# 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

Friday, 17 May 2024 at 9.30am

(Day 029)

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| 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

1 THE COMMISSIONER: Good morning. We're all set to go in
2
3 MR GLOVER: Yes, Commissioner. The first witness today is
4 Mr Josh Carey, and he's in the witness box. I'm told he
5 will take an oath.
6
7 **<JOSHUA MICHAEL CAREY, sworn: [9.30am]**
8
9 **<EXAMINATION BY MR GLOVER:**
10
11 MR GLOVER: Q. Mr Carey, could you state your full name
12 for the record, please?
13 A. Yes, Joshua Michael Carey.
14
15 Q. You are the executive director of service delivery for
16 the Western NSW LHD?
17 A. Yes.
18
19 Q. And in preparation for giving your evidence today, you
20 have prepared an outline of your evidence; is that right?
21 A. Yes, I have.
22
23 Q. I will just have that brought up on the screen. It is
24 [MOH.9999.1195.0001]. You may have a hard copy there.
25 Feel free to use the hard copy rather than the screen,
26 should you wish. Have you had a chance to read it again
27 before giving your evidence today?
28 A. Yes, I have.
29
30 Q. Are you satisfied that its contents are true and
31 correct?
32 A. Yes.
33
34 MR GLOVER: Commissioner, that will be tendered at some
35 stage during the course of the day.
36
37 THE COMMISSIONER: Sure.
38
39 MR GLOVER: Q. Mr Carey, if you take up your outline,
40 and in paragraph 4 you give us a little bit of an overview
41 of your service delivery portfolio, but just in general
42 terms, can you describe your area of operations and
43 responsibility in that portfolio?
44 A. So the service delivery directorate basically brings
45 together all of our front line services across the health
46 district. That includes our acute hospital services across
47 the 38 different facilities, our district-wide mental

1 health services, which includes the large mental health
2 hospital in Orange, and also some of our community-based
3 services, so that would be community health nurses, child
4 and family services, other examples of those, aged care
5 services in terms of access and moving patients into the
6 residential aged care space.
7
8 Q. And that portfolio was established with your
9 appointment in about February of last year; is that right?
10 A. Yes. That's correct. So prior to that we had
11 a slightly different executive make-up across the district
12 and a lot of the community-based services or programmatic
13 services were managed by another executive portfolio, and
14 we had more a discrete acute service focus within the
15 director of operations. The decision was to integrate
16 those two portfolios and therefore creating the service
17 delivery directorate.
18
19 Q. In paragraph 5 of the outline, Mr Carey, you tell us
20 in the last sentence that your role has significant input
21 into the development and oversight of strategic and
22 business plans, et cetera. We've heard a little bit of
23 evidence about the planning function within the district
24 this week, but can you just describe to us how your
25 function plugs into that process?
26 A. Sure. So the district planning team takes the lead
27 role in this particular space, particularly for our
28 strategic planning and longer-term health service planning
29 across the organisation. My role and that of my team would
30 be to participate as part of that, so subject matter
31 experts would largely come from my broader team, senior
32 clinical leaders, other senior service leads across the
33 district would participate in that planning. They would
34 also, on the other side of what might be the data-based
35 element of the planning, look at the different models of
36 care that we would implement post the planning process as
37 well, so how we would actually operate some of these
38 services into the future.
39
40 Q. So as part of that planning process, is there an
41 assessment, with the assistance of your team, of the
42 services that are needed in various areas of the district?
43 A. Yes, definitely. So an example, a recent example that
44 we're currently working through is the clinical service
45 planning for Orange Health Service. That is a large
46 referral hospital in this district, has a broad reach in
47 terms of the services and the populations that it supports

1 and, equally, with the mental health service located on the
2 same campus there, we do have a full clinical service
3 planning approach under way that incorporates those two
4 discrete business units and I say that because they have
5 different accountable leads through to me, so the general
6 manager of the acute Orange Health Service as well as the
7 director of mental health services participate in that
8 along with their clinical leadership teams. A number of
9 working groups have been established for the different
10 specialty areas, where we will consult very broadly with
11 those individual groups on their thoughts and experience
12 with the current service and where the demand pressures
13 are, innovation into the future, where services could
14 evolve, the conversations under way, obviously supported by
15 strong data and evidence that would back up some of the
16 points that could be made going forward.
17
18 Q. That example involves an assessment of service needs
19 in what I might describe as a larger regional centre. What
20 about for the more rural and remote areas of your district,
21 what does your team plug into that process?
22 A. So that would occur in the small community the same
23 way. A lot of the time it will be off the back of what
24 might be an infrastructure development process. That has
25 tended to be more of the planning process, particularly
26 through the NSW Health arena, your capital funds to
27 redevelop the hospital, Blayney Multi Purpose Health
28 Service would be an example of that, so that is an outcome
29 of that particular planning process but, equally, the same
30 principles would apply that we would source the data. My
31 service leads, as a part of that particular facility, would
32 participate in that, other district-wide services that
33 would interact with a smaller service, because we will have
34 a lot more of that occurring at a smaller site where you
35 have visiting services.
36
37 So the same principles would certainly apply. I think
38 the evidence has been given prior to me there's certainly
39 a lot of community input into that, and you would say that
40 that also occurs at an Orange Health Service level as well,
41 you would collaborate and consult with the relevant health
42 parties within any community, but I guess you are asking me
43 specifically around my team and so my service leads and
44 senior clinicians that form part of that service would
45 participate in those planning conversations.
46
47 Q. And what is the particular perspective that they

1 bring, you described them as subject matter experts. So if
2 we just focus on those more rural and remote service areas.
3 A. Sure.
4
5 Q. What does your team bring to that discussion?
6 A. So they would complement what data and evidence is put
7 in front of them. So if you think about Blayney, that
8 would be projecting out what the population demands might
9 look like over the next 5, 10 years, obviously the ageing
10 factor that would accompany some of that and, for a service
11 like Blayney, which is a multi-purpose health service, they
12 have a residential aged care component to their business
13 and they would be experiencing quite significant demand in
14 that space, and certainly within the Blayney planning
15 process we could clearly see that there was a growing
16 demand for aged services in that particular region.
17
18 The outcome of that process, though, would have
19 suggested that there should have been more aged care beds
20 built potentially through the MPS model. However, given
21 a site like Blayney where it actually has quite a connected
22 community, it's not far from big centres like Bathurst and
23 Orange, there is a private market there for aged, and that
24 certainly did see us then retrench back to what is our core
25 services, being the acute, sub-acute service response.
26
27 Obviously we wouldn't abandon the residential aged
28 care component of that, but we didn't see an expansion, but
29 I guess it was a known comment, as part of that process,
30 that there was definitely an ageing demand in that
31 particular community but we were using the market to
32 support the expansion of those services.
33
34 Q. Is it your team that's involved in the assessment of
35 the availability of services delivered by the private
36 market in that context, or is that within the remit of
37 another area?
38 A. They would comment on that, given that they would be
39 local, largely living in those communities, they would be
40 aware of the private parties that operate in those
41 communities. The broader assessment though would certainly
42 happen at a more of a corporate level through the planning
43 function.
44
45 Q. Can you go to paragraph 7, please, and in this
46 paragraph you describe some key principles that have guided
47 the evolution of your portfolio over the last almost

1 18 months. Can I just ask you about some of them. In
2 paragraph 7(b) you describe service delivery's natural
3 referral networks. Do you see that?
4 A. Yes.
5
6 Q. Can you just explain what you mean by that?
7 A. So the size of this district is extensive, as you are
8 probably all aware. There is two quite distinct areas, and
9 we talk about the northern referral network, which is very
10 much Dubbo and to the north, where we have a lot of our
11 small rural communities. There is about 25 hospitals and
12 services that would then feed into Dubbo for access to that
13 next level of care.
14
15 Then we have the southern referral network, which is
16 Orange is the major referral service. Bathurst equally is
17 a referral service but slightly smaller than Orange in
18 terms of its specialised services that it offers.
19
20 Q. What you are describing is pathways for patients in
21 more rural or remote areas of the district being referred
22 to one of the major centres; is that right?
23 A. That's right, yes.
24
25 Q. When you describe them as "natural", are these things
26 that have developed over time, or are they structured and
27 defined within the policies of the LHD?
28 A. They have evolved over time is how I would respond.
29 That has become more formalised, though, in a sense in
30 recent times. It follows the pathways that people may
31 travel for their other access to services. So
32 particularly - so if you use Dubbo as a example, yes,
33 people will need to travel in here for the more specialised
34 nature of health care; equally, they may need to travel
35 here to access other goods that they may require that
36 aren't serviceable in their local communities, other
37 government agencies that may exist here in town that they
38 do not have access to as well.
39
40 So that's why I say "natural". There is a natural
41 movement of the population just across our region. We
42 haven't attempted to adjust that in any formal sense other
43 than where services may require, so prior to the Dubbo
44 redevelopment in the recent time, where we now have greater
45 access to oncology, radiation oncology services, and our
46 cardiology services, some of that referral would have gone
47 into Orange from a district point of view, but we now have

1 a more established northern and southern footprint for some
2 of those specialised services to take that pressure off
3 just one particular hospital.
4
5 Q. Is the identification and support of these networks
6 part of the input that your team would have into the
7 service delivery planning process?
8 A. Yes. I think that is an area that I am particularly
9 focusing on since being appointed to the role. It has
10 certainly been there, but having more cooperation between
11 our services that sit as part of those referral networks is
12 a focus for me. And the reason I say that is that
13 a service like Dubbo is overwhelmed on most days in terms
14 of the demand for that acute acquired need. We have only
15 a certain number of beds, or we're constrained by workforce
16 at different times in Dubbo equally as other sites across
17 this district, and having patients received and managed
18 appropriately and also returned in a timely manner back to
19 community is important, and there is a lot of logistics
20 that go into that where we need cooperation between our
21 health services to ensure that that patient movement
22 happens seamlessly.
23
24 Q. Is it the case that that cooperation that you are
25 speaking of is on the pathway to maturation but isn't yet
26 there?
27 A. Yes, it certainly exists. I think it could be more
28 improved, and that's some of the reason for the reshaping
29 of service delivery to ensure that we establish that to be
30 more seamless for individuals, so personalities potentially
31 could have played more of a role previously and we're
32 having a more structured way forward.
33
34 Q. Is it a focus of yours because - tell me if you
35 disagree - ensuring these referral networks are optimised
36 is important to the district being able to efficiently
37 utilise its resources, both people and facilities and
38 financial?
39 A. Yes. Yes. Definitely. I think, you know, we know
40 that we have a number of unused bed capacity outside of our
41 base hospitals and trying to best utilise that where it's
42 safe to do so for patients is really important. So yes.
43
44 Q. Can I ask you to go to subparagraph (d), where you say
45 that clinical streams should evolve into clinical networks.
46 Do you see that?
47 A. Yes.

1
2 Q. Why is that a particular focus of your work?
3 A. The clinical streams or clinical networks, as they
4 will be known into the future, are the glue to connect our
5 hospital services mainly, but you could argue the broader
6 health services. When I talk about this, it's more of
7 a specialised nature in some sense where we do have three
8 referral hospitals in this district. That may not
9 necessarily be the case in other districts where you have
10 a very clear more tertiary or senior service provider. We
11 need to have those clinicians connecting as peers leading
12 the future clinical service evolution. Having consistency,
13 standardisation of practice is really important.
14
15 The clinical streams perform that function. However,
16 just thinking about the last 10 years, so I've been with
17 the organisation for over 10 years, when we started with
18 clinical streams, for the same purpose that I've described,
19 we were probably less structured in our approach with that
20 and partly because it was the first time that we had
21 introduced that type of work in this organisation, and
22 there was multiple specialty areas that popped up as
23 a result of that, some of which you could argue are more
24 programmatic or already established business units in the
25 organisation. So a lot of work has been done in the last
26 12 months to reconsider what those clinical networks look
27 like, being more targeted with their clinical specialty
28 areas, which are mentioned further on, that are very
29 clearly aligned to those three referral hospitals,
30 however, acknowledging that other services would need to
31 interact with those clinical specialties and we would have
32 necessary representation from our small rural partners in
33 some of that space as well.
34
35 So it - that's the intent. The headline of some of
36 this, though, is to improve clinician engagement, so having
37 clinical leadership at the forefront of where service
38 delivery should evolve is highly important and we believe
39 this network model will see that improve.
40
41 Q. It is important not only for clinical standardisation
42 but from a workforce perspective, would you agree?
43 A. Definitely. I think that is an area that we will see
44 evolve. Workforce planning historically has been done more
45 so at a hospital level, potentially at a regional level
46 with our small hospitals because we do have a general
47 management structure over multiple small hospitals that

1 assists, largely nursing based, but we do see the clinical
2 networks providing some form of engagement of how we can
3 improve that workforce planning, particularly when we need
4 to consider future workforce models that may not actually
5 be in existence yet and what we know to be the workforce
6 pressures in all disciplines.
7
8 Q. But also clinicians being engaged with their
9 professional peers as best they can in their locality is
10 important for attracting and retaining them in your
11 district, would you agree?
12 A. Yes.
13
14 Q. And do you see this work as being one of the means
15 that may be deployed to address some of the workforce
16 challenges that we will come to in due course?
17 A. Yes.
18
19 Q. Can I take you --
20
21 THE COMMISSIONER: Q. Can I just ask, paragraph 21 of
22 your statement --
23
24 MR GLOVER: That's where I'm going.
25
26 THE COMMISSIONER: Q. -- where you are talking about
27 population and demographic changes.
28 A. Yes.
29
30 Q. And internal migration, and Bathurst, Dubbo, Mudgee
31 and Orange growing. Tell me if you don't know. Are
32 Bathurst, Dubbo, Mudgee and Orange growing through this
33 internal migration, or are people also coming from outside
34 the LHD?
35 A. Well, it would be a combination of both, is probably
36 where I should --
37
38 Q. When you say it would be, is that an assumption or is
39 that known from data?
40 A. It would be an assumption of mine.
41
42 Q. Then, in paragraph 23, you talk about - you say the
43 existing funding models do not adequately acknowledge the
44 fixed cost of services for some of the EDs, and you talk
45 about the 38 EDs that the LHD runs across the region. We
46 were told yesterday that you have got seven EDs that have
47 less than 1,000 presentations a year. Did you hear that,

1 or you know that?
2 A. Yes.
3
4 Q. And of those thousand presentations a year, certainly
5 the impression, and I think the evidence was, most of them
6 are in triage category 5 or 4. You are aware of that?
7 A. Yes, yes.
8
9 Q. And we were told, by contrast, there are EDs with
10 something like 45,000 presentations a year.
11 A. Yes.
12
13 Q. And I assume - I don't think it was in evidence but
14 I assume that those hospitals that are having 45,000
15 presentations a year are the larger hospitals like Dubbo,
16 Orange, Bathurst; would that be right?
17 A. Yes, that's correct.
18
19 Q. I assume you have got solid data on all 38 EDs about
20 how many presentations there are per year?
21 A. Yes.
22
23 Q. And the triage levels of the patients that are
24 presenting themselves to the EDs; correct?
25 A. Yes.
26
27 Q. With the seven with less than 1,000 per year - and I'm
28 not sure whether it goes beyond this - do you know if there
29 have been any representations by the LHD to the ministry
30 that perhaps some of these EDs should be closed?
31 A. Not in recent time, no.
32
33 Q. What does that mean, that in the past --
34 A. In my time in the organisation, there are examples of
35 this in our district. So two small facilities that operate
36 purely as multi-purpose health services would have
37 previously, and this is prior to my time joining the
38 organisation, would have operated an ED, and possibly acute
39 beds. However, they no longer - people can still go to
40 those facilities, obviously, but you would not be triaged,
41 you would be rediverted to another service. So it has
42 been, done but not in my tenure with the organisation.
43
44 Q. You see in the last sentence of paragraph 23 you have
45 said:
46
47 *Funding models do not acknowledge this*

1 *increased fixed cost ...*
2
3 I take it that's because it's based on activity?
4 A. Well, yes and no. So the small hospital funding
5 model, it still features on activity but there's been -
6 from a national level, there was a framework developed that
7 still considers what might be a broad activity component
8 and therefore what they would expect a fixed cost baseline
9 to be. That hasn't kept up with the changes in the
10 workforce space. That model would have been established,
11 you know - well, obviously it's national, so multiple
12 different medical remuneration arrangements exist across
13 the country, but certainly in New South Wales, we would
14 have had a fee for service basis. That would have been
15 reflective of the activity that is part of that small
16 hospital funding model.
17
18 As that has evolved where we have now either locums in
19 place or what might be alternative remuneration
20 arrangements in place to access our acute medical input,
21 that hasn't kept up with the model, in my view.
22
23 Q. Is it your opinion, or is it the opinion of, to your
24 knowledge, others in the LHD, that rather than having to
25 keep open EDs that see less than 1,000 presentations a year
26 at triage level 4 and 5, that money would be better spent
27 either not having those EDs or offering a different
28 service?
29 A. Definitely. I would definitely agree with that.
30 I think as soon as you have the ED, signage, whatever,
31 ambulances can arrive, you need to have triage trained
32 nurses, which we do struggle to retain and, therefore, you
33 are accessing agency at an extreme rate - so the list goes
34 on. So I would definitely agree that that particular
35 funding for any community could be rediverted to what is
36 more appropriate for that community, and it wouldn't mean
37 that people couldn't access that next level of care, they
38 would just be clearer pathways for them to do that.
39
40 Q. Do I take from that answer, if the community could be
41 brought along --
42 A. Mmm.
43
44 Q. -- which obviously involves proper communications as
45 to what might be the best use of funds to provide medical
46 services that are needed, and if there wasn't political
47 pressure, there might be a different design about how

1 things are done in relation to the 38 EDs?
2 A. I think so.
3
4 Q. Is that right?
5 A. I personally think that most communities want access
6 to a health service. I don't think they would necessarily
7 understand the confusion that sometimes exists when we
8 start to get into definitions about what these services
9 are. We hear it very often, a lot of community would
10 expect us to also have that doctor in town to be the GP.
11 That's not our role. You have heard that this week and I'm
12 aware from others. The community don't think like that.
13 They just want to access healthcare services and be
14 supported as they navigate through the different layers.
15
16 So I personally think the conversation with community
17 could be quite open as we take that forward, when we're not
18 looking to completely exit, which is some of the concern.
19 This is about alternative investment in community, not
20 disinvestment.
21
22 Q. This is about EDs that are in hospitals or
23 infrastructure that are providing other services as well;
24 correct?
25 A. Yes.
26
27 THE COMMISSIONER: Thanks.
28
29 MR GLOVER: Q. Mr Carey, if we stay at around
30 paragraph 21, there are a few other things I want to ask
31 you, and I will try and do this without covering the same
32 ground?
33 A. Sure.
34
35 Q. In paragraph 22, building from the challenge you
36 describe in paragraph 21 about the changes in the
37 demographics, you describe there being a challenge to
38 matching the funding streams to those services. About
39 halfway down paragraph 22 you say that:
40
41 *Drivers of the current funding model are*
42 *population and demand weighted, and in*
43 *theory are appropriate, however, the*
44 *existing funding model ...*
45
46 And then you set out two particular issues in (a) and (b).
47 Can you just tell us in practical terms what those

