you need to do so; is that fair?
A. Yes, there is.

Q. There is no similar meeting taking place in Condobolin and for the other parts of the shire?
A. There is not in Condobolin. In Tottenham there is a meeting that happens monthly, the Tottenham Welfare Council, where, and I won't have the right job title, but the nursing unit manager comes along and talks about issues at the Four Ts.

Q. That's part of the Four Ts model, if I can put it that way?
A. That's right, yes.

Q. Do you think there would be benefit in the council engaging with the LHD - that is, the Western NSW LHD - in relation to the health needs of the community within the shire?
A. I don't think it would hurt. I think, yes, there would be benefit. I think it would be more beneficial if they were also engaging with the other allied health providers in the community, who are better placed - the local pharmacist, the dentist, the physiotherapist, those types of people would have more valuable feedback than council. Myself and the rest of the councillors, aside from our dentist, don't have a particularly deep knowledge of medical issues that we could provide, other than the community's opinion on the delivery of services.

Q. Yes. But what about in terms of hearing, from the LHD directly, explanations of decisions as to where services might be delivered, for example. Would that be of benefit?
A. Yes.

Q. Why?
A. It would give us information that we could then distribute amongst our community and at least go some way to calming any unrest that might develop over issues that

the community's becoming aware of.

Q. It would enable the council to engage with its community more fulsomely on those issues?
A. Certainly more knowledgeably in our dealings on issues.

Q. Just in relation to the Four Ts model, were you involved in discussions and collaboration with the local health district in relation to the implementation of that model?
A. I attended some of the meetings, not all. Our former mayor, the current deputy mayor, was the lead representative from council on that.

Q. To the extent that you either attended in person or - did you receive reports from the then mayor as to his involvement in that process?
A. Yes.

Q. And do you have a view as to whether the level of collaboration and engagement in relation to the Four Ts model was a positive from the council's perspective?
A. Yeah, I think it is positive. It's not perfect. I think that each of the communities would much rather have a permanent GP in their hospital or offering private practice in the towns, but in the absence of that, I think the community are happy with the service that the Four Ts model has provided to them.

Q. What about the extent and nature of the collaboration between the council and the LHD in relation to that model?
A. I think --

Q. Was it effective, in your view?
A. Yes, I think the collaboration has been effective. I keep putting my council funding hat back on, and I don't mean to, but it's a financial burden on council that they can't afford to continue to do long term and into the future.

MR GLOVER: Thank you, Mr Tory.

I have no further questions of this witness, Commissioner.

THE COMMISSIONER: Thank you. Mr Cheney?

MR CHENEY: Commissioner, there are no questions for this witness.

THE COMMISSIONER: That was a long think about it.

Thank you very much, sir. We're very grateful for your time. You are excused.

THE WITNESS: Thanks very much.

<THE WITNESS WITHDREW

THE COMMISSIONER: All right. So we adjourn until 10 o'clock tomorrow?

MR GLOVER: 10 o'clock tomorrow.

THE COMMISSIONER: All right. We will do that. Adjourn until 10 o'clock in the morning.

AT 3.38PM THE SPECIAL COMMISSION OF INQUIRY WAS ADJOURNED TO TUESDAY, 14 MAY 2024 AT 10AM

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