1 challenges mean for the district in attempting to not only
2 plan for the delivery of services but fund those services
3 where they are needed?
4 A. Sure. So the comment I made earlier today and in the
5 submission around that internal migration, that is accurate
6 where we can see populations shrinking and others growing
7 within our footprint. However, like we just discussed,
8 maintaining that ED and other services at that hospital
9 level in small community, fixed cost remains, so you can
10 come back to 1,000 a year, 200 a year, that cost will
11 remain.
12
13 And the current funding model considers district-wide
14 boundary, population increase. For us, that isn't material
15 when you compare it to a metro. So, you know, 2,
16 3 per cent on average in a given year, which is what the
17 funding model would reflect across the region, is not the
18 same as 6 or 7 per cent that might be being experienced in
19 Dubbo or Orange or Bathurst, and therefore creating that
20 demand on services.
21
22 A district like ours also under that same funding
23 arrangement operates with a small funding hospital and
24 the true ABF funding arrangements, where you are matching
25 activity, therefore funding, to demand. That's very
26 difficult for that to continue to coexist in my mind,
27 because there is suggestion that the small hospital funding
28 model has the variable nature to it. That doesn't happen
29 in practice, because you have very much got a fixed cost.
30 There is very little cost that will be reduced by that
31 population movement into a larger centre. Equally, the
32 expansion of an ED to cope, such as Dubbo, far outweighs
33 what you would actually extract from a variable cost from
34 a small facility.
35
36 So it is significant impact from a funding point of
37 view, because where we need to invest in services - ie, the
38 large base hospitals across the district - we don't have
39 the funding to support that.
40
41 Q. I take it that the challenge is also that you are not
42 necessarily able to redeploy the funding that you do have
43 because of the need to maintain and fund the fixed costs in
44 those other services across the district?
45 A. That's exactly right.
46
47 Q. Aside from realigning services in the manner that you

1 have discussed with the Commissioner this morning, do you
2 have any views as to how those challenges might be
3 overcome?
4 A. I do think it is quite an open conversation with
5 community about what we are wanting to provide. You know,
6 there is an example in here and you have heard a lot of it
7 previously, the Four Ts is an example of where we have
8 engaged well with community and obviously stepped into an
9 area of service that we wouldn't have previously, but it's
10 been to the benefit of that particular community to have
11 access to the right care that they require. But, equally,
12 that's shared amongst multiple communities, so the GP that
13 we employ is not in every community every day. That's
14 structured across those four communities.
15
16 Q. That requires planning and engagement from service
17 providers in the community in addition to the LHD; correct?
18 A. Yes. So there was a huge amount of consultation,
19 community input through that whole process. I wasn't in
20 the role when that particular decision and service was
21 created, but it was well considered, it had a lot of
22 community input, obviously support of ministry, other
23 layers of government.
24
25 Q. That's an example of the LHD stepping into a space
26 that it otherwise wouldn't have to provide a service that
27 wasn't available; correct?
28 A. Yes.
29
30 Q. And that's to the benefit of the community; you agree?
31 A. Yes.
32
33 Q. And, also, it has positive benefits for the
34 maintenance of the health of the community at large;
35 correct?
36 A. Yes.
37
38 Q. And, in time, do you perceive that projects like that
39 will also assist in meeting some of the challenges that the
40 LHD faces in ensuring that the demand for its acute
41 services is not if not overwhelmed, at least strained or
42 stretched by the lack of primary care in the community?
43 A. Yes.
44
45 Q. So that's another example of the way service delivery
46 can be tailored to meet the funding challenges. Is there
47 any changes to the funding model or approach that you

1 perceive would also assist?
2 A. I think that if there was greater acknowledgment
3 within the system that there are alternative funding
4 sources and that those avenues are a little easier to
5 navigate. So the Four Ts, we have 19(2) exemption in that
6 particular community. The process to obtain 19(2)
7 exemptions is quite significant. There was supportive
8 sponsorship for that to go through as a holistic group,
9 because of the Commonwealth engagement and other government
10 input at the time. We have had multiple 19(2) exemptions
11 granted across the district. However, it's done on an
12 individual community basis where you are going through
13 every single process at the same time. So I'm not
14 suggesting that you wouldn't need to engage locally.
15 However, when you have got PHN, it might be multiple groups
16 that are actually managed by the same organisation, so if
17 we think in our north west, where we do have a more
18 corporate medical practice structure in place, where they
19 manage the different practices, why can't we engage on
20 a regional basis where we know that the same factors are
21 influencing the issues in those particular communities to
22 either obtain that 19(2) exemption - it would be much more
23 efficient to look at it on a regional basis where you have
24 common factors across all - to have access to that
25 particular funding. That's one way I think that would make
26 that a lot easier, because right now, we would have to do
27 it 35 times in order to obtain that exemption if it was
28 appropriate.
29
30 Q. Your district has taken a number of steps into what
31 might be considered the primary care space; correct?
32 A. Yes.
33
34 Q. Four Ts is one. The virtual service is another?
35 A. Yes.
36
37 Q. And the district has also engaged a provider to
38 operate primary care clinics in certain parts of the
39 district; is that right - Ochre Health, I think?
40 A. We haven't engaged them to provide general practice;
41 we have engaged them to provide the acute medical input.
42 So we engaged them to provide the acute medical input, so
43 they would come through our ED for appropriate medical
44 intervention as required, or service our acute beds. And
45 also they would provide support to our RAC beds. That's
46 the contract. Essentially, though - and that's at a higher
47 rate than you would have previously paid a fee for service

1 GP VMO in those communities.
2
3 Q. But there isn't one in those communities?
4 A. That's right. There was none. We have, therefore,
5 contracted - what happens as a by-product of that contract
6 is that particular organisation set up general practice so
7 they are independent running those general practices that
8 obviously complements our services, but we're then
9 purchasing those acute medical services.
10
11 Q. I take it the point you are making is that the
12 district has done that because it sees a need to step into
13 that space; correct?
14 A. Yes, otherwise there would not have been any service.
15
16 Q. And the current funding models do not necessarily
17 recognise that the district is doing so or --
18 A. Not at all. That's a significant multi-year contract
19 that we went to market for through a strong procurement
20 process. However, there was no funding granted to support
21 any increase in that cost of service.
22
23 Q. And would you agree that going into the future, it's
24 likely that the district would need to do more of this type
25 of work - that is, stepping in to what might be
26 traditionally considered the primary care space due to what
27 you have described as the failure of that market?
28 A. Yes, I do.
29
30 Q. And in addition to 19(2) exemptions, is there anything
31 in particular that you would like to see changed about the
32 funding model to support the district to do so?
33 A. I think - so 19(2) is an obvious path, if we are truly
34 stepping into that primary care space. That's the nature
35 of the Medicare funding. You also heard yesterday that
36 there is unaccessed Medicare funding across the footprint.
37 And the question I sometimes ask myself is that, you know,
38 we have activity based funding, of which the Commonwealth
39 contribute a percentage of, and then we have Medicare
40 funding, ultimately still two both Commonwealth funding
41 streams. Whether we do need to completely jump into
42 whether it's Medicare pays or the activity based funding is
43 a question for me because ultimately Commonwealth are
44 paying at some point for both and whether there are other
45 ways of capturing the activity if we were to look at an
46 activity-based scenario where ultimately the Commonwealth
47 is supporting that particular service.

1
2 Now, you could argue that the state has to input into
3 that, and that is accurate, but we already are through the
4 high costs that we are establishing services to be
5 maintaining these communities. So I haven't answered your
6 question - I think the funding model needs to evolve to
7 support that and I personally think that we need to make it
8 less complicated rather than more, and wanting to continue
9 to look for alternative funding sources, when in fact, we
10 just need to be clear about what services we are going to
11 provide in these towns, what is the demand, and how do we
12 create some of the structures in order for that to happen
13 when we've got multiple opportunities, activity based
14 funding or the like. I am not convinced that 19(2) is the
15 sole solution.
16
17 THE COMMISSIONER: Q. Can I just ask you something so
18 that I make sure I understand what you meant when you were
19 talking earlier about the LHD having multiple 19(2)
20 exemptions across the district, then you said:
21
22 *... it's done on an individual community*
23 *basis where you are going through every*
24 *single process at the same time. So I'm*
25 *not suggesting that you wouldn't need to*
26 *engage locally. However, when you have got*
27 *PHN, it might be multiple groups that are*
28 *actually managed by the same organisation.*
29
30 What did you mean by "multiple groups that might be managed
31 by the same organisation"?
32 A. Sure, what I was referring to there is in our north
33 west, where we do have a partner that is running all of
34 those practices, to engage once rather than multiple times.
35 Does that make more sense?
36
37 Q. Can I also ask you, just on the Four Ts project, in 28
38 of your statement you said:
39
40 *The model has recently been reviewed by the*
41 *Sax Institute.*
42
43 I assume that was a review in writing?
44 A. Yes.
45
46 THE COMMISSIONER: Is that in the material?
47

1 MR GLOVER: You will be receiving it shortly.
2
3 THE COMMISSIONER: Q. Can I just ask you what you mean
4 by the next two sentences, it is clear enough, the next
5 sentence:
6
7 *The review found that the project had*
8 *a generally positive impact on patient care*
9 *outcomes.*
10
11 That's obviously your summation based on what the review
12 said. Then, the next sentence:
13
14 *However, it may not be economically viable*
15 *to expand this project across the whole*
16 *of ...*
17
18 the LHD. Is that based on something in the review, or is
19 that an opinion based on something else?
20 A. It was part of the review in the sense that the review
21 highlighted the loss that the organisation is making on
22 that particular service. And I think you heard that in
23 previous evidence. We are making a loss. So the state --
24
25 Q. So if you multiplied that loss multiple times, that's
26 what you mean by it may not be viable if we expanded this
27 much further?
28 A. Yes, that's correct.
29
30 MR GLOVER: Q. Mr Carey, in paragraph 23 you make the
31 observation that the visiting medical officer arrangements
32 are now somewhat limited. This is perhaps related to some
33 of the ground we've covered earlier today, but do I take it
34 from that observation in that paragraph that the
35 traditional model of the local GP providing services into
36 the MPS is not something that is sustainable going forward
37 in your view?
38 A. Yes. Where we have reducing general practice in town
39 and the current remuneration arrangements, I think, more
40 GPs are electing not to provide that acute medical service
41 to our hospitals, and I imagine that's partly financially
42 based, if they are only able to attract a fee for service
43 arrangement but, equally, the demand, when they are running
44 quite busy practices or they're looking themselves to
45 possibly move out of those practices - that's an issue. So
46 I don't necessarily see that improving in the short term.
47

1 Q. And that leads, as you have observed, to either the
2 district using locums for those services; correct?
3 A. Yes.
4
5 Q. Other innovative models like the virtual service?
6 A. The virtual general - the vRGS, we call it, the
7 Virtual Rural Generalist Service, it is a very successful
8 model, we have high calibre clinicians participating in
9 that model. I think what has been attractive, though, is
10 that it is something that people don't have to live
11 necessarily in a community that may not benefit them or
12 their family, we have multiple clinicians who participate
13 in a service outside of our region. There are quite
14 structured arrangements for them to, however, have
15 a presence in the district, so 25 per cent of their
16 contracted arrangements is to have some physical input into
17 our services, which is important to have that connection to
18 our region and services, but on the whole, the service has
19 been quite successful and it means we now have acute
20 intervention consistent across the organisation.
21
22 Q. The district has retained those generalists to provide
23 that service virtually?
24 A. Yes.
25
26 Q. Has consideration been given to retaining generalists
27 to provide that service in the community as well?
28 A. Not necessarily. We have certainly spoken about the
29 Four Ts and whether that should be expanded, but we haven't
30 taken any formal steps to progress any of that.
31
32 Q. In paragraph 25 you observe there's concern for
33 ongoing funding sustainability of the vRGS service. What's
34 that concern?
35 A. So the reason that we stood up vRGS was at a time -
36 and this was pre the pandemic - where we were seeing
37 escalating locum costs across the organisation, very much
38 in our small rural services, and the idea at the time was
39 to, you know - when I say that, we may have been employing
40 a locum for the thousand presentations in particular
41 services over the course of a year, so there could be weeks
42 where they may have done or seen not a lot of activity at
43 all but at a high price, so the vRGS service was introduced
44 to be a more efficient response to some of that, but the
45 point I'm trying to make there is that we already had
46 a high-cost service in locum, the vRGS service is still
47 a more expensive service than the former fee for service

1 arrangements that we would have otherwise had in place, and
2 we weren't funded for that. That would have been at
3 a point in time a driver of the forecast variance for the
4 district at that point in time. So yes, we've got now
5 a more sustainable service, but it is a more expensive
6 service than what our foundational funding would have
7 otherwise supported.
8
9 Q. The foundational funding being what would have been
10 fee for service VMO?
11 A. Yes, that's right.
12
13 Q. Which is something I think that you have agreed with
14 me earlier is not sustainable going forward?
15 A. Yes, that's right. And in addition to this, where
16 we - if you had a GP VMO, when they were coming in to
17 support our RAC patients, they would have billed those
18 services through to Medicare, because essentially they are
19 private patients in their own home, it's just that they
20 live in an MPS. Under this model, because we're a local
21 health district, and it's virtual, we are unable to access
22 Medicare for that type of service. So you are effectively
23 paying for that aged care service in the public health
24 service. Does that make sense? So that's a double hit, in
25 my mind.
26
27 Q. It's been suggested in earlier evidence this week that
28 some of these challenges that derive from the fragmentation
29 of funding between Commonwealth and state could be
30 significantly alleviated if there was a single point of
31 responsibility for the delivery of what I will describe as
32 primary care using pooled funds. Do you have a view about
33 that?
34 A. Look, I think that would certainly make it easier.
35 The nature of the pooled funds would just be the question
36 I have in that space, so exactly what does that --
37
38 Q. As a concept though?
39 A. As a concept, yes, I think it's something we should
40 consider.
41
42 Q. Can I just ask you briefly about the issue of
43 workforce you raise in paragraph 30 and, in particular, the
44 opportunity you describe in the last sentence.
45 A. For the medical --
46
47 Q. Yes.

1 A. So I think you heard with Professor Arnold, the
2 question was certainly asked of Professor Arnold whether we
3 could reconsider some of our medical training programs for
4 rotations into our smaller sites. I believe his answer was
5 yes, we could, but there was a number of steps that we need
6 to take in order to achieve that. I do think that's some
7 of the solution. That won't be the solution everywhere but
8 where there may be close proximity for our services to
9 operate in that manner, you may well then have a more
10 consistent pipeline and --
11
12 Q. When you say "close proximity", are you referring to
13 smaller services --
14 A. Around a larger centre where we have traditionally had
15 those training programs.
16
17 Q. Could I take you back to paragraph 10.
18 A. Yes.
19
20 Q. In paragraphs 10 to 13 you tell us about the mobile CT
21 service.
22 A. Yes.
23
24 Q. In paragraph 11 you refer to some of the benefits that
25 have been produced by that service.
26 A. Yes.
27
28 Q. Are the matters you set out there taken from some form
29 of evaluation that was done by the district?
30 A. We are taking the steps for a more formal evaluation
31 process. Some of these stats were provided from the
32 director that is responsible for that service, just taking
33 stock of the service now being in operation for I think it
34 would be about 12 months. So --
35
36 THE COMMISSIONER: Q. That's what you are referring to
37 in 12, isn't it? Paragraph 12?
38
39 MR GLOVER: Q. The more formal evaluation?
40 A. Yes, yes.
41
42 THE COMMISSIONER: Q. Who is conducting that, is that
43 internal or --
44 A. We likely will have some external input. We haven't
45 made a choice on who that partner will be. They're just
46 firming up the framework.
47

1 Q. But the savings referred to at 11(a), (b) and (c) and
2 (d) are internal work?
3 A. Yes.
4
5 MR GLOVER: Q. In paragraph 13 you tell us that the
6 ongoing operating expenses are not easily considered as
7 part of the current funding models.
8 A. Yes.
9
10 Q. Do you see that?
11 A. Yes.
12
13 Q. What's the particular issue that you are drawing
14 attention to there?
15 A. So at the time when we were progressed - so this
16 business case was supported with capital funding from
17 government to create the service. However, there was
18 obviously an operating cost associated with that, one, the
19 running of the truck but also the employment of the staff
20 and other consumables associated with the service, annual
21 maintenance to the equipment. That isn't supported in the
22 current funding model.
23
24 Q. Ongoing funding?
25 A. Yes, because it's essentially a block service in some
26 respects, because you are looking to stand up a service and
27 there's no clear mechanism to attract block funding for
28 a service such as this. There is a Medicare funding
29 source. That, however, does not cover the cost of running
30 that particular service. So similar to the Ts, where we're
31 making a loss, we are making a loss on this service as
32 well.
33
34 Q. If I can just break this up, the service was designed,
35 a case was put to ministry to support its establishment;
36 correct?
37 A. Well, the capital funding, yes.
38
39 Q. Some capital funding was received to purchase the
40 equipment and get the service up and going; correct?
41 A. Yes.
42
43 Q. But no funding for the ongoing delivery of the service
44 is provided to the district; is that right?
45 A. Not on the specific basis, no. So, you know, argument
46 could be that the district's funded, full stop, but for
47 this particular service, there is no discrete funding and

1 it is difficult, when it's got that mix of a private
2 revenue source, ie being Medicare, that it is assumed that
3 that will be the funding. It doesn't cover the cost.
4
5 Q. Do I take it that you see this as a particularly - an
6 innovative solution to the challenges of the vast geography
7 of your district?
8 A. Yes.
9
10 Q. And do we take if from the answers you have given that
11 you see considerable benefit in there being discrete
12 funding sources for initiatives of this kind?
13 A. Yes. Whether there is funding or some consideration
14 of these types of innovation how they fit into the current
15 funding model. So if we elect to have more of a block
16 component, then there should be avenues for us to explore
17 that, and you could argue that should be happening at the
18 time of the business case for the capital, that you
19 actually equally explore the ongoing operating costs of
20 that particular service.
21
22 Q. That's a fairly strong argument, isn't it?
23 A. Yes.
24
25 Q. And I take it that, given the constraints on the
26 budget envelope that Mr Spittal told us about yesterday,
27 there is not a lot of head room to develop and fund
28 innovative projects like this?
29 A. No, and this particular project, albeit it has been in
30 place for 12 months, it was a very long process, so I've
31 been with the organisation over 10 years, this was one of
32 the first cases that I recall us submitting and that's how
33 long it took to get through the system. You know, it's
34 complex to create what we have with the equipment on the
35 back of this truck. However, it just - innovation doesn't
36 naturally funnel through the system, I suppose, at times.
37
38 Q. Sorry, say that last --
39 A. Innovation doesn't naturally funnel through the
40 system.
41
42 Q. Why do you say that?
43 A. I think because we have a very structured funding
44 arrangement that needs to fit in the box - so we have
45 activity based funding. Activity equals NWAU equals price,
46 does that make sense? Outside of that, there is
47 acknowledgment of this small hospital funding, but it's

1 really just an off to the side. If it is not then
2 a program sponsored by government, so a policy decision
3 with discrete funding, there isn't a lot opportunity in the
4 system for an option like this, in my view.
5
6 Q. A lack of flexibility, that's what you are describing?
7 A. Yes.
8
9 Q. Aside from the difficulties faced with the mobile CT
10 service, has that lack of flexibility at least delayed the
11 implementation of innovative approaches or models of care
12 in your experience?
13 A. No, that's not entirely fair with this particular
14 example. I think that the nature of being clear on what
15 the capital cost was going to be and then aligning that up
16 to government priorities for capital commitments was part
17 of the issue.
18
19 Q. Sorry, perhaps I wasn't clear. Leaving aside the
20 issues that you describe with ongoing funding about the
21 mobile CT service, the lack of flexibility in the funding
22 model to support or encourage the development and
23 implementation of innovative approaches - have you seen
24 that in your own experience within the district?
25 A. We do it a lot, and I think there is evidence of that.
26 I think when there may have been a little more head room in
27 the system, we were able to take a few more of those
28 opportunities. Now we can't. And that is quite
29 restrictive. And most of those innovations, while we
30 supported, were largely supported internally and therefore
31 are compounding the current financial situation, if that
32 makes sense.
33
34 So when you have now got costs increases in particular
35 clinical disciplines, that is now driving the financial
36 results. However, where we may have been making these
37 losses previously and could absorb, that's now quite
38 exposed. I hope that makes sense.
39
40 Q. Yes. Can I ask you to go now to paragraph 18. In
41 paragraphs 18 and 19 you tell us about the virtual ADHD
42 service. Do you see that?
43 A. Yes.
44
45 Q. I just want to ask you about the arrangement that's
46 been reached with the Sydney Children's Hospitals Network.
47 You tell us that there's been some difficulty in recruiting

1 a paediatrician and clinical psychologists to that service;
2 correct?
3 A. Yes.
4
5 Q. The way that that has been resolved is to enter into
6 a partnership with the children's network?
7 A. Yes.
8
9 Q. How did that partnership come about, firstly?
10 A. This was one of the first tasks that I established
11 when I took on the role. So the service had been supported
12 with program funding, and albeit pilot funding from the
13 ministry. My understanding is the team had gone out to
14 attempt to recruit multiple times for the specialist
15 paediatrician, which is part time, and the clinical
16 psychologist, both temporary, because the nature of the
17 funding is temporary and advertisements went out for
18 temporary. This skill set is quite limited in our region.
19 So I made a call to my counterpart at Sydney Children's and
20 there was a lot of interest in this particular project and
21 they have supported us with the recruitment of those two
22 clinical roles that sit within Sydney Children's and now
23 form part of our model. It's quite successful, in my mind,
24 and I think they - we wouldn't be operating this service
25 right now if we weren't able to access their support to
26 recruit those temporary services.
27
28 Q. That's the benefit of a network type arrangement?
29 A. Yes.
30
31 Q. And how does the funding for that project operate in
32 particular in relation to those two positions that have
33 been provided by the children's network?
34 A. Sure. So there is program money over three years
35 provided to the district. It would have - the build-up of
36 that would have been based on individual positions, so
37 part-time cost of a paediatrician, clinical psychologist
38 and other roles. We basically then are invoiced by Sydney
39 Children's through health arrangements to cover the cost of
40 those salaries and wages.
41
42 Q. In the last sentence of that paragraph you tell us
43 that the ongoing funding to support the project is of
44 a concern. Do you see that?
45 A. Yes.
46
47 Q. Is that because, at the moment, it's pilot funding

1 only?
2 A. Yes.
3
4 Q. And there is no commitment one way or the other as to
5 whether it will be funded on an ongoing basis after that
6 funding expires?
7 A. Yes. So right now, we understand that at the
8 three-year mark, that funding would otherwise disappear.
9 It could be renewed, it could be supported if evidence is
10 appropriate. But I've seen too many examples where those
11 types of funding aren't retained, they might go on to a new
12 priority, which I do understand that. The nature of this
13 particular service, the reason I call it out, though, is
14 that without that funding, our avenue to support its
15 longevity would be Medicare, because some of this would be
16 Medicare eligible. That will not cover the cost of this
17 service. You're talking about highly specialised
18 clinicians. But it's the right type of service for this
19 district.
20
21 I expect to see really strong outcomes as a result of
22 this, and having families access for support of their
23 children that we know is a wait list pressure across this
24 organisation, and so it's the right service, but we will be
25 challenged in the three-year mark about how we, ongoing,
26 support. It is just another example, like the Ts, others
27 that I've given you, that we are making a loss on these
28 services if we want to continue them.
29
30 Q. In that answer you referred to having seen things on
31 a number of occasions. Just so at least I'm clear, is what
32 you are describing that pilot programs are funded for the
33 initial phase, stood up, and then there is no discrete
34 funding on an ongoing basis for those projects but, rather,
35 it needs to be absorbed within the existing funding network
36 of the LHD if it is to continue?
37 A. Yes. And I think, on some level, if there was a clean
38 activity capture for this type of service - there will be
39 activity, but it is outpatient by nature, so it won't be
40 overly complex in terms of its weighting to fit in the
41 activity based funding scenario, therefore, it won't even
42 feature as a material increase on any growth, if that makes
43 sense.
44
45 So I think all well mannered these particular pilot
46 programs are great, but there is no natural connection for
47 them into ABF, which would be how it would be considered to

1 work. You might have some seed funding, you establish the
2 service, the activity would then just be rolled into your
3 normal way of doing business. These types of services
4 won't achieve that. So there needs to be some
5 consideration for that. I think when we're also putting
6 fund pilot funding down, actually, what's the longer-term
7 funding option for this.
8
9 Q. Would you agree also an assessment of what's the
10 capacity of the district to absorb this within its existing
11 budget envelope?
12 A. Yes.
13
14 Q. Finally, Mr Carey, can I just ask you some questions
15 about what you describe under the heading of
16 "Opportunities" in paragraphs 31 and 32. The Commissioner
17 has touched on some of this so, I will try not to repeat
18 it, but in the middle of paragraph 31, you refer to - you
19 say that whilst the MPS model works:
20
21 *... it may be more efficient for the mix of*
22 *services provided to be less focused on*
23 *emergency and acute care and more directed*
24 *towards aged and primary care.*
25
26 Do you see that?
27 A. Yes.
28
29 Q. The Commissioner has covered with you perhaps some
30 opportunities to realign some of those services away from
31 emergency departments. I want to explore with you
32 directing the MPS model into primary care. What do you see
33 as the particular opportunity in that space?
34 A. So I think, similar to what we did speak about
35 earlier, that most - where we have a multi-purpose health
36 service model, it will be in those very small communities
37 and the nature of the model was to always have that focus
38 on integration. We largely do that, and in some cases, you
39 know, we would have collocation with general practice,
40 I think you have heard that in previous evidence. So
41 that's probably where I'm going.
42
43 I think if, though, there was some consideration, if
44 the district were to explore more examples like the Ts,
45 where we're running general practices in these communities,
46 ensuring that it is connected to this multi-purpose model,
47 I think, is important, so that you will continue that

1 integration of all types of service that are appropriate
2 for a community. It just so happens that we have
3 continued, in most examples, to have that ED access - what
4 we spoke about earlier, that could be more of
5 a community-based primary model, but you are essentially
6 using the asset that you have available and the staff in
7 the more appropriate health service model.
8
9 Q. And the approach that you have described in that
10 answer would go some way to addressing the fact of the
11 existing or perhaps historical GP VMO model becoming less
12 and less sustainable going forward?
13 A. Yes. The other point that I was making in this
14 particular example when we talk about funding, however, is
15 that the district receives a grant from the Commonwealth
16 for the residential aged care places, so that's the beds
17 and, in some sense, a community package. They are quite
18 static. So in the instance that we were at a 20 or
19 30 per cent occupancy rate, I guess the district wins in a
20 sense that you've got a revenue stream that's fixed. Most
21 of our services are at 100 per cent capacity and we have
22 demand.
23
24 The thought is that that grant covers the cost of
25 delivering those aged care beds. The integrated nature of
26 the service is always difficult for us to truly highlight
27 their costs associated with that, but we have done some
28 work to look at that over different times, and what that
29 has highlighted is that the grant does not cover the cost
30 of the aged care component of activity across that
31 particular service. That is --
32
33 Q. Has that been raised with the ministry, that issue?
34 A. Yes.
35
36 Q. Are you aware of whether the ministry has raised it
37 with its Commonwealth counterparts?
38 A. I'm not aware if they have, but it certainly has been
39 raised and it is connected to the small hospital model and
40 there is work being done to reconsider that model, but
41 I think it's important that we do really highlight this
42 particular aspect, when we do have a funding source from
43 the Commonwealth connected to this, the small hospital
44 funding model, but where it's clear that that is not
45 covering the cost of that particular service.
46
47 THE COMMISSIONER: Q. If we boil everything down to its

1 core, your LHD doesn't seem to me to be suggesting to me
2 there should be some radical change as to how costing or
3 funding of acute services should be done for your large
4 public hospitals; correct?
5 A. Yes.
6
7 Q. The great issue you face is, as you have said in 24,
8 which seems absolutely clear on the evidence, that in many
9 locations within your LHD, primary care is either failing
10 or non-existent, as you say; correct?
11 A. Yes.
12
13 Q. And the difficulty with that is that the Commonwealth
14 provides the funding stream but not the service; correct?
15 A. Yes.
16
17 Q. And the funding stream assumes that there is a market;
18 correct?
19 A. Yes.
20
21 Q. And if the market is not there, neither is the funding
22 stream; correct?
23 A. Yes.
24
25 Q. But there has to be primary care, a system, wherever
26 people live; correct?
27 A. Yes.
28
29 Q. Otherwise, the health outcomes will fall off a cliff?
30 A. Yes.
31
32 Q. Or be nowhere near as good as they should be.
33 A. Exactly.
34
35 Q. Correct?
36 A. Yes.
37
38 Q. And so the problem that needs to be addressed is how
39 we ensure that in places where primary care is failing, it
40 is funded somehow, and the workforce issues are overcome,
41 so that people at a minimum can at least obtain good
42 primary care and perhaps also aged care --
43 A. Yes.
44
45 Q. -- and all the ancillary things that that involves;
46 correct?
47 A. Yes.

1
2 MR GLOVER: Q. If steps like that aren't taken, the
3 burden on the acute facilities run by NSW Health will only
4 ever continue to ever grow; correct?
5 A. Yes.
6
7 Q. Perhaps overwhelming the system in the not too distant
8 future; would you agree?
9 A. Yes.
10
11 Q. Finally, Mr Carey, in paragraph 32 you direct us or
12 draw attention to the service agreement having a key metric
13 associated with overall budget variance. Do I understand
14 that the issue you are raising in that paragraph to be,
15 firstly, that key metric, in circumstances where the budget
16 envelope isn't at the moment sufficient, does not allow you
17 and your team and your wider district to implement some of
18 the innovative approaches to delivery of care that we have
19 discussed today?
20 A. That - yes, that's part of it.
21
22 Q. What's the other part?
23 A. What I was trying to explain there is we've talked so
24 much about all the multiple funding sources that exist - so
25 you've got activity based, you've got small hospital, then
26 you will have these program items. The program components
27 are quite quarantined. That might be appropriate, so you
28 are getting money for a virtual ADHD service, you should
29 put that money towards that particular service. And so
30 when they are quarantined like that, there is very little
31 movement when you are trying to balance that zero bottom
32 line. If you then step back to the small hospital funding
33 or the activity based - so activity based funding is where
34 we can get our growth. So again when you talk about
35 a service like Orange, Dubbo or Bathurst, growing evidence
36 to support the growth, you should therefore attract funding
37 from the system. And, yes, we have. But, however, the
38 inflating cost in our small sites is where we're adjusting
39 the budget to achieve a zero result, and this district has
40 done for 10 years, until now.
41
42 And that's the point I'm trying to make, is that you
43 are held to a zero, when there is know cost factors that
44 are being experienced in small sites, and this district is
45 then hamstrung to invest in the services in our larger
46 regional centres that we desperately need to just cope with
47 the demand because we're propping up this fixed cost and at

1 times probably not what the community requires - we've
2 talked about that, ED access for a small number, when it
3 might be more appropriate health service. So that's the
4 point I'm trying to make is that you are held to a zero,
5 which I do understand. However, there is zero wriggle room
6 at times for the consideration of a district like ours
7 where you have got a very rural footprint and a very fixed
8 component of cost that will escalate or deescalate,
9 whatever, versus where there is true growth, and there
10 needs to be some consideration of those two components in a
11 district like ours;
12
13 Q. Let's see if I can break that up a little. Held to
14 a zero - financial accountability is important, you would
15 agree?
16 A. Yes.
17
18 Q. But by being held to a zero in circumstances where the
19 current model doesn't take into account some of the unique
20 features of the smaller facilities that you have described
21 today and the ability of the district to meet those within
22 the district envelope, perhaps the KPI isn't necessarily
23 appropriate for a district like yours; is that the
24 proposition?
25 A. Yes. Yes.
26
27 MR GLOVER: Thank you. I have no further questions for
28 Mr Carey.
29
30 THE COMMISSIONER: Mr Cheney, do you have any questions?
31
32 MR CHENEY: No questions, Commissioner.
33
34 THE COMMISSIONER: Thank you very much, sir, for your
35 time. We're very grateful. You are excused.
36
37 THE WITNESS: Thank you.
38
39 **<THE WITNESS WITHDREW**
40
41 MR GLOVER: The next witness is Dr McClintock.
42
43 DR WATERHOUSE: Commissioner, we have Dr McClintock on the
44 stand.
45
46
47

1 **<COLIN KINGSLEY MCCLINTOCK, affirmed: [10.37am]**
2
3 **<EXAMINATION BY DR WATERHOUSE:**
4
5 DR WATERHOUSE: Q. Dr McClintock, could you please state
6 your full name?
7 A. It is Colin Kingsley McClintock.
8
9 Q. You have a copy of the outline of your evidence there,
10 I see; is that correct?
11 A. I do.
12
13 Q. Have you had a chance to review that before today?
14 A. I have.
15
16 Q. And would you say that it is true and correct in terms
17 of the content?
18 A. There are some very minor things which I will come to.
19 I would like to - I will probably break convention here,
20 and I know this was done at the start of the double
21 hearings but at a personal level I have to acknowledge that
22 we're meeting and I'm giving evidence today on Wiradjuri
23 land and I will acknowledge Elders past, present and future
24 and emerging, thank you.
25
26 In terms of minor typographical errors, paragraph 4,
27 I started work full time in Dubbo on Monday, 4 February
28 2008, not that I'm counting the days or weeks. In
29 paragraph 10, it notes my involvement in the district's
30 community engagement process. It mentions that I'm - I sit
31 on the northern sector. I'm actually on the central west
32 sector. But that is it, otherwise very comfortable with
33 how it looks and reads, thank you.
34
35 DR WATERHOUSE: Commissioner, that will form part of the
36 bulk tender in due course. We have it up on the screen but
37 for the transcript, it is [MOH.9999.1197.0001].
38
39 Q. So Dr McClintock, you are a board member and have been
40 a board member for the past seven years; is that correct?
41 A. It is. I commenced in January 2017.
42
43 Q. And you are the chair of the healthcare quality
44 complaints committee?
45 A. I am.
46
47 Q. I understand that you took on that role late last

1 year. Were you previously a member of that committee?
2 A. Yes, in terms of subcommittee involvement as a board
3 member, I have always sat as a member of the HCQC. And
4 I have not had an opportunity to dip into any of the other
5 subcommittees. I've previously, prior to my role on the
6 board, been a member of our MADAAC, but as a functioning
7 full-time clinician and a board member, I think that I am
8 exempt from attending that meeting, I think, in terms of
9 by-laws.
10
11 Q. Does MADAAC stand for the Medical and Dental
12 Appointments Advisory Committee?
13 A. It does.
14
15 Q. You are a renal physician and also I understand
16 a general physician; is that correct?
17 A. Yes. I hold dual College of Physicians accreditation,
18 dual fellowships in both renal and general and acute
19 medicine.
20
21 Q. Have you always practised in both renal and general,
22 or is one more recent than the other?
23 A. Renal medicine is my longer fellowship. My personal
24 belief in terms of practice, when dealing with a catchment
25 population such as Dubbo hospital, as a primary LGA and as
26 primary catchment and its secondary catchment, which covers
27 our rural towns, when you are faced with a population of
28 between 120 and 140,000 catchment, actually, I feel that
29 you - there is a requirement to practise predominantly in
30 your sub-specialty and what I'm really talking about is at
31 an outpatient level, but also provision of acute care, and
32 the general medicine component is I think slightly
33 different to what you might conventionally think of as
34 a true general physician, where I feel trained and
35 workplace able to provide acute general medical on call to
36 a regional referral sized hospital, but in outpatients,
37 I think that medicine has progressed for a population of
38 that size far beyond traditional models of care in general
39 medicine, and therefore I try and stick about 90 per cent
40 to my sub-specialty of renal medicine in specialist
41 outpatient care.
42
43 Now, I say 90 per cent because there is no question
44 some of what I do is general medicine and some of it is
45 incredibly complex general medicine, but into other fields
46 through necessity, and I'm happy to expand on that further
47 if necessary.

1
2 Q. That's okay at this stage, thank you. So in
3 paragraph 5 of your outline, you mention that you are the
4 director of physician education at Dubbo hospital, and that
5 this is part of the Royal Prince Alfred Hospital network,
6 and that you are involved in the annual recruitment of
7 medical registrars. Could I clarify first, is that for
8 basic physician trainees, or does it also include advanced
9 trainees?
10 A. So in terms of recruitment process, that is for the
11 Royal Prince Alfred basic physician training network, you
12 are absolutely right. We have expanded, however, over
13 time, College of Physicians accreditation at Dubbo hospital
14 in advanced training, so I do have a supervisory role in
15 two of those accreditation areas. One is advanced training
16 in general and acute medicine and the other would be
17 accreditation at advanced training level in renal medicine.
18
19 Q. But in terms of that network with the RPA, that only
20 involves BPT--
21 A. It only involves basic physician training in large
22 part, but we do - we have been a pilot site in New South
23 Wales for what we call our dual training model at advanced
24 training, so that is where we aim to train senior registrar
25 in dual fellowship, so general and acute medicine, aiming
26 to also have them accredited in a sub-specialty, and we -
27 those are stand-alone positions that we develop for
28 individuals that we have, in a sense, groomed - that's
29 a terrible word sometimes, but we have groomed through
30 previous exposure in earlier stages of their training as
31 individuals who are going to excel as potential future
32 leaders or clinical leaders in the country, so we would go
33 out of our way to try and construct a training program that
34 will suit their needs with the eventual aim that they will
35 come back into regional site and work full time, and
36 therefore, on occasion, we have networked with Royal Prince
37 Alfred Hospital in those jobs.
38
39 Q. Now, just going back to the recruitment, the annual
40 recruitment process, if we could, does Dubbo have equal
41 standing with the rest of the network in the sense that
42 a trainee could be allocated to work at Dubbo hospital or
43 Camperdown RPA or anywhere within the network, or does it
44 rely on the trainee wanting to come and work in Dubbo?
45 A. I would say a little bit of both, that individual
46 basic physician trainees will, at the start of I think
47 either each year or their contracted period - and of course

1 basic physician training is moving to three-year contracts
2 at the moment - they will nominate which terms that are
3 available within the network as their preferred choices,
4 and Dubbo might come up in that. Alice Springs is very
5 popular in the RPA network. But of course - and we're
6 talking about seven rotating registrars per term, so
7 28 across a calendar working year, and not every single
8 person will have nominated RPA - sorry, Dubbo hospital as
9 a top choice, so some people will just be told "You are
10 rotating out". That's accepted. But --
11
12 Q. Do you have ever trainees actually withdraw because
13 they either can't leave Sydney or don't wish to come out --
14 A. Very occasionally, people who have been rostered to
15 rotate out to Dubbo would undertake a second level swap
16 with someone. Usually that's for family reasons.
17
18 Q. And do you have opportunities to accommodate people
19 with families if they move out here for a term?
20 A. Yes, we do, and in fact, we have a basic physician
21 trainee currently who chose or requested - so I mentioned
22 the terms are traditionally three months - requested
23 a six-month allocation to Dubbo and that individual has
24 moved their entire family out, because their spouse is also
25 able to work from home largely, and I think that's
26 fantastic, that we are starting to see that kind of
27 commitment to rural period of work.
28
29 Q. So they will do three months in one location, one type
30 of sub-specialty, and three months in another, will they?
31 A. Yes. So we've got the ability in Dubbo to rotate them
32 through different experiences in terms of clinical
33 sub-specialty, yes.
34
35 Q. You mentioned that they are three-year contracts.
36 Could a trainee spend their entire three years in Dubbo?
37 A. No, they can't with current accreditation of basic
38 physician training. They can spend in Dubbo currently -
39 because our basic physician training accreditation is as
40 a network site and as a network site I think it's sitting
41 at six months total.
42
43 Q. So they must then rotate around?
44 A. Must rotate through, and I think that's - although I'm
45 very biased towards Dubbo and regional rural training,
46 I think at that stage of training, there are - there will
47 always be a requirement to have experience in a tertiary

1 level or quaternary level unit, even if that individual is
2 aiming towards regional future practice.
3
4 Q. Do they go to Bathurst or Orange at all, or are they
5 part of separate networks?
6 A. So Bathurst is split between the Nepean and RPA
7 network, so two basic physician trainees historically have
8 rotated from Nepean and two from Royal Prince Alfred
9 network, and Orange is entirely Westmead network.
10
11 There are some challenges around that, because of
12 course there are three regional referral hospitals that sit
13 within one local health district, and I think there would
14 be some benefits from having the linkage at training level
15 substantively with our ministry defined tertiary referral
16 site, which is Royal Prince Alfred.
17
18 Q. And what would be required to effect that sort of
19 a change?
20 A. A foundational disruption of current network training,
21 which could be done, but would require really examining
22 that closely to look at a Machiavellian level, whether the
23 end would justify the means. But that is true of many
24 parts of health care.
25
26 Q. Are there particular experiences that a trainee may be
27 able to have in Dubbo because it is perhaps a smaller
28 cohort, that they - would they have more autonomy to do
29 things, get to do different things they may not be able to
30 do at a tertiary hospital?
31 A. Yes, so what you are talking about is
32 a very-oft-mentioned and discussed part of training, that
33 there is more autonomy, more access to pathology, more
34 access to acute care and more access to procedural work,
35 under supervision, of course, and so I will - I shake my
36 head sometimes in disbelief, actually - sorry, RPA - but
37 some of our trainees that come out, the lack of exposure is
38 terrifying and the reliance on certain other services to
39 provide procedural work in our tertiary/quaternary level
40 sites.
41
42 I think we keep it real in Dubbo and we give excellent
43 training, and you will hear that, of course, from just
44 about any regional physician, and I really think for basic
45 physician trainees, their term in Dubbo is when they move
46 from a resident medical officer to becoming a registrar.
47

1 Q. We heard evidence from the chief medical officer,
2 Professor Arnold, on Wednesday, that college accreditation
3 had been withdrawn from Bathurst hospital. I appreciate
4 that's not part of your own responsibility area. Were you
5 involved at all in that, because of your role for BPTs at
6 Dubbo hospital?
7 A. Yes, I was involved with probably two time points
8 leading up to that withdrawal of accreditation because of
9 my time - so I took on the role of director of physician
10 education in Dubbo I think in June 2008, which would make
11 me a very longstanding DPE in New South Wales, and
12 I haven't seen everything, but I've seen a lot, because
13 I've supervised a lot of medical registrars now. So
14 probably that time scale led two different network
15 directors of training for the RPA network to ask if I could
16 speak to director medical services at Bathurst and the
17 sitting director of physician education to see if I could
18 perform a role in redirecting and improving.
19
20 So I guess what I'm saying was that there were
21 attempts being made to prevent a catastrophe from
22 happening, and that was the withdrawal of basic physician
23 training accreditation. I think that was a long road that
24 unfortunately came to pass in the end very rapidly, and
25 I think that - you know, I don't - because, you know,
26 I wasn't there, it's not my hospital, and perhaps a shock
27 therapy was required because it has led to very, very
28 significant positive change. I'm aware of that with the
29 reintroduction of trainees and things are now going well.
30 But it's unfortunate when these things happen and it has
31 a knock-on effect for other regional training sites, that
32 this can happen. I'd prefer, of course, that it hadn't
33 happened.
34
35 I'm not answering the question very well, I know.
36 But, yes, I did try. Look, to specifically come back and
37 answer your question, what I was met with was a strong -
38 from a now long-gone locum director of medical services at
39 Bathurst, a strong belief that all aspects of training for
40 BPTs, basic physician trainees, would be sorted out by the
41 mother ship, RPA, so that when they came to the regional
42 hospital, they were workhorses and service oriented only,
43 and that was a very unfortunate viewpoint to take, because
44 that will torpedo training in the country. It was
45 a dastardly belief, and that's what I tried to subvert,
46 because, of course, training in a regional site must
47 include education. It's not just work-placed learning; it

1 must include education support, and I think what we can do
2 really well, and I'd like to think we do excessively well
3 in Dubbo, is pastoral care and support.
4
5 Q. Was there any involvement from you, when it actually
6 was withdrawn,the accreditation, given you are on the
7 board? Was there any board engagement with this issue or
8 was this managed entirely at a management sort of level?
9 A. It was predominantly managed by the executive and
10 Professor Mark Arnold had just onboarded at the time in his
11 role as chief medical officer, so Professor Arnold was
12 substantively involved in onsite involvement, but of
13 course, I had unofficial involvement in discussions with
14 what had occurred with the then director of network - the
15 network training director at RPA and then rapidly the next
16 person that took over that role, and certainly I gave - and
17 I also gave some support directly to Dr Riton Das and
18 Dr Marco Metelo, so that's the director physician education
19 at Bathurst and the director medical services at Bathurst.
20 I had some discussion with them around what I thought could
21 be changed to rapidly bring trainees back.
22
23 Q. I want to move on to more board related matters now.
24 Can you start just by telling me a bit of an outline of the
25 professional backgrounds of the members of your board?
26 A. So we have backgrounds - starting with myself, I guess
27 I'm a clinician, a full-time clinician. We have financial
28 and accounting backgrounds in two of our members. We have
29 allied health backgrounds, two different allied health
30 members in two different areas of allied health. We have
31 a local government and remote representative. We have
32 tried to maintain a high value Aboriginal member, and that
33 person has resigned over - I don't know why, but I assume
34 too many other commitments, which is unfortunate, so that
35 position's been - of the member has been unfilled for about
36 six weeks now.
37
38 Q. Do you come from different parts of the district, or
39 are you all based in Dubbo?
40 A. Different parts, and I think that's absolutely vital.
41
42 Q. I understand that boards are appointed by the minister
43 on advice from the ministry and the board chair. Do you
44 think that that is an effective way to ensure the right
45 skill set for your board?
46 A. Well - so I guess the process is EOIs through
47 advertisement of people who would like to apply and then

1 those EOI responses are looked at and sifted. I believe
2 that the chair of the board has some input into that
3 process as well. I suspect it's not the best way of doing
4 things, and that more energy and time and resources could
5 be put into finding better representation, because I think
6 that there would be - I'm of a strong opinion that one
7 voice can't be the good for everyone, so you do require
8 broad representation. Of course, that's part of
9 governance, I think. And I believe that putting out EOI
10 adverts for this is not enough to - of a net to bring the
11 best people in to guide a board.
12
13 So I think that more resources could be done to give
14 better input for the health minister to appoint high value
15 people, and that has nothing against any sitting board
16 member at the moment. I just think the process is probably
17 not involved enough for something that's so valuable.
18 We're talking multi-billion dollar organisations, in
19 reality.
20
21 DR WATERHOUSE: Commissioner, that might be a good moment
22 to take a break.
23
24 THE COMMISSIONER: Yes, we will take a break until 20 past
25 11. We'll adjourn until then.
26
27 **SHORT ADJOURNMENT**
28
29 THE COMMISSIONER: Whenever you are ready, we can resume.
30
31 DR WATERHOUSE: Q. Just before the break, we were
32 talking about your role on the board, and I wanted to take
33 you to paragraph 7 of your outline, where you have
34 discussed about the board being responsible for effective
35 governance, both clinical and financial, and then you go on
36 to say that often the board is drawn into operational
37 matters and you give the example of an acute staffing
38 shortage resulting in service delivery failure that may be
39 picked up by the media. What role does the board play when
40 those situations arise?
41 A. I guess I could preface that by saying as a full-time
42 clinician, you might imagine that I like talking about
43 operational matters, and that annoys some of my other board
44 members who want to stick with governance. So I quite like
45 the cut and thrust of operational matters.
46
47 Where the board come into being - so a rural or MPS

1 level facility that has an acute staffing issue, what we
2 can do, and what we have done, is look at an engagement
3 process there. So an example would be last year where
4 something like that had occurred, we nominated one of the
5 board members to join the executive to get boots on the
6 ground to understand the situation and to look at ways in
7 which we could value-add, I guess, to direct, to some
8 extent, some form of performance improvement or realign the
9 staffing problem.
10
11 Now, I can't possibly say that we would find a magical
12 fix, but I think that if you have applied for and you want
13 to join a board, one would think that you are doing it for
14 the common good of community. I know that's why I did it,
15 and certainly if I thought that I could provide some sort
16 of support to executive to correct this problem, which
17 might be insurmountable in reality, but I would like to
18 have the opportunity to do that, and if I had the time
19 I would like to be those boots on the ground.
20
21 Q. And when you say that you are drawn into these issues,
22 does it mean that it takes away time that you would, as
23 a board, be wanting to spend on other matters?
24 A. Of course it does, and that's, you know, why some
25 board members would lament the time that it's taken, but
26 I think you have to discuss these things as board members,
27 because in reality when these things occur, and they maybe
28 absolutely out of your physical hands to resolve, but it
29 gives, as a simple barometer, a really good understanding
30 of the health of your organisation or the challenges you
31 face.
32
33 So I think you have to be up-front and discuss these
34 things, but it has to be balanced ultimately that, yes, you
35 don't suck away all the time and that you can move on to
36 discuss governance issues as well. So we would acknowledge
37 that, but I can think several time points we've had very
38 robust discussion around exactly this issue.
39
40 Q. Is it a particular element that the media is involved,
41 that is when it tends to become something the board needs
42 to address? Is the media the key factor --
43 A. I think media has a major role in it but not always,
44 but perhaps from the executive's point of view, the risk of
45 media involvement could be why it's being discussed. Those
46 sort of things I don't care about at all. I just care
47 about the common good, I'm afraid. Maybe I'm a rarity in

1 that.
2
3 Q. When you say you don't care at all --
4 A. About media. To me, it's irrespective of whether
5 media is involved in a system process. Media can be
6 involved, there is a right of free speech of course, but if
7 there is a problem, then it's a problem and we should deal
8 with it, irrespective of whether media are involved.
9
10 Q. Can the media's involvement sometimes cause people to
11 worry more than perhaps they need to in terms of what's
12 happening?
13 A. Of course they could, yes, sensationalism. That's the
14 value of media, journalism.
15
16 Q. The chief executive yesterday gave evidence about the
17 fact that there is a forecast deficit of $48 million for
18 the current financial year, which is a new thing that the
19 district is facing, new as in this year, and he said that
20 it was almost all because of the cost of medical locums and
21 agency staff, primarily agency nursing staff. Is premium
22 labour a focus for the board currently?
23 A. I think it's probably our biggest focus. It's
24 certainly mine. How do you think I feel in my 17th year
25 working as a clinician in this local health district, and
26 I think my voice would be similar to very many voices,
27 where I'm at a point where I think there are 100 different
28 things we can improve but I can't get anything done because
29 we're over budget, spending on high-cost workforce, and
30 I really do hesitate to use the words "high cost low
31 value", because some of those workers are excellent and
32 provide excellent care, but at the end of the day, they
33 will never be resident advocates for regional and remote
34 health care. They are coming in and doing a much needed
35 job as a contractor, and if I can't get things done or we
36 can't get things done --
37
38 THE COMMISSIONER: Q. What do you mean more fully by
39 "I can't get anything done"?
40 A. So we have - basically, there is a financial freeze on
41 everything because we're so over budget.
42
43 Q. Give me some examples, then, of what you want to get
44 done but can't get done?
45 A. Specific examples, okay, great. Where do I start? So
46 a specific example would be that - so I play the long game,
47 Commissioner. I'm planning to complete my clinical career

1 in Dubbo. I'm committed. I'm here. I'm Dubbo. I'm
2 Mr Regional, and I really want to see things improve, and
3 so a specific example would be that we have - we're trying
4 to capacity build in specialist workforce; we have
5 appointed a second full-time respiratory physician who has
6 a fellowship in sleep medicine. We, of course, have got
7 very high rates of obstructive sleep apnoea, an obesity
8 related hypoventilation, and we have an absolute
9 requirement to have a public based sleep laboratory,
10 a level 3 service, it's called. So our sleep fellowship
11 respiratory physician, supported by myself, wrote
12 a business case for a public sleep lab, which would then
13 dovetail into a fledgling respiratory failure service for
14 this region, and we got that initially approved and then,
15 of course, it's been torpedoed. So we don't basically -
16 you know, there's no service at all.
17
18 Q. Tell me why there are very high rates of obstructive
19 sleep apnoea in this LHD.
20 A. So we've heard I think yesterday from Mr Spittal, our
21 CEO, around our obesity rates are very high, so that would
22 be a direct input into high rates of obstructive sleep
23 apnoea. You know, call me an idealist, but if you are
24 going to develop - so there are very many private sleep
25 laboratories working in this area across New South Wales,
26 but if you want to deliver the care to the people that need
27 it most in regional/rural, then this should be a public
28 hospital based, state funded service that is going to be
29 delivered without an out-of-pocket expense, otherwise you
30 will not deliver that care actually to the people who
31 require it most.
32
33 Q. Now, I can guess, but I'm not a clinician - and feel
34 free to give me as much detail as you want, why there are
35 such high rates of obesity that lead to these problems in
36 your LHD?
37 A. So we're talking about social determinants of health
38 here, and therefore, I greatly believe that if we're going
39 to - that actually - you know, and this is health care
40 delivery in every case, we have two parallel challenges.
41 So we currently have in the west of the state and remote
42 areas terrible health outcomes, the worst in New South
43 Wales. So how are we going to achieve an
44 intra-generational change for the health --
45
46 Q. Perhaps that's a better question. What do you need,
47 do you think, to address and improve these high rates of

1 obesity? That might be a better question. What's needed?
2 A. So we need a refocus on, as I say, current care and
3 access to care, to achieve --
4
5 Q. What kind of care? Primary care?
6 A. It is both primary and secondary care, of course.
7 Because there are great strides that you can achieve within
8 five years in health outcomes, I would say. So
9 intra-generational, with application of current primary and
10 secondary care, but that of course must work in parallel
11 with health promotion aspects, whether that's our early
12 life projects --
13
14 Q. By "health promotion" you mean --
15 A. Public health.
16
17 Q. -- projects, initiatives that encourage people to
18 change lifestyle and personal behaviours that might be
19 causing the obesity?
20 A. Yes, because there is a great deal of medical
21 literature on small spend, hugely - huge gains, if
22 delivered effectively, and the public health physicians
23 would lament about the small amount of funding they receive
24 to achieve that because of the potential for great
25 outcomes. You know --
26
27 Q. What else is needed for the kind of radical
28 improvement you are talking about in a five-year span?
29 A. So - well, looking at another example, this week we've
30 had the Australian Cardiovascular Association, we've had
31 a workshop on Wednesday that I attended and spoke at and
32 then we had a brainstorming session on Thursday morning.
33 They are looking at accessing Commonwealth funding to try
34 and halve the rate of acute myocardial infarction using -
35 they would like to use Western New South Wales, or our
36 local health district and experience as a pilot site to
37 look at a real-time method of halving heart attack rates
38 with a five-year time scale using a robust dashboard based
39 model that is freely accessible by primary and secondary
40 care to deliver rapid access to basic preventative medical
41 strategies or lifestyle change in combination with rapid
42 access that doesn't really exist at the moment to
43 investigation, to pick up patients at an earlier stage.
44 It's pretty convincing that we can do that, but again, it
45 comes back --
46
47 Q. This is like prompts to the actual patients to --

1 A. Well, it could be anything from prompts, but there is
2 medical therapy technology that would make this achievable.
3 But it always comes back to - and I noticed this was
4 discussed widely yesterday - whose responsibility is it to
5 do this work? And maybe we just need one unified body to
6 be responsible.
7
8 Q. While we're on this topic, and so I don't interrupt
9 Dr Waterhouse more than we need to, can you also help me
10 with paragraph 21 of your statement, which is related to
11 what we were just talking about, where you tell us that -
12 I mean, it reads like a typographical error. I'm sure it's
13 not. People are approximately 200 times more likely to
14 require dialysis living in Brewarrina than in central
15 Sydney.
16 A. Yes.
17
18 Q. Why is that?
19 A. Well, Brewarrina, you know, is I think our district's
20 only Modified Monash level 7 site. It's our only LGA
21 that's classified as very remote. The Indigenous
22 population of Brewarrina I think sits at about 56 per cent.
23 The LGA is 1200 people. We run six dialysis chairs at
24 Brewarrina MPS.
25
26 Q. But what's - why is it 200 times?
27 A. So we're talking about extreme rates of diabetes and
28 hypertension. It's an area that we still see --
29
30 Q. This is diet driven?
31 A. Yes, you know, that's a simplified argument,
32 Westernised diet.
33
34 Q. You tell me in as much detail as you can.
35 A. Westernised diet, the impact of that on Indigenous
36 people, the socioeconomic problems of Brewarrina all
37 inputting into poor health outcomes and I honestly believe
38 the proudest - the thing I'm proudest about doing as
39 a clinician is that I'm 16 years and two months into
40 unbroken longitudinal chronic renal care to the Brewarrina
41 LGA, and I do not do that on my own, I have built capacity
42 locally with people to help me achieve - or try to achieve
43 the delivery of care to Brewarrina. I try and be there
44 monthly, and I'm not sure that I'm winning is the reality.
45
46 Q. Let's divorce ourselves from reality for a moment for
47 the purposes of this hypothetical, and let's assume that

1 money and workforce aren't an issue. What, in your
2 opinion, would need to be done to significantly reduce that
3 200 times?
4 A. I can answer that more broadly, that - and it's the
5 answer to everything - we need to somehow achieve
6 a dependable, longitudinal, unbroken primary care delivery
7 for our remote communities, and very remote communities,
8 and much has been spoken about in this hearing already
9 about that, and I don't have all the answers for that,
10 I might have some.
11
12 So we need unbroken primary care access, and I can
13 tell you across 16 years, I've seen so many primary care
14 practitioners come and go across that 16 years, and it's
15 almost, I can see, sinusoidal variations in how controlled
16 health is, even in my eyes, you know, when our primary care
17 clinician comes in after maybe a broken period of trying to
18 get someone else resident in Brewarrina, things have got
19 a bit rocky, they remain rocky but gradually re-find their
20 feet over one to two years, then things progress well and
21 then they leave again.
22
23 So it's all about provision of primary care. Then the
24 second part of it, and I think it comes to what I said
25 earlier regard intra-generational change to health
26 outcomes, because in reality, what I'm talking about is
27 access right now to care beyond primary, and that comes
28 into secondary care, which is I guess my expert area, and
29 how do we provide - and we come back to what has been said
30 before, demand and needs analysis for a very remote LGA.
31 What, as a developed country health system, should we be
32 expecting is available on the ground and/or within
33 a certain distance, in terms of access to, say, let's say
34 specialist services, for Brewarrina? And I would suggest,
35 and in my evidence I've spoken about hub and spoke, so I'm
36 talking about capacity building a specialist workforce in
37 Dubbo that then outreaches into these sites to deliver that
38 care, that complements itself with virtual care delivery,
39 so all of my patients in Brewarrina I will also follow up
40 via virtual care at times, but all of them I see
41 face-to-face as well.
42
43 So we need to undertake the work that looks at - and
44 it's not complicated, Mr Commissioner, it is not
45 complicated - that says "This is the care we should be
46 delivering." Then there is another tranche of care that is
47 in reality tertiary level. This care will always be more

1 or less delivered in major metro. And what is the path -
2 what is the transparent pathway that a community member can
3 have to negotiate those systems of care? And unless we
4 acknowledge what is needed and plan for it, and then plan
5 workforce and fund that workforce, we won't get anywhere
6 unless we take the responsibility to do that work. And
7 I am not --
8
9 THE COMMISSIONER: Q. Tell me if I'm wrong, but the plan
10 would be to reduce the need for that tertiary care by
11 having the adequate levels of primary care.
12 A. Yes, because if it's in Sydney, what proportion of
13 Brewarrina people do you think really access that care?
14 And so we're talking about, in this great country of ours,
15 people, and whether Indigenous or otherwise, not receiving
16 vital care at all, because it doesn't exist.
17
18 And yet this work is not complex. It is not complex
19 to do. And I don't even think that it's - you know, it's
20 not expensive work to do.
21
22 Q. By "vital care", you are not distinguishing
23 necessarily between primary, secondary, tertiary - they are
24 all vital; correct?
25 A. Yes, because we can define what should be there.
26 Basically, we're talking about services that should be
27 deliverable by our regional referral centres. So I'm
28 talking about cardiology, I'm talking about respiratory
29 medicine, I'm talking about gastroenterology, neurology,
30 renal medicine, medical oncology, haematology, but I'm also
31 talking about dermatology, I'm talking about vascular
32 surgery. We can define what a service population of
33 130,000 people, which is Dubbo's catchment, should be able
34 to access, and then we can look at how the access is
35 achievable for people in regional sites with complementary
36 virtual care processes and systems like that, and we also
37 should have service level deliverables of care into
38 tertiary, where it's never going to be acknowledged that it
39 should be resident in Dubbo, okay?
40
41 And, look, I will give you a couple of examples. The
42 first would be - and my wife is also a renal and general
43 physician. We arrived together. In my statement, I've
44 talked about that we are now 3.8 full time equivalent renal
45 medicine, and we also all do general medicine in Dubbo, and
46 within probably a five- or six-year time frame of arriving
47 in Dubbo, I believe that we started to gain control of

1 a single clinical service that was like a run-away train,
2 okay? And by "control", I mean actually delivering the
3 care that community members should be able to expect for
4 renal medicine.
5
6 So what does that mean for ministry or treasury? What
7 it means is that I believe that we reduced our renal
8 medicine DRG admission rate at Dubbo hospital by half,
9 okay? And so, for me, that means that we reduced our bed
10 occupancy rate for renal medicine by four at any one time,
11 and if we apply the current belief that an acute care bed
12 in New South Wales for 24 hours is $1,901, simple
13 arithmetic will tell you what I believe we've reduced in
14 terms of cost, and I think that's about $2.7 million
15 a year.
16
17 We had the Leading Better Value health care tranches
18 from a previous premier, one of which was renal supportive
19 care where in ninth decade of life and beyond we can make
20 an ethical and appropriate quality of life and longevity of
21 life decision that dialysis provision would not be in the
22 ethical benefit of that patient, so we control that pathway
23 and encourage and develop understanding at a community
24 level that that's the right thing to do ethically. So
25 we're not reflexly dialysing people at huge cost, system
26 cost.
27
28 We've increased, I believe, access to renal
29 transplantation by 400 per cent. So if you look at things,
30 I reckon our dialysis numbers are static. Look at Western
31 Sydney's. So control of a clinical service is cost
32 effective, and I believe it's cost effective to, if we
33 include renal transplantation is one-third of the cost of
34 dialysis, approximately, to the system, not dialysing at
35 all, although in terms of clinical follow-up for me it's
36 actually more involved, because I don't abandon my patients
37 but it's cheaper to the system to not dialyse someone,
38 hence Leading Better Value health care tranche, and
39 decreased bed occupancy.
40
41 So I think that 3.8 full-time equivalent renal
42 physicians living and working and passionate about what
43 they do in Dubbo is saving the system, annualised, three to
44 five million dollars a year. That more than pays for our
45 salary, unless you want to pay me more. And I don't need
46 to be paid more.
47

1 But - so if we extrapolate that system of cost
2 savings - so why are we frightened to look at capacity
3 building in professional workforce? Why should shouldn't
4 we lift that rock and say, "This is actually going to
5 deliver the care that will make a difference, and it will
6 be cheaper in the long run perhaps", but everyone's too
7 scared to do it, because when we do it, we're going to
8 expose the system to failure, because we're going to start
9 to see under that rock what we're not doing right now, and
10 people will run scared from that, and I believe they're
11 doing that. But we have to change it because it's just -
12 because, let's go back, Commissioner, to when I started
13 work in Dubbo. I predate a resident cardiologist in this
14 town. Do I look that old?
15
16 Q. No.
17 A. Thank you. How can that be that I predate a resident
18 sub-specialty cardiologist in Dubbo, okay? And if you
19 asked the general public about that, they would - what?
20 And we think we're winning? And, look, we are progressing.
21
22 In January, across this local health district, we had
23 six FTE cardiology, and in just four months we've gone from
24 1 FTE in Dubbo to 3. They are all overseas trained
25 physicians. They are all high quality. I was directly
26 involved in their recruitment and involved in the two we've
27 just appointed, their supervision for the College of
28 Physicians and Ahpra.
29
30 But why do we have - you know, I'm moving into
31 something else here, you know, but how do we have a system
32 that is so maldistributed that you wouldn't, as
33 a cardiologist, want to come and work where your exposure
34 to the acute part of your sub-specialty is at its highest?
35 You know, why do we have that maldistribution? Well - and
36 I'm going to move on to something else now, but the reason
37 is because we've got a system that is set up that allows
38 individuals coming out of specialist training to tread
39 water in Sydney, because there are so many ways in which
40 you can still earn a living without a public appointment in
41 a major hospital in Sydney, and you might have heard about
42 this before.
43
44 You know, if I finish training and there are two
45 vacant jobs in Dubbo as a cardiologist, but it may very
46 much not suit me personally to leave Sydney and the great
47 restaurants of Sydney - don't get me started about the

1 restaurants of Dubbo, that's another story entirely - but
2 we have a system that's set up where I can just enter
3 private rooms and bill Medicare and bill the patient
4 directly an out-of-pocket expense, because that will be
5 what's happening, and I can take admitting rights to
6 a private hospital, and it may be a very undistinguished
7 private hospital, and I can make a good financial living,
8 fairly rapidly, rather than just going and taking up
9 a full-time position in a regional site to work.
10
11 So how do we change that trajectory? People talk
12 about you can't conscript doctors in Australia. Maybe we
13 need to hone that a little bit so that we at least reduce
14 the outlets of other opportunity to ensure that you go
15 where the work is. Because I can assure you, it doesn't
16 happen in other healthcare systems. You have to go where
17 the work is. And sometimes that will be, whether you like
18 it or not, and often it will be because that's absolutely
19 what you want to do. And, look, we are making progress,
20 but there is a lot more progress that we can make.
21
22 And I know this is becoming a little bit of
23 a soliloquy, but let's talk about services that don't exist
24 at all --
25
26 Q. You haven't beaten Mr Spittal for the longest answer
27 yet, so keep going - not that it wasn't a good answer, but
28 keep going.
29 A. So our LHD is 279,000 and a bit people. Do you think
30 there is a vascular surgical service for this LHD?
31
32 Q. You are going to tell me there is not?
33 A. There is not. How can that be? 280,000 people, there
34 is no vascular surgical - no local health district defined
35 or responsibility taken vascular surgical service. I've
36 got a funny accent. I'm from Scotland originally.
37
38 Q. Nothing wrong with that.
39 A. I grew up in - I schooled in Aberdeen, so I'm not -
40 I wasn't born in Aberdeen shire. Aberdeen shire is 240,000
41 people, serviced by Aberdeen Royal Infirmary. They have
42 a tertiary level vascular surgical unit. This local health
43 district is larger than Aberdeen shire by population and it
44 has no vascular surgical service at all that has been - had
45 any input by Ministry of Health, government or the tools of
46 government, local health district. And I sit on the board.
47 What is going on?

1
2 The services we do have are drive in, drive out,
3 fly-in, fly-out, and we have two outstanding vascular
4 surgeons who basically my wife and I have coerced to come
5 and create fistulas for our dialysis patients at Dubbo
6 hospital and, thankfully, when they come - because they
7 only do fistula work for us predominantly because they do
8 want to give back, and you can imagine what it's like
9 trying to get someone from Bourke or Brewarrina, Walgett,
10 to RPA to have a fistula created for dialysis access, so
11 they understand that coming and doing that in Dubbo is
12 really valuable, and when they are here, they offer
13 a private day of clinic or rooms for general vascular
14 consultation, okay?
15
16 So that service for Dubbo exists because of me and
17 word of mouth. Where's the responsibility? Like, what
18 the? Your jaw drops at that. It really does.
19
20 Q. I'm detecting your frustration.
21 A. Yes. So if you talk to our two vascular surgeons,
22 what are the key issues or blocks, because they tell me,
23 "Well, I don't know how long I can come and do general
24 vascular consultation, because" - and you might be aware
25 that the majority of general vascular work is now
26 endovascular, with the new breed of vascular surgeons.
27 Vascular surgeons are struggling in the public system in
28 metro to get access into interventional laboratories to do
29 their endovascular work, and if we add a completely
30 unplanned for vascular surgical group, and we have the
31 highest rates of peripheral vascular disease in the central
32 west and our remote areas, they can't get access in Sydney
33 for these patients right now. So how can we - so what they
34 say to me is "How can I continue consulting, because I'm
35 just blowing out and blowing out the waiting list to get
36 these patients seen".
37
38 So their impending vascular catastrophe becomes
39 a catastrophe, it ends up in Dubbo emergency department and
40 then we're retrieving them because of critical limb risk
41 when that's all preventible. It's not just Dubbo. Exactly
42 the same thing is happening in Orange, because a general
43 surgeon and vascular surgeon retired the year before last
44 and Orange is now falling back on two visiting vascular
45 surgeons, and Bathurst I don't think has any service at
46 all.
47

1 Don't get me started about dermatology and various
2 other --
3
4 THE COMMISSIONER: Q. I might leave that to
5 Dr Waterhouse.
6 A. So dermatology, there is no service at all. So if we
7 don't do that, it comes back to that demand and needs
8 analysis. If we don't do the work for these basic things,
9 then who is taking the responsibility to ensure that the
10 services actually happen? And it's very different if
11 a service is missing in Sydney or Melbourne in your local
12 government authority area, because you will have better
13 access still in metro to primary health care, you will ring
14 a mate 20 kilometres across town and say, "Can you see this
15 person? Maybe you can even bulk bill them, because I went
16 to university with you and you are a vascular surgeon. Can
17 you sort this person out for me, because I've lost my local
18 referral pathway." This is a key distinction for regional
19 and remote, is there isn't that network back-up of
20 services.
21
22 So if you lose a critical service, there won't be
23 anything there at all, or if we haven't done the work to
24 assess what we really want to see in terms of services,
25 it's an unmeasurable lack of presence. And we're talking -
26 we're not talking about neurosurgery here, which should
27 never be based in Dubbo.
28
29 THE COMMISSIONER: I understand.
30
31 DR WATERHOUSE: Q. The answer that you have given has
32 covered a lot of what I was going to be asking you about,
33 and the Commissioner's questions, but I just want to tease
34 out a couple of aspects.
35
36 In paragraph 22, you sort of summarise there the
37 solution that you see for these issues, to a degree. I'm
38 interested to know - so you are saying that a similar
39 approach could be taken to what you did for renal medicine?
40 A. Mmm-hmm.
41
42 Q. And you talk about, first of all, deciding the
43 services that should be provided - this is in
44 paragraph 23 - deciding what key services should be
45 provided.
46 A. Mmm-hmm.
47

1 Q. My question is, who should be making that decision and
2 on what basis?
3 A. I actually think for secondary - for what I would
4 describe as secondary services, so specialist services, be
5 they surgical, medical or otherwise - I actually think that
6 should be work that's undertaken by the local health
7 district. Bearing in mind that the workforce delivery
8 starts to look complex because of the interplay of a staff
9 specialist model or specialist recruitment and the VMO
10 model with private rooms, of who takes responsibility to -
11 you know, command control of what's available or what's
12 happening in your local government area. For example, and
13 this has been alluded to by others in other hearings,
14 a gastroenterologist, for example, could decide that they
15 are going to move to Dubbo and set up private rooms, but
16 the reality is we would track that because they would want
17 to have, one would imagine, public hospital admitting
18 rights.
19
20 So acknowledging some of the complexity around VMO and
21 private rooms versus staff specialist, which is under
22 complete command and control, obviously, of the local
23 health district and the local public hospital, I think it
24 should be the local health district and ministry that
25 undertake service planning.
26
27 Q. So the local health district and the ministry?
28 A. Well, the LHD is an extension of ministry, with the
29 devolution of system and process into LHDs, so we will
30 simplify that to local health district. I think it should
31 be us. But I think you and I could do it this afternoon
32 with a napkin because, you know, this is not a year of
33 work. It's probably two hours and a pen and a piece of
34 paper to write down, because I can tell you what community
35 should have based in Dubbo. I think you could as well.
36 It's quite simple.
37
38 Q. So parking the services for a minute, you then go on
39 to talk about developing a model of care before then
40 working through the funding commitment and the engagement
41 of the workforce. How would you see it working to develop
42 the model of care before you had the specialists available?
43 What would that look like? Putting aside the employment
44 categories of staff specialist, et cetera, what would the
45 model of care look like if there aren't the specialists on
46 the ground already?
47 A. So I think that because of course it's going to be

1 hybridised, we will have some workforce in key areas
2 already and, as you say, we would have missing workforce in
3 other areas for a service that we believe should be
4 provided. So in that situation, we would have to look at
5 interim measures to provide some support. Now, that could
6 be - because one thing I've learned very much is - so let's
7 say I get my magical wish and we do this work and we fund
8 all of this additional workforce to achieve it. I would
9 suggest absolutely, and I think that's what you are getting
10 at, that this would be a multi-year process of bringing on,
11 attracting and onboarding that workforce, because we want
12 high quality people. We don't want a knee-jerk response
13 and appoint through desperation. I have learned the hard
14 way that you should never do that. You are better to work
15 towards that common goal of capacity building, workforce
16 that's high quality and is going to be resident - we would
17 define it should be resident.
18
19 So what do we do in the interim, and I want to see, or
20 I would like to see, transparency around what the back -up
21 option is, and the reality is that if it doesn't exist in
22 the area, it's going to come back to, I think, your
23 tertiary referral service, and we are at a point where, if
24 we're talking about consultative care or sub-acute/acute
25 support to regional hospital or into outpatient
26 care/primary care, I think we're at a point, we're talking
27 about very clear service delivery contracts with those
28 services at tertiary.
29
30 I've been talking about this at board level for about
31 two years, and in reality, what I'm coming back to, and
32 I was talking about in the break, that I am ultimately
33 a renal physician and general physician. When I'm on call,
34 I end up with acute dermatology under my care, which is
35 very hard for me. I think I'm reasonably broadly skilled
36 by now, but some of that is pretty hard for me, and I have
37 no support. You know, I think I'm a fairly senior
38 clinician, or getting there, I'm the clinical director of
39 medicine, I sit on a governing board. If I ring our
40 tertiary referral centre and ask for the on-call
41 dermatologist, and my first words are "I'm ringing from
42 Dubbo, this is who I am, I really need some advice", the
43 answer I get is, "We're not giving it to you because it's
44 not our responsibility. Medically legally, we're not
45 allowed to do it, blah, blah, blah", click.
46
47 Q. You have had that experience?

1 A. Absolutely. And everyone has that experience, because
2 the only way to get round that with our ministry-level
3 defined tertiary/quaternary centre, which is Royal Prince
4 Alfred Hospital, is a number - by no means all, by the
5 way - a number of the sub-specialty services at RPA,
6 despite that, will refuse to talk to someone from our
7 catchment area, a clinician from our catchment area,
8 because they are saying "It's not our responsibility any
9 longer". That's not to say that if I was to ring them and
10 frame it that I have a patient that requires inpatient
11 transfer, they will acknowledge still that it's - "We are
12 the ministry defined tertiary referral, so we'll accept
13 that patient." So I could get a conversation started by
14 saying "This is who I am, I've got a really sick
15 dermatology patient. I think they need to come, and
16 I think they need to be transferred", and they will quickly
17 work out whether they really do, and if they don't, click.
18
19 I can tell you the other sub-specialties that is
20 happening - and look, I don't attribute blame to that.
21 It's really difficult to know whether that's a role they
22 should be performing in the current environment, and
23 I actually strongly believe that we require now
24 remuneration service agreements to provide that support as
25 interim measures. So I don't blame anyone. But we need
26 the support and acknowledgment this stuff is happening, for
27 services that we don't have anything to help, because we
28 need to do it for the common good, and the general public
29 would believe that this sort of stuff is not happening in
30 our healthcare system, and it's not just happening for
31 Dubbo. I've spoken to colleagues in Orange. They get
32 exactly the same response.
33
34 Q. So when you say a remunerated service agreement, what
35 you are talking about - correct me if I'm wrong - are you
36 meaning that tertiary hospitals, such as RPA, should be
37 actually receiving funding that is for them to provide this
38 service for you?
39 A. To provide the service, yes.
40
41 Q. And is that limited to a phone or virtual service, or
42 are you saying that should involve people coming out from
43 those tertiary hospitals to the rural sites?
44 A. I think what you could look at is - so I think it's
45 really important, coming back to that idea of planning what
46 should be here. So let's just say, okay, we've done
47 a specialist needs analysis for dermatology for Dubbo and

1 its service population, and that's defining let's say 4 FTE
2 dermatology on the ground in Dubbo, outreaching and picking
3 up the current service to Bourke, for example. Let's say
4 that's our planning proposal and we're going to fund those
5 clinicians. But it might take the five- to 10-year time
6 frame to actually achieve the goal, okay? But we're
7 working on it. And then, as an interim period, we would
8 then work on what interim service, with the one key that we
9 need to be really mindful that when we start to set up
10 whether it's fly-in fly-out, virtual care, those sort of
11 models, that it is an interim measure, because we've
12 defined that this particular service should be resident,
13 and then filling that outreach gap into remote sites, okay?
14
15 And what exactly that model for dermatology might look
16 like, I would think the best way of doing it would be
17 hybridised between fly-in, fly-out and telehealth, and then
18 acute - some sort of video consultation service for acute
19 problems.
20
21 Now, Dubbo does have a dermatology service, it's
22 fly-in fly-out and VMO based, two days a week, and we have
23 now created a sessional clinic once per month with one of
24 those fly-out, so we have a bulk-billed service. But
25 that's the tip of the iceberg. So we have achieved a
26 little bit because of this problem of having no service.
27
28 Q. Can you give an example of the sort of condition you
29 are talking about from a dermatology point of view that
30 would require that level of involvement, just someone who
31 would need to be admitted for their dermatology condition.
32 A. Bullous pemphigoids.
33
34 Q. So some serious condition like that that could be life
35 threatening, effectively?
36 A. Absolutely. You know, and by no means - look, I think
37 bullous pemphigoid a tertiary dermatology service probably
38 should come down, but you would be surprised, you know, and
39 sometimes if you ring one day and they don't want a bar of
40 you, you just ring the next day. I don't want to sound
41 sensational, but this is what's happening. And I think
42 it's just the transition and expectation that there need to
43 be clearer pathways around how these - how this care is
44 delivered with probably a generational change of attitude
45 about what we expect to deliver working at a tertiary
46 hospital.
47

1 It is hard to do it over the phone, you know, it
2 really is. But we need to acknowledge the deficits and
3 work on what are relatively straightforward fixes that are
4 cost effective, because it will keep later disease from
5 arriving into our emergency departments, which is high cost
6 and very detrimental to that individual's health outcome.
7
8 Q. Should the networks you have in mind also involve
9 people travelling in the opposite direction, to do
10 upskilling at the tertiary sites or quaternary sites?
11 A. I think that there would be definitely sense and
12 opportunity around that, coming back to continuing
13 professional development. And of course, as regional
14 specialists, I think majoritively we would all be doing
15 that and remaining engaged with tertiary education and unit
16 meetings and case discussion, and of course the virtual
17 platforms that have come out of the COVID-19 period have
18 made that so much easier.
19
20 So I can now - so, for example, our renal biopsies go
21 to Westmead's anatomical pathology and since COVID they
22 have run their weekly renal biopsy meeting on a virtual
23 platform, so any Thursday late afternoon I can jump on to
24 that now, so that would be an example.
25
26 Q. If we just go to paragraph 26, you talk there about
27 the role of the ministry or that the ministry should direct
28 the overarching strategy. Given everything that you have
29 said, what role do you see the ministry playing, more
30 specifically? Can you expand on that?
31 A. This is a very good question, and I'm glad you asked
32 it. So if you devolve - and I think we're coming back to
33 the health services tack here around devolution of
34 ministry's responsibility to local health districts, and
35 there are very many good reasons for that to happen, but
36 when we're tackling a workforce issue and a training issue
37 for doctors, right, do you think that a smaller -
38 financially smaller local health district such a Western
39 NSW LHD and the incumbents within that, as in the
40 workforce - do you think we have the devolved power to
41 change belief and direction within specialist training
42 committees within the College of Physicians and within the
43 College of Surgeons, I shudder to say? Of course we don't.
44 But perhaps ministry and government do. But we don't. And
45 I'm pretty bombastic at times.
46
47 Q. So it is at that high level of decision-making and so

1 on?
2 A. Yes. You know, to, I don't know, give - I would love
3 you to give the specialist training committee in cardiology
4 a bit of a slap around the chops to get some commonsense
5 into them, because shouldn't you be coming to me to send
6 advanced trainees in cardiology out to Dubbo hospital,
7 where the ST-elevation myocardial infarction rate is three
8 times Sydney local health districts, because capacity
9 training is everything and you are going to get the best
10 exposure to acute cardiology in your training that is
11 achievable in New South Wales at Dubbo hospital, but I'm
12 wrangling with that STC at the moment as a renal physician,
13 in my role, I guess, as the director of medicine, to get
14 accredited training because we now have the senior clinical
15 workforce to make it a realistic goal to have an accredited
16 cardiology trainee.
17
18 I guess what I'm coming back to is the pompous bow-tie
19 wearing nonsense of metro-centric training that says "You
20 are all a bunch of idiots in the country. Why on earth
21 could you possibly train high-quality doctors?"
22
23 Q. I have nothing else to ask you about workforce but
24 I want to go back to a couple of things about premium
25 labour, and I want to do that through the lens of the
26 committee that you chair, the health care quality
27 committee. Maybe if we go to paragraph 12 of the outline.
28 You mentioned that some of the people that come out to do
29 fly-in, fly-out work, locum work and so on, are giving
30 excellent care, and I think you said that because they are
31 contractors, they are not staying resident in the area and
32 advocating for what the area needs.
33
34 One of the things that you refer to in paragraph 12 is
35 the governance responsibility for morbidity and mortality
36 processes, and I'm interested to know how you ensure there
37 is effective M&M processes in those sites that are relying
38 on high usage of premium labour?
39 A. So the - so morbidity and mortality meetings are,
40 thankfully, very prevalent across our district, and where -
41 so they are prevalent obviously and quite clearly at
42 regional referral hospital levels, and an example, for
43 example - sorry, an example would be we have a general
44 medicine morbidity and mortality meeting, clinical meeting
45 that's very well attended at Dubbo hospital. It is not
46 organised and chaired by myself, a colleague does that. We
47 have onboarded, I can tell you - through, because of HCQC

1 and our clinical governance decision, we've taken on board
2 the CEC's support tool for running morbidity and mortality,
3 so we've fed that into our general medicine M&M.
4
5 There would be expected to be equivalent meetings
6 occurring in Orange and Bathurst and I believe they are, so
7 that's general medicine. Then obviously you would be aware
8 of the clinical streams, so they will have responsibility
9 to bring morbidity and mortality into the sub-specialty
10 streams. So an example that I'm part of is the renal
11 stream, so we have morbidity and mortality as part of our
12 clinical stream meeting in renal and then that is repeated
13 across those streams, and so there is a devolution through
14 our directorate of clinical governance and the HCQC into
15 those key areas to ensure morbidity and mortality is
16 happening.
17
18 Then we move out into the more - so the rural and
19 procedural sites and a clinical level morbidity and
20 mortality is happening, I'm thankful to say, and that is
21 under the directorate of the Virtual Rural Generalist
22 Scheme, and will cover the MPS sites at a GP VMO level, so
23 it is an umbrella morbidity and mortality meeting at
24 a clinical level. It is quite robust. It meets I think
25 monthly and it is two hours in length, and the reason
26 I know it is robust is because I join it myself to ensure
27 that it is happening.
28
29 Could that - could that be more - could
30 morbidity/mortality at a clinical level be more prevalent
31 for rural facilities? Of course it could, and I think
32 that's an area that we need - we can and need to develop
33 further. But I would suggest to you that the fact it's
34 happening at all is - and it's relatively new and I think
35 it's about three years, but it is very significant
36 progress.
37
38 Q. What I'm wondering in particular is if you've got
39 a temporary locum who has only flown in, perhaps even only
40 for a weekend, to work in an emergency department, and
41 there is a complication associated with a patient they see,
42 will there be a process for following that up, even though
43 they have long gone --
44 A. Yes.
45
46 Q. -- to be able to ensure that any learnings are
47 applied?

1 A. Yes, so that would - of course, and it comes down to
2 the severity, so if we're talking about a Harm Score 1 or 2
3 that clinician's been involved in, locum or not, as part of
4 the serious adverse event review, that clinician, locum or
5 otherwise, unless they have left the country, will get
6 pulled into that process.
7
8 Q. In paragraph 13 you refer to the committee providing
9 a framework for identifying trends in deteriorating
10 outcomes and increased harm or performance that's outside
11 the expected requirements, and ensuring there is a plan to
12 address any issues and also receiving updates as that plan
13 is rolled out. Are the data presented in a way that
14 highlights if premium labour is impacting quality of care?
15 A. I'm going to say at face value no, to that question.
16 But if we identify, as you say, a key trend that is - that
17 we flag as concerning, when we undertake the work to drill
18 down and understand what's leading to that change, then we
19 may - I can only say "may" - we may uncover that what you
20 are asking has been part of the problem.
21
22 Q. So if you see trends in adverse events, say there are
23 more adverse events at a particular site, part of the
24 analysis will be to drill down and look at the level to
25 which it is relying on locums and agency staffing?
26 A. Yes, you have to do that, yes.
27
28 Q. What about for things like hospital-acquired
29 complications, do you look at the trends of those by site
30 to see whether or not there is an agency or locum aspect?
31 A. Yes, if we identify, on the key performance indicator,
32 a deterioration, then we would look at the site or sites
33 that's leading to that change, and a particular area where
34 we're doing that in right now is in hospital thrombotic
35 disease events, and an example would be we've identified -
36 and this is preliminary work because it is happening right
37 now - we've identified that Dubbo is one of those
38 facilities where we believe we've dropped below performance
39 levels.
40
41 So in the last four weeks we've formed a working group
42 to address that and, of course, we could uncover within our
43 facility that - we could uncover that a change in workforce
44 and style of workforce has led in some way to this.
45 I don't think that will be the case for thrombotic disease
46 but it could be for other things, and look, we are very
47 dependent in our emergency department on agency staff, so

1 it's possible.
2
3 Q. And if that were the case, if premium labour were
4 found to be a factor or a potential factor in an increasing
5 rate of concerning incidents or complications, how would
6 the committee work through trying to have plans that
7 address that particular aspect? I realise you are trying
8 to reduce premium labour cost, but what other aspects of
9 quality?
10 A. Look, I hope that this might answer your question.
11 So, for example, the working group that we've put together
12 in Dubbo has been convened by our director of nursing and
13 we've put a haematologist with a sub-specialty interest in
14 thrombosis into that working group and, one, we therefore
15 believe that if you've got your director of nursing and
16 a senior clinician involved, then you will cover in a
17 feedback loop your two key workforce areas that could be
18 contributing to a change in your outcome data and I guess,
19 you know, that would be replicated in any key area that we
20 were seeing deterioration, whether that's falls, pressure
21 areas, maternal outcomes, but look, if we uncovered that it
22 was an agency nursing workforce issue, if what you are
23 really asking me is would that be a problem? Yes, it would
24 be.
25
26 You know, we can obviously feed back and try and
27 induce change in that area with that workforce, but it's
28 going to be time consuming for our senior nursing workforce
29 to try and institute that change, I think, because some of
30 that staff's going to be continuing to come and go until we
31 can repair the permanent workforce again.
32
33 DR WATERHOUSE: Commissioner, I have no further questions
34 for the witness.
35
36 THE COMMISSIONER: Thank you. Mr Cheney, do you have any
37 questions?
38
39 MR CHENEY: No questions, Commissioner.
40
41 THE COMMISSIONER: Thank you very much, doctor, for your
42 time. We're very grateful.
43
44 THE WITNESS: Thank you.
45
46 THE COMMISSIONER: You are excused.
47

1 **<THE WITNESS WITHDREW**
2
3 MR GLOVER: The next witness is Dr Williams.
4
5 **<ROBIN HILL LLOYD WILLIAMS, sworn: [12.23pm]**
6
7 **<EXAMINATION BY MR GLOVER:**
8
9 MR GLOVER: Q. Dr Williams, could you state your full
10 name, please?
11 A. Yes, Robin Hill Lloyd Williams.
12
13 Q. You are a general practitioner in practice in Molong?
14 A. That's right.
15
16 Q. You have been in practice at Molong since about 2007;
17 correct?
18 A. Yes.
19
20 Q. Prior to that, you were in practice at Gulgong for
21 about 10 years?
22 A. Yes.
23
24 Q. Prior to that, you trained and practised in the United
25 Kingdom?
26 A. Yes, in Wales. Trained in London but practised in
27 Wales.
28
29 Q. In anticipation of you giving some evidence today, an
30 outline of your evidence has been prepared; correct?
31 A. Yes.
32
33 Q. Have you had a chance to read that outline before
34 giving your evidence today?
35 A. I have.
36
37 Q. And are you satisfied that it's true and correct?
38 A. Yes.
39
40 MR GLOVER: That will be tendered in due course. It's
41 relatively hot off the press, Commissioner. I take it you
42 have a copy.
43
44 THE COMMISSIONER: I do electronically and hard, yes.
45 Thank you.
46
47 MR GLOVER: Q. In addition to some of the history of

1 your practice that I covered very briefly with you, you are
2 also the chair of the board of Western Health Alliance
3 Limited, since 2016; correct?
4 A. (Witness nods).
5
6 Q. That's the entity that operates the Western NSW
7 Primary Health Network?
8 A. I've been on the board since 2016 but chair since
9 2019.
10
11 Q. And the Western New South Wales PHN covers the
12 geographical area coinciding with both the local health
13 district in which we sit now but also Far West as well; is
14 that right?
15 A. Yes, about 53 per cent of the land area of New South
16 Wales.
17
18 Q. If I can come directly to the issues that you address
19 in paragraphs 14 and following of your outline, under the
20 heading of "Access to primary care", you start by telling
21 us that the ability to access primary care in rural and
22 remote locations is a significant issue and, then, in
23 paragraph 16, that the primary health care market is
24 failing. Do you see that?
25 A. Yes.
26
27 Q. Just so we're all on the same page, when you refer to
28 "primary care" in that context, what do you have in mind?
29 A. Basically, everything outside hospital care, the big
30 hospitals, a lot of primary care is actually delivered in
31 the smaller MPSs, so primary care means everything outside
32 the Orange, Bathurst, Dubbo and Broken Hill health
33 facilities, and includes general practice, allied health,
34 community nursing.
35
36 Q. Access to specialists outside of the hospital setting?
37 A. Well, specialists tend to congregate inside hospitals,
38 so - but access is an issue the further west you go,
39 certainly.
40
41 Q. And when you tell us in paragraph 16 that the primary
42 health care market is failing, what do you mean by failing?
43 A. I think - I've been practising now in Western
44 New South Wales since 1997. I first came here in '85 as
45 a resident, actually, to Dubbo, when I had finished my GP
46 training in Wales and my registrar in Wales, where I was
47 doing obstetrics, was Australian and he actually came here

1 as an VMO in obstetrics, John Tooth. So when I had
2 finished my GP training in Wales, I was ready - my wife and
3 I thought we would have a year in Australia before we
4 settled down into Wales into practice. So in those
5 intervening years, which is getting on for 40 years - well,
6 38 years - I have never seen general practice in such
7 a crisis as it is presently.
8
9 When I qualified, 60 per cent of my cohort in medical
10 school in London ended up in general practice, and I think
11 those figures were largely the same in Australia when
12 I came here in '85/'86 initially. We're now down to less
13 than 15 per cent. So the vast majority of new graduates
14 are not going into general practice and there is a huge
15 workforce crisis, and I think that's a huge issue.
16
17 I firmly believe that it's an unsustainable system
18 that we have at the moment where primary care is failing
19 because of workforce issues. And if you don't have
20 a workforce to provide that service, then it just moves -
21 it just kicks the can down the road and the local health
22 district in the hospitals will end up having to deal more
23 and more with emergency department admissions or
24 presentations, which puts even more pressure on the state
25 health system. So my feeling is that we need to really
26 address the issue, the primary issue that primary care
27 needs to be fundamentally overhauled in order for us to
28 move forward.
29
30 Q. If I can just break up some of those concepts.
31 Dealing with first the decrease in the number of
32 practitioners electing to go into general practice, has
33 that been on a steady downward trend, to your observation,
34 or has it increased in recent years?
35 A. I think it's certainly been a steady trend, but
36 I think it's been accelerating of late. I think part of
37 that is due to the funding, inasmuch as that there was
38 a freeze on Medicare payments for a number of years and it
39 remains to be seen whether the changes that came through in
40 last year's budget are going to make a fundamental
41 difference regarding that.
42
43 Q. The bulk billing incentives you are referring to?
44 A. Yes. I feel that they will make a big difference, but
45 it's a long lead-in, because just because you change the
46 funding today doesn't mean to say that we're going to get
47 a result tomorrow. Quite often there is a long lead-in for

1 us to get a real change in attitudes.
2
3 I also feel that the way that general practice is
4 funded in particular is not fit for purpose anymore. It's
5 still stuck in the old cottage industry model of care,
6 where you've got individual practices with their own ways
7 of doing things, which is very unattractive to young
8 graduates. The registrars that I have coming through my
9 practice are not interested in running a business, they
10 just want to do clinical care and they don't want to take
11 any financial risks regarding that. They want to know what
12 their income is going to be, they want to know that when
13 5 o'clock comes they can go home and not worry about the
14 rest of the quantum of general practice. Certainly,
15 rurally, it's not a nine to five job.
16
17 So consequently, the new cohort of young graduates
18 coming through are not looking for that old style model of
19 general practice. So I think that we need to move
20 fundamentally away from the fee for service for everything.
21 I think we need a blended system where you have block
22 grants for practices, and I do think that we need to look -
23 we need to incentivise, you know, hard work so that people
24 who work harder are remunerated better, but I think the
25 whole idea of everything being based on the MBS is very old
26 fashioned and should really be changed, and it doesn't use
27 the idea of - at present everything has to come through the
28 general practitioner.
29
30 I work as part of a team in my practice. Our practice
31 nurses do a lot of work for me. I still have to eyeball
32 the patients and talk them through what has been discussed
33 with my nurses, but that's the more contemporary model of
34 care and certainly, in Molong, where we are collocated in
35 HealthOne with community health staff, are very much
36 dependent on their input into the holistic look at patient
37 care, and that's where I think that we need to be looking
38 at funding into the future.
39
40 Q. And that's part of the integrated care work that you
41 address in your outline?
42 A. Yes.
43
44 Q. I will return to that in a moment, if I may.
45 A. Sure.
46
47 Q. Just building on some of the concepts that you have

1 developed in that last answer, do I take it that part of
2 the reason why you are of the view that the primary health
3 care market is failing is because the notion that primary
4 care being delivered through GPs in a private market is
5 something that is not sustainable going forward in your
6 view?
7 A. Yes, I do. I think so, yes.
8
9 Q. In that answer where you referred to the
10 unattractiveness of newly qualified practitioners having to
11 run their own practice and become small business owners, is
12 that something that has been relayed to you?
13 A. Yes, certainly. I mean, I'm very fortunate in my
14 practice in Molong, for a number of reasons. A lot of my
15 registrars like the idea of an integrated approach. We pay
16 them a salary from day dot and, then, if they earn more
17 than that salary, they earn more money. But we certainly,
18 right from the beginning, always said we didn't want them
19 to be focused on a through-put of patients in order to pay
20 their mortgage at the end of the month. It was very
21 important that they were guaranteed an income, and three of
22 my young ex registrars have all returned to the practice as
23 associates and they are all going to take on the practice
24 collectively in September when I give up, or retire from
25 clinical work after 43 years. So I think that model does
26 work.
27
28 Now, it's not just about the financial side, because
29 I offered them a profit share agreement right from the
30 beginning, but it was the integrated care side as well that
31 they liked to work in as part of a team, and also, I'm very
32 fortunate in the geography, being in Orange, just outside
33 Orange, 35 kilometres from Orange, they can live in Orange
34 and drive out 20 minutes to Molong to work. So that's
35 helped me a great deal in making sure there is
36 sustainability of services in Molong moving forward.
37
38 Q. So by developing a largely salaried model within your
39 own practice and the benefit of some geography to Orange,
40 you have been able to sustain and then provide a succession
41 plan in your practice?
42 A. Yes.
43
44 Q. Is that a model that is likely to gain traction in
45 some of the more regional or remote parts of the two
46 districts that your PHN services?
47 A. I believe so. I believe that if you said to a young

1 doctor "Look, we'll give you - this is your package,
2 regardless of how many patients you see, we'll allow you to
3 practise to the scope that you are comfortable with and
4 that you will be supported" - I think that's a model that
5 we - I would see that would be very, very advantageous into
6 the future. I do think that we need to fundamentally
7 change the way that general practice is run away from this
8 small business model. If it works in a town, fine, carry
9 on with it. I mean, it's working in Molong. But that's
10 dependent on my three associates staying there in the
11 future. Who knows.
12
13 Before they joined the practice, I was there with one
14 other GP and we've had a through-put of registrars. That
15 colleague of mine, Adrian Zambo, retired a couple of years
16 ago now and, as I said, I've reached my sell-by date
17 clinically in September. That worked for a number of
18 years. I don't think that model is going to be working
19 into the future.
20
21 Q. Your PHN has done some analysis of some towns within
22 the region it covers as to whether they would have access
23 to GPs in future, hasn't it?
24 A. Yes, what we have tried to do is, looking at place
25 based care - and that's a work in progress, but basically,
26 looking at an LGA level and asking the communities what
27 they would like, and then trying to work out how we can
28 support practices to do that.
29
30 Now, that's a multi-pronged approach and I think it's
31 very important that we have dialogue with the ACCHOs, the
32 RFDS, with other key players, but I think this is where the
33 state health needs to step into the place, into this space.
34
35 Q. Just pausing there, why do you say that?
36 A. Because - I don't know if you looked at my CV, but
37 having been on the RDN and --
38
39 Q. It is very long.
40 A. -- also the PHN and a few other --
41
42 Q. The LHD board?
43 A. Yes, the LHD board as well, there's a lot of movement
44 between state, Commonwealth and local government, and
45 nobody, you know, in a soccer term, puts their foot on the
46 ball and actually looks about where we should be kicking it
47 next.

1
2 Q. When you say "movement", what do you mean by that?
3 A. Well, the issue we have is that traditionally, because
4 general practice is funded by the MBS, it's assumed that
5 it's - primary care is a Commonwealth responsibility. When
6 I was the LHD chair, one of the issues that we had, and I'm
7 sure Mark Spittal may have discussed this yesterday, is
8 that when primary care fails in a town, the default
9 provider of services becomes the LHD, for which they are
10 not really funded. So, consequently, this puts huge
11 pressure on the MPSs to really provide an emergency
12 solution, a bandaid approach to care, so people present as
13 a default to ED departments, as they do throughout the
14 state when they can't access general practice services.
15
16 So if you've got that situation, I think the burning
17 platform for the state health now is that if there is no
18 primary care, the more remotely you go into the future,
19 they will be providing that service. So I think it is
20 incumbent on one arm of government to step into that space
21 and take responsibility and develop a service that is fit
22 for purpose and fit for the 21st century.
23
24 To do that, I think you are going to need - state
25 health is going to need a lot more expertise about primary
26 care, which traditionally doesn't really have, because it
27 has in the past been very focused on hospitals and
28 secondary and tertiary services, so never really stepped
29 fully into the primary care space, and I think that down
30 the track, they need to.
31
32 Q. The service that you are referring to in that answer,
33 is that a service of providing primary care within the
34 community as opposed to providing it as a provider of last
35 resort when patients attend an emergency department?
36 A. Yes, that's right, because primary care is a lot more
37 than just waiting for something to happen and for somebody
38 to turn up with a myocardial infarction from the community.
39 If you can develop preventative care, chronic disease
40 management and really engage with patients to try and
41 prevent a worsening of their health status, that's going to
42 be the real health benefit and financial benefit down the
43 track, because prevention is a lot cheaper than trying to
44 cure somebody when they are going to need, you know,
45 airlifting down to Sydney, having had the CVA or whatever,
46 you know?
47

1 Q. It's critical to the maintenance and promotion of the
2 health of the community; correct?
3 A. Absolutely. And this is where integrated care, which
4 is something that we tried to develop when Minister Skinner
5 was minister, and we, as an LHD, were one of the three LHDs
6 that were part of that project where we tried to manage
7 patients, case conference, bringing the whole allied health
8 team on board to try and work with patients about lifestyle
9 modification, and being very on top of care, of their
10 diabetes or their hypertension or whatever, to try and make
11 sure that there wasn't that worsening in their condition,
12 and I think that was really starting to show a benefit, but
13 then the program got changed, ministers changed and the
14 whole process sort of started to unravel and then we got
15 COVID and then life after COVID has changed considerably.
16
17 Q. And the type of integration that you are referring to
18 in that answer and in paragraphs 10 to 13 of the outline is
19 designed, is it not, to overcome some of the fragmentation
20 in the delivery of healthcare services that has developed
21 by close attention to funding sources?
22 A. That's right. I say in paragraph 13, it does seem
23 crazy that I as a clinician and the patient would see me
24 about the same condition and there is a different funding
25 source depending on if I see them in my rooms or if I see
26 them in the MPS, and that is something that then means that
27 you can't really control spending, there is a toing and
28 froing between Commonwealth and state about who is
29 responsible, and certainly when Kevin Rudd was elected as
30 Prime Minister in 2007, I remember he then talked about
31 stopping the blame game between Commonwealth and state,
32 about who was responsible for what, and talking about the
33 Commonwealth taking on all out-of-hospital care including
34 the smaller hospitals, but that got lost in the ether
35 somewhere and has never been --
36
37 THE COMMISSIONER: Q. He lost his job.
38 A. Yes. Ministers come and ministers go, and when that
39 happens, policy changes. That's why I've come to the view
40 that probably, the state health department has real skin in
41 the game here because of the huge pressures put on their
42 emergency departments by a failure of primary care, and
43 I think that's why we need an arm of government to say "All
44 right, we will step in and we will actually actively
45 advocate for primary care".
46
47 To do that, we have to be very careful, and that's

1 something else I said in my statement, that we don't allow
2 for the financial pressures, which, you know, you have
3 heard about in state health to suck everything into the
4 Orange, Bathurst and Dubbos and Broken Hills, because the
5 media is telling us about the ramping of ambulances,
6 et cetera, et cetera.
7
8 Q. Your point being that if, in your example, NSW Health
9 was responsible for the delivery of primary care, if the
10 funding streams could be resolved, that that would have to
11 be quarantined so it wouldn't be subsumed into the acute
12 care setting; is that the concept?
13 A. Yes, absolutely, because if you allow primary care to
14 flourish and you encourage it, the long-term gain is that
15 you will save a lot of health money by prevention and
16 improve morbidity and mortality.
17
18 If you don't, if you just sit on your hands and wait
19 for the status quo to stay as it is, then the whole system
20 will collapse because the hospitals will not be able to
21 deal with the huge tsunami of diabetes, cardiovascular
22 disease, morbid obesity - you know, all of these things
23 will happen if we just wait for - if we don't try and
24 prevent it at the sharp end, which is primary care.
25
26 Q. The idea that one entity or agency has ultimate
27 responsibility for the delivery of primary care is
28 something you develop further in paragraphs 18 and 19 of
29 the outline. You've gone into some detail there to
30 describe the concept, but what I want to explore with you
31 is how that might actually work, in your view, in practice,
32 assuming you could overcome the legislative and political
33 challenges involved?
34 A. Well, I think the reason why I would like to see this
35 happen is because it means that the buck would stop with
36 that entity. There wouldn't be any of this "Oh, actually,
37 this is Commonwealth responsibility", or "It is a state" -
38 and there has been so much of that down the years where you
39 ask a question about who is responsible and everybody goes
40 "Somebody over there". And I think that that authority of
41 somebody saying "Right, this is what you are charged to do"
42 and then making it in such a way that certainly what we're
43 looking at on the PHN level is listening to an LGA at an
44 LGA level and talking to communities and asking them "What
45 would you like to have" and negotiate with them saying
46 "This is what we can achieve and this is what we can't
47 achieve", "No, you can't have a CAT scanner in Brewarrina

1 but you can have primary care there, and if you can't have
2 it there every day of the week, you can have it with
3 support from local practitioners". This is where one of
4 the few benefits of COVID is that we've enhanced our
5 telehealth and video health capabilities. So now it's
6 a lot easier to actually look after patients. I see
7 patients, I go to Yeoval once a week, which is 47Ks away.
8 I'm actually getting paid now for the six days a week I'm
9 not there for giving advice or talking to the nursing home.
10 Previously I was on a - you know, I was a freebie. This -
11 all of these things will help.
12
13 So I think that if we had a hub-and-spoke model where
14 doctors could go out from Dubbo one day a week, two days
15 a week, to more peripheral areas, but the medical record,
16 again, is available so that a new clinician can then look
17 at that and say "Well, this is what has been done" - you
18 know, knowledge is power, and if you've got clinicians that
19 have got access to that, they can provide very good care
20 remotely without actually having to be there. But I think
21 you do still have to have people there on the ground for
22 periods of time, but not necessarily all of the time.
23
24 Q. I will come back to the issue of access to records in
25 a moment, but about halfway down - sorry, about a third of
26 the way down paragraph 19, you say:
27
28 *I envisage that local health districts and*
29 *primary health networks should co-design*
30 *service solutions for specific locations of*
31 *crisis with local community input ...*
32
33 Et cetera.
34 A. Yes.
35
36 Q. Is that something that you think should be happening
37 now as well as in the ideal situation that you have
38 described to us today?
39 A. Well, it is. I mean, that's something that we are
40 trying to work with - there is a crisis in Far West as we
41 speak where we are trying to work around solutions. The
42 problem for the primary health network is that, as
43 commissioners of care, we don't actually provide it, and
44 that's where I would like to see a unitary authority
45 actually take carriage of this, and it has to be, you know,
46 ring-fenced money so that it's not siphoned off to the
47 bigger centres.

1
2 Q. Take carriage of the planning and delivery of care?
3 A. Yes.
4
5 Q. Is that what you have in mind?
6 A. Yes, I think so.
7
8 Q. Let's just assume for the purpose of this question
9 that that might take a little while to get off the ground.
10 A. Yes.
11
12 Q. In the meantime, does the same concept, though, hold?
13 That is, that you see significant benefit in the districts
14 and the primary health network, and perhaps others, coming
15 together to plan services?
16 A. Absolutely. I mean, in regards to that, at a board
17 subcommittee level we have now had a meeting with both
18 Western and Far Western LHD boards - chairs and board
19 members and CEs - in order to try and look at common areas
20 for common planning where we can help each other.
21
22 We do work probably better with the LHDs than most
23 PHNs do around the country just because of the individuals
24 involved. You know, there's not that many people here so
25 we all know each other and that personal relationship is
26 very, very useful.
27
28 The downside for us as a PHN is that our masters are
29 the Commonwealth. The downside for the LHD, even though
30 there is devolution, is that ultimately, ministry decides
31 what is or what isn't done. So that's why I feel that we
32 need more devolution of power and we need devolution into
33 who runs primary care. I think that that would then see
34 real benefit, because actually, if we looked at support at
35 an LGA level, we could then listen to our communities, and
36 I think listening to our communities is really what's very,
37 very important, because for so long all levels of
38 government have tended to say, "We know what's best for
39 you. This is what you can have." And that isn't always
40 necessarily what people want or need, the more rurally that
41 you go.
42
43 Q. In that answer, do I understand you to be describing
44 that, even now, when attempts are made to engage in joint
45 planning, one runs head long into the fragmentation issue?
46 A. That's right. Because, you know, you can have
47 a conversation at a local level and agree to something,

1 but - and there is has always got to be a but - the people
2 who actually run the whole service are the people who
3 control the purse strings.
4
5 Q. In those questions about planning I made reference to
6 the PHN and the LHD. Are there others involved in the
7 delivery of health care in the community that you think
8 should be part of that process?
9 A. Well, certainly of late, RFDS has been providing huge
10 amounts of support into the primary care space, and I think
11 they are very important. Local government quite often are
12 very important because they provide infrastructure, so they
13 need to be - that's why I think at an LGA level you need to
14 have that dialogue at a local level. You know, one of the
15 reasons I'm in Molong, when I moved from Gulgong, is that
16 Cobonne council built the HealthOne in collaboration with
17 NSW Health, a purpose-built facility. So I moved from
18 Gulgong to Molong, started my practice and it's built from
19 there. Cobonne have been very very supportive. We have
20 recently opened an outreach surgery to Cudal, they
21 supported us financially to do that, and continue to do so,
22 for which we're very grateful.
23
24 I do an outreach to Yeoval. I'm supported there by
25 UPA Yeoval, because in supporting me and providing rooms to
26 me, and a receptionist and part funding of a practice
27 nurse, they are certain then that they get me every week to
28 actually come and see their, you know, nursing home
29 patients.
30
31 So it's a quid pro quo, but that works very well. And
32 I think that's - at a local level you can get a lot done
33 through partnerships and dialogue and helping each other,
34 which is something we do a lot of in the country.
35
36 Q. We heard a little bit about HealthOne yesterday, but
37 from the perspective of a clinician, in a HealthOne
38 practice, can you just tell us what the program is and how
39 it helped you raise and sustain your practice?
40 A. Well, the thing about the HealthOne program is that
41 everywhere you go, it's different. So it's a blanket term,
42 used initially to be where community health and general
43 practice are collocated. Certainly that's what we have in
44 Molong. We have a shared reception area and we work very
45 closely. The community health staff are on the other side
46 of the corridor and our practice is on this side of the
47 corridor.

1
2 My dream for it hasn't been realised as much as
3 I wanted it to when we started in 2009, inasmuch as
4 I wanted to have completely shared medical record and
5 everything to be shared between the community health and us
6 as a general practice. But that fell foul of privacy
7 issues from NSW Health about who owned the data, who was
8 accountable to who. The original idea was to have a shared
9 governance across the whole facility, but that just never
10 got off the ground because, again, state health and general
11 practice and other players couldn't really - we're always
12 going to be working for different masters, and that's why
13 I think that, ultimately, a unified authority to look after
14 primary care in communities is the answer. So it's - get
15 away from this "us" and "them", but it's that we all work
16 for one service.
17
18 Q. The issues you talk about in relation to information
19 sharing in that answer are picked up in paragraph 25 of
20 your outline. I take it, from a clinician's perspective,
21 the ability to have access to a single record in relation
22 to a patient is valuable?
23 A. Absolutely. I mean, I can access my hospital patient
24 through EMR from home, so I go in and see my patients at
25 the hospital, but if I'm rung after hours or whatever,
26 I can access the notes and that works very well. But that
27 doesn't talk to my general practice software, and if I was
28 to convert my practice to EMR, I'd go broke tomorrow,
29 because EMR doesn't talk to the Commonwealth regarding MBS
30 billing. So, you know, if we had an integrated system, it
31 would be much, much better.
32
33 I do it diligently, but I find it quite frustrating
34 often to write myself discharge letters to say, you know,
35 "Dear Dr Williams", and "This is what happened while our
36 patient was in hospital". That's part of the information
37 thing. One record across the whole system would - is the
38 goal, but I don't know if that's going to happen any time
39 soon.
40
41 Q. Are you familiar with NSW Health's single digital
42 patient record project?
43 A. Yes.
44
45 Q. Do you have a view about whether it would go any way
46 to addressing --
47 A. It may do, but again, this comes back to the funding

1 and how much input is there from general practice in its
2 design, because if it works very well for the hospital, it
3 may not work very well in general practice. So, yes,
4 that's --
5
6 MR GLOVER: I note the time, Commissioner, I've got about
7 20 minutes or so to go.
8
9 THE COMMISSIONER: If it's okay with the reporting staff,
10 I think I would rather let the doctor finish.
11
12 MR GLOVER: I might be shorter. I just gave an outside
13 estimate. Yes.
14
15 Q. Can I just return to the topic of planning. I just
16 want to explore with you how you see the planning of
17 healthcare services that has been most effectively
18 undertaken. I take it that you agree that if not the
19 first, at least a very early step, would be to identify the
20 needs of the population?
21 A. Yes.
22
23 Q. At a relatively place-based level, to pick up some
24 language you used earlier; correct?
25 A. (Witness nods).
26
27 Q. Does that happen now?
28 A. Not enough, no. It's very ad hoc and - you see, this
29 is one difference which I was surprised about when
30 I emigrated is that in the UK you can't just start
31 a practice where you want. I had to wait about a year to
32 find a practice in north Wales, where I wanted to live,
33 which is where I'm from. So basically I had to wait for
34 a retirement or a death before I could actually go into it,
35 you know, to apply for a job, because the idea being that
36 everywhere - every community has a certain number of
37 doctors so they don't all congregate in West Kensington,
38 you know? And I was surprised that that is not the case
39 here. It's the other way around. You can actually go
40 anywhere you like.
41
42 There are incentives for districts of workforce
43 shortage so that overseas doctors can come in, but there is
44 no real planning about, well, actually, we've got
45 a community here that needs this number of clinicians, and
46 those jobs should be available. At the moment, people can
47 go wherever they like. This was a case in point with the

1 recent round of registrar allocations to Western New South
2 Wales. I think 20 composite registrars came from Sydney
3 and they all went to Dubbo, Orange and Bathurst, from what
4 I understand. Very few went to the smaller communities.
5 So no workforce planning around that, looking at actually
6 what are the needs of the population.
7
8 So the needs of the population tend to become very
9 secondary in any decisions. It seems to be the needs of
10 what the clinicians want to do comes first. As Colin
11 McClintock was saying, the same applies to specialists.
12 You know, there are a lot of specialists in Sydney who
13 don't need to work in the public system, they can work
14 perfectly well in the private system and be within
15 10 minutes of the beach. I don't necessarily think that's
16 good workforce planning for the country. So I think that's
17 something we should really be looking at.
18
19 Q. Assuming you had the power to fix that tomorrow, what
20 would you do to change that?
21 A. Well, if I had the power to do it, I would probably
22 say that I would try to encourage that registrars have to
23 come out to smaller towns for at least six months, and by
24 "smaller towns" I mean not Dubbo, Orange or Bathurst, but
25 actually smaller towns, where they could be supported
26 fully, where they actually would learn rural medicine.
27 I think that if they came out for six months rurally, they
28 would learn more medicine than they would in far more time
29 in a larger regional centre.
30
31 Q. Why do you say that?
32 A. Because they would be exposed to a lot more pathology,
33 a lot more - you know, there is a lot more morbidity there,
34 there is a lot more sicker people that really need to be
35 helped, and that's just a fact that we have. That's why
36 the further west you go, the morbidity rates and mortality
37 rates go higher and higher, because there is not enough
38 boots on the ground to provide services.
39
40 Q. So that's an example of what might be done in general
41 practice. Do you have a view based on your long experience
42 in what I might call administrative - medical
43 administration roles through boards and the like, about
44 what might be done in the specialist space?
45 A. I would - I would like to see that the specialist
46 pathways have to have a rural component as well, and that
47 would be very difficult to do, I think, because I think the

1 colleges would be outraged that people had to go rurally to
2 learn anything, whereas I actually think that not only
3 would they learn quite a lot about the real world, but they
4 would also support rural patients as well. So that would
5 be part of the social component of being a doctor.
6
7 Q. At a practical level, how would the introduction of
8 the pathways that you have just described address some of
9 those workforce maldistribution issues?
10 A. I think the big issue is that if people come rurally,
11 there is a proportion that actually will stay, because they
12 will realise that it's not quite as horrendous as they fear
13 it might be. It's actually a very, very good place to
14 work. I've thoroughly enjoyed my 27 years in rural
15 New South Wales. It's - the medicine is challenging, but
16 it's very, very enjoyable, and I think that a lot of
17 clinicians, if they do come out west, might actually stay.
18
19 Q. In addition to the various roles that we've identified
20 this morning, you also have some involvement with the
21 Charles Sturt University and I think one of the University
22 of Sydney's rural medical schools; is that right?
23 A. Yes. We take registrars from both CSU and USYD and
24 I'm on the governing council of CSU. That was
25 a ministerial appointment and that's until July next year.
26 I really went on to that board in order to try and help
27 with developing, really, what I would like to see happen,
28 is a pathway for a medical school through to general
29 practice, certainly rurally, and I think that that's
30 something that I would like to see develop. Now, we're
31 only into the third year of that medical course now, so I'm
32 probably not going to be around long enough to really see
33 that develop, but I would like to see it made easier for
34 young graduates to come through the process, to train
35 locally, general practice, you could do all of your
36 training rurally, and then there would be a pathway for
37 them then to have practices to which they can go.
38
39 I figure that's - to try and ease that path for new
40 graduates is very important, because at the moment, there
41 are so many blockades in the way to make it difficult for
42 them to actually fulfil a career, and a lot of them just
43 say, "Look, it's too difficult, I'm not bothering. I will
44 go back to the city. I will pick up a job. I can work
45 three days a week. Earn enough money." And you might lose
46 them.
47

1 Q. That initiative is relatively early days. Do you see
2 it bearing fruit to develop the pathway that you just
3 described?
4 A. I think - I certainly think so. I think that should
5 be the way. And this is again where state health does have
6 a lot of power, because intern jobs and JMO jobs are all in
7 the purview of state health, and I think that if there was
8 a real focus by state health to say, "Well, you want to
9 come to Orange", or "You want to come to Dubbo. What are
10 your career plans? Are you going to stay rural?" and
11 encourage that, then I think that we could - certainly for
12 general practice, we could then get a pathway.
13
14 I was fortunate enough to - when I had finished in
15 London as an undergraduate, I came back to Wales to do my
16 intern jobs, and then I was able to get a three-year GP
17 rotation with obstetrics and paediatrics and psychiatry and
18 emergency and general medicine and two six-month stints in
19 teaching practices as a registrar. I knew I had three
20 years of a focused training program in the same area, and
21 so, as inevitably happens, I met my wife, who was a nurse,
22 we got married, she was from North Wales as well and we
23 stayed in North Wales, and then went into practice. I was
24 in practice there for 10 years. You may wonder how I have
25 ended up in New South Wales, but that's another story.
26 I got seduced by the blue skies back in '86.
27
28 Q. Just turning briefly to paragraph 22 of your outline,
29 just while we're on this topic, in that last series of
30 answers you have touched on - I might misquote you - the
31 concept of the power of the state health system in this
32 space.
33 A. Yes, yes.
34
35 Q. Is that what you have in mind when referring to an
36 opportunity to develop a whole of system approach?
37 A. Yes.
38
39 Q. Just - what does that look like in your mind?
40 A. Well, as I said, my experience back in Wales, back in
41 the mid '80s was that I did my intern year, then I was
42 guaranteed three years in the same locality. The best jobs
43 for training to be a GP. It made my life so much easier
44 knowing that I was fixed. I mean, I was able to marry,
45 I was able to buy a house, I was able to do all the stuff
46 that normal people do, and which doctors often can't do
47 because they are sent all over the place.

1
2 So that sort of stability of knowing that you have got
3 a pathway for your career I think is very comforting and if
4 you marry that up to the fact that at the end of it, you
5 can get a job where you are guaranteed an income and you
6 don't have to worry about setting a shingle up somewhere
7 and starting a practice - those are the fundamental things
8 that everybody, you know, doctors, non-doctors, everybody
9 wants that security about, you know, have I got enough
10 money to live; have I got job security; can I stay in the
11 area that I want to stay? If you take that out of the
12 equation, they can then just focus on learning their craft
13 and becoming good doctors. So it takes away all that
14 pressure. You know, so you don't end up having to go off
15 and do locums here, there and everywhere to pay your way.
16 That stability is important.
17
18 Q. So the whole of system that you refer to in
19 paragraph 22, tell me if I have got any of this wrong, but
20 would include the university, the specialist college?
21 A. Yes.
22
23 Q. And the public health system?
24 A. Absolutely.
25
26 Q. Anyone else?
27 A. Well, I guess you will have to bring the existing GPs
28 on board, if there are any left rurally, that is, down the
29 track. And it is important that the community is a part of
30 that, too, that there is input from communities. But
31 I think it's a whole of system - we've got to get away from
32 this fragmentation. The whole system is fragmented with
33 vested interests that don't actually look at the core of
34 what we actually are here for, which is to provide health
35 services to our communities. That's what we should be - we
36 should be starting from that point first and then working
37 back about how we can achieve it.
38
39 Q. And if a whole of system approach of that kind were
40 adopted, I take it from what you say in paragraph 22 and
41 what you have said today, you see that as being one way in
42 which some of the workforce issues might be able to be
43 addressed by offering those placements in areas of need?
44 A. That's right.
45
46 THE COMMISSIONER: Q. So what you have just said,
47 really, is we work out, for example, for this LHD, what are

1 the health services that the community needs so that there
2 is proper provision of primary health care and, if needed,
3 specialist health care, and then we work out how it's
4 funded?
5 A. Yes, absolutely.
6
7 MR GLOVER: Q. I might build on that. I think I started
8 on the process and we went in a different direction, but
9 you identify what is needed; correct?
10 A. Yes.
11
12 Q. You identify the resources that are currently on the
13 ground meeting that need?
14 A. Yes.
15
16 THE COMMISSIONER: Q. And by "what is needed", not just
17 now but looking to the future as well?
18 A. Yes, yes, that's right.
19
20 MR GLOVER: Q. So the resources you have got now and the
21 resources that you project to have in the future?
22 A. Mmm.
23
24 Q. Identify the gaps?
25 A. (Witness nods).
26
27 Q. And then identify the resourcing that you have got to
28 address both the needs and the resourcing requirements; is
29 that a fair summary?
30 A. It is, and I think it's very important, when you look
31 at - when you start looking at the resources currently put
32 into a locality, the MBS, the underspend per capita of the
33 MBS in a lot of these more remote areas is far less than it
34 is in metro, because there just aren't the clinicians to
35 provide the services --
36
37 THE COMMISSIONER: Q. By "underspend", you mean when
38 there is a market failure it's not tapped into?
39 A. That's right. If there is nobody there to provide
40 a service, gee, it is cheap, because nobody is claiming any
41 money, until they turn up at the ED department of Dubbo, in
42 a state of, you know, huge distress and then how much does
43 that cost in real terms to try and patch somebody up.
44
45 MR GLOVER: Q. Could I just finally, Dr Williams, round
46 out a couple of points that you raise about integrated care
47 in paragraphs 10 to 13 of your outline. We've touched on

1 some of this, but I just wanted to close out the point that
2 you raise in paragraph 11.
3 A. Yes.
4
5 Q. You have described earlier in your evidence the
6 benefits of integrated care, particularly in communities
7 like yours.
8 A. Yes.
9
10 Q. And then, in 11, you tell us that achievement of that
11 aim is best facilitated by clinicians having a higher
12 degree of autonomy to do things locally?
13 A. Mmm.
14
15 Q. What do you mean by that?
16 A. Well, I think the important thing is that certainly in
17 general practice, you want to be practising right at the
18 top of your scope. You need to feel that you can guide
19 local services, and you would have to do that by talking to
20 your community. But we try and develop services in Molong
21 across my practice and the MPS, and the things that we can
22 thrash out locally as solutions are much better than
23 sending it up the food chain and waiting for a response,
24 because if you do that, quite often there is a deafening
25 silence. So quite often what we need to do is work out
26 what is best for our communities, what is best for us as
27 clinicians and a flat approach using all of the team,
28 focusing on the patients.
29
30 Q. So by "autonomy", you mean the ability of the
31 clinicians, be they in the local MPS, the general practice,
32 allied health, I think you suggest paramedics as well --
33 A. Yes.
34
35 Q. -- to come together to design the type of service
36 needed in that locality?
37 A. For what works locally, yes.
38
39 Q. And you mentioned in an earlier answer that sometimes
40 if you send things up, there might be silence, but are
41 there any particular barriers that you see in the way at
42 the moment to that aim being achieved?
43 A. Well, certainly I mean if you look at - you know, at
44 Molong we get sent back a lot of sub-acute patients post
45 fracture, from Orange, so they try and clear beds,
46 et cetera. Quite often we are sent back patients who need
47 placements in a nursing home. We don't have a social

1 worker. We only have a physio 0.6, and she is worked off
2 our feet. We don't have an OT and we've only just had
3 a speech pathologist appointed, or starting this week. So
4 when Orange want to clear the decks and move people out to
5 make beds, they send them out to the peripheral sites, but
6 they don't give us the tools with which to actually sort
7 those patients out expeditiously. So if - and the budget
8 for Molong is not dictated by Molong, it comes from further
9 up the food chain. So, again, if there was more autonomy
10 locally, I think we could provide a better service, because
11 probably we would try and get more allied health in and
12 come - find a way of improving the numbers of our allied
13 health staff.
14
15 Q. Lastly, Dr Williams, I might have asked you this
16 earlier, and if I have I apologise, but do I take it, given
17 the evidence you have given about the market failure of
18 primary care in rural and remote regions and the prediction
19 for further crisis on the horizon, that you would accept
20 that the VMO model, of which you are one, is not
21 sustainable long term?
22 A. Yes, it's interesting you talk about the VMO model,
23 because we've modified that in Molong. I found that it
24 was - I mean, I'm still - I'm technically a VMO, but the
25 way that my funding comes through, it isn't on a fee for
26 service. I've just come into a contract to say this is how
27 much I get paid per day,, if I do 24 hours, it's this rate.
28 If I don't do 24 hours but I do the ward round and clear up
29 what is there in emergency, then it's a different rate. So
30 that means that it's a flat rate and, again, that's
31 something that I think is a much better way of doing things
32 than, you know, coming in and saying, "I did an ECG on that
33 patient", you know, "Who was in the toilet that day so
34 I didn't see them", et cetera, et cetera. You know, the
35 fee for service model I think is - the contract with us is
36 basically I'm contracted to do the work and the finances
37 are just set in stone.
38
39 Q. In addition to the limitations of the funding model,
40 though, do I take it, given - I will withdraw that and
41 approach it a different way. The PHN some time ago did
42 some work which predicted that about 40 towns within your
43 area would be left with no GPs?
44 A. Yes.
45
46 Q. That was in about 2019, that work was done; is that
47 right?

1 A. Yes, yes.
2
3 Q. Do you have a sense of how that projection is tracking
4 as you sit here today?
5 A. I think we're heading in that direction,
6 unfortunately, and I feel that, again, that's why the - you
7 know, as part of the VMO model, I think that's - it's not
8 fit for purpose anymore.
9
10 Q. That's perhaps coming directly to the point. If there
11 is no GPs on the ground, there is no GPs to be GP VMOs;
12 correct?
13 A. That's right.
14
15 Q. And do you see anything on the horizon that would turn
16 that trend around to leave the GP VMO model in rural and
17 remote regions as being a viable one into the future?
18 A. I think the only way that it would become viable would
19 be if we had a unitary authority to run primary care and
20 then, what you call them, as GP VMOs or staff specialists
21 or whatever doesn't matter, but the important thing is that
22 we need a unitary authority to drive this, and that way we
23 have you will the players in the same tent and they are all
24 actually answerable to each other and not to different arms
25 of government.
26
27 MR GLOVER: Thank you, Dr Williams. No further questions.
28
29 THE COMMISSIONER: Q. Just so we're clear about one of
30 the answers you gave earlier where you mentioned Mr Rudd
31 and stopping the blame game, was the ultimate report that
32 came out of that that you had in mind the report of the
33 National Health and Hospitals Reform Commission (2009), a
34 report that, amongst many recommendations that have been
35 touched on in evidence in this Inquiry so far, made the
36 recommendation that the Commonwealth should assume
37 responsibility for all primary health care policy and
38 funding; is that what you had in mind?
39 A. Yes. And that didn't really happen.
40
41 Q. It doesn't seem to have.
42 A. So if it didn't happen, and that was 2009, we're
43 15 years on, so something's got to be done now, because the
44 situation is a lot worse now than it was then.
45
46 THE COMMISSIONER: Thank you. Mr Cheney, do you have any
47 questions?

1
2 MR CHENEY: Just one matter, if I may, very briefly.
3
4 **<EXAMINATION BY MR CHENEY:**
5
6 MR CHENEY: Q. Dr Williams, may I ask you briefly about
7 this unitary authority that you have in mind. You come
8 here with the benefit of some years, six or seven years, as
9 chairman of the local LHD?
10 A. Yes.
11
12 Q. And I take it you have had frequent interaction, since
13 your chairmanship, with the LHD in your practice --
14 A. Mmm.
15
16 Q. -- and in other settings. So you would be well
17 familiar with the competing demands that are on the
18 healthcare dollar administered by the LHD?
19 A. Yes.
20
21 Q. And as you made clear in your statement, primary care
22 funding, notionally, at least, is the responsibility of the
23 Commonwealth.
24 A. (Witness nods).
25
26 Q. May we take it that in proposing the unitary
27 authority, you have in mind that it would be funded by the
28 Commonwealth without any drain on the existing funds that
29 are allocated by the LHD to secondary and tertiary care?
30 A. Absolutely, yes. I mean, I would see it as the
31 Commonwealth would need to fund that, but whether they
32 would be willing to fund it and give responsibility to that
33 entity I'm uncertain. But certainly the way that the
34 funding for primary care is at the moment through the
35 Commonwealth is not really fit for purpose for failed
36 markets. So thin markets, no, it doesn't - it just doesn't
37 work.
38
39 THE COMMISSIONER: Q. The funding is not fit for the
40 service that is required?
41 A. That's right.
42
43 Q. Because it's an MBS scheme, it's a scheme of
44 schedules?
45 A. Yes.
46
47 MR CHENEY: Q. And again, I think it is clear enough,

1 but the unitary authority that you contemplate would
2 operate only in those areas where the primary care market
3 has failed?
4 A. That's right.
5
6 MR CHENEY: Thank you, Dr Williams.
7
8 THE COMMISSIONER: All right. Nothing emerged out of
9 that?
10
11 MR GLOVER: No, Commissioner.
12
13 THE COMMISSIONER: All right. Thank you very much,
14 doctor, for your time. We're very grateful.
15
16 THE WITNESS: Thank you.
17
18 THE COMMISSIONER: You are excused.
19
20 **<THE WITNESS WITHDREW**
21
22 THE COMMISSIONER: Have we got just one more witness left?
23
24 MR GLOVER: No, that's the evidence.
25
26 THE COMMISSIONER: That's it?
27
28 MR GLOVER: Yes.
29
30 THE COMMISSIONER: Okay. I thought we had one more
31 witness to go.
32
33 MR GLOVER: No.
34
35 THE COMMISSIONER: Okay - oh, there's one that the
36 statement is just being tendered. Sorry about that.
37
38 MR GLOVER: Correct.
39
40 THE COMMISSIONER: So do we adjourn until 10am on
41 Wednesday in Broken Hill for hearings?
42
43 MR GLOVER: We will. Can I just wrap up some documentary
44 matters first?
45
46 THE COMMISSIONER: Yes, please do. You might have to
47 tender - well, someone at some stage will have to now

1 tender the National Health and Hospitals Reform Commission
2 report. Is that in your hand?
3
4 MR GLOVER: It would be a miracle if it were, but no, it
5 is not, but it will be added to the list for this week
6 perhaps.
7
8 THE COMMISSIONER: That should be tendered at some stage.
9 It's June 2009, it's circulating on emails that have been
10 sent to me.
11
12 MR GLOVER: All right. Well, I might even do it this way,
13 Commissioner: can I hand to you a list. If I deal with
14 the list first, Commissioner, in the usual way, there is
15 a tender --
16
17 THE COMMISSIONER: This is the tender bundle?
18
19 MR GLOVER: It is. E.001 to E.086. Can I suggest, given
20 what has just passed, that we mark as E.087 the document
21 that you have just referred to, and we will have that added
22 to the list as well.
23
24 THE COMMISSIONER: All right. We will admit as exhibits
25 all of the documents listed in E.001 to E.086 on a sheet
26 that I have been given, and E.087 can be the final report
27 of the National Health and Hospitals Reform Commission of
28 June 2009.
29
30 MR GLOVER: Thank you, Commissioner. The other thing that
31 you should have been handed is a folder.
32
33 THE COMMISSIONER: The Four Ts model?
34
35 MR GLOVER: The Four Ts model evaluation report. That
36 comes accompanied with a proposed non-publication order.
37
38 THE COMMISSIONER: Yes, just so I know - I'm happy to make
39 it, but what's the reason?
40
41 MR GLOVER: I will tell you immediately. That document
42 was provided to us by our learned friends, and it comes
43 with this issue that the contents of it are the subject of
44 some academic work that is not yet published and is
45 undergoing review, and should we make it public there would
46 be a risk of us interfering with that work, hence the
47 proposed non-publication order.

1
2 THE COMMISSIONER: So it gets admitted into evidence but
3 I make the non-publication order that's in front of me.
4
5 MR GLOVER: Yes, and it would be marked confidential
6 exhibit 6 until further order.
7
8 THE COMMISSIONER: It can be marked as confidential
9 exhibit 6 and I make the order, pursuant to section 8, that
10 is dated 17 May 2024.
11
12 **CONFIDENTIAL EXHIBIT #6 FOUR Ts MODEL EVALUATION REPORT**
13
14 MR GLOVER: Thank you, Commissioner, that completes the
15 documentary matters.
16
17 THE COMMISSIONER: All right. Is there anything else,
18 Mr Cheney?
19
20 MR CHENEY: No, Commissioner.
21
22 THE COMMISSIONER: So I'm right, Wednesday, 10am in Broken
23 Hill? We've got site visits on Monday and Tuesday, I
24 think.
25
26 MR GLOVER: I was querying the 10am time, it is definitely
27 Wednesday, and if it's not 10am, we will tell everybody if
28 it's earlier.
29
30 THE COMMISSIONER: There is no reason that it wouldn't be
31 10am at this stage, is there?
32
33 MR GLOVER: There are two quite full days, but we can
34 address that.
35
36 THE COMMISSIONER: Let's nominally adjourn until 10am on
37 Wednesday - what day of the month is that - at Broken Hill.
38
39 MR GLOVER: I'm told 9.30.
40
41 THE COMMISSIONER: 9.30, is it?
42
43 MR GLOVER; Yes, thank you, Commissioner.
44
45 THE COMMISSIONER: Okay, let's adjourn until 9.30 next
46 Wednesday in Broken Hill.
47

1 MR GLOVER: Thank you, Commissioner.
2
3 THE COMMISSIONER: We'll adjourn until then. Thank you.
4
5 **AT 1.30PM THE SPECIAL COMMISSIONER OF INQUIRY WAS ADJOURNED**
6 **TO WEDNESDAY, 22 MAY 2024 AT 9.30AM**
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**$1,901** [1] - 3061:12
**$48** [1] - 3055:17

## '

**'80s** [1] - 3091:41
**'85** [1] - 3076:44
**'85/'86** [1] - 3077:12
**'86** [1] - 3091:26

## 0

**0.6** [1] - 3095:1
**029** [1] - 3015:25

## 1

**1** [2] - 3062:24, 3073:2
**1,000** [4] - 3023:47, 3024:27, 3025:25, 3027:10
**1.30PM** [1] - 3101:5
**10** [13] - 3019:9, 3022:16, 3022:17, 3035:17, 3035:20, 3037:31, 3044:40, 3046:29, 3075:21, 3082:18, 3089:15, 3091:24, 3093:47
**10-year** [1] - 3069:5
**10.37am** [1] - 3046:1
**100** [2] - 3042:21, 3055:27
**10am** [6] - 3098:40, 3100:22, 3100:26, 3100:27, 3100:31, 3100:36
**11** [4] - 3035:24, 3053:25, 3094:2, 3094:10
**11(a** [1] - 3036:1
**12** [7] - 3022:26, 3035:34, 3035:37, 3037:30, 3071:27, 3071:34
**12.23pm** [1] - 3075:5
**120** [1] - 3047:28
**1200** [1] - 3058:23
**13** [6] - 3035:20, 3036:5, 3073:8, 3082:18, 3082:22, 3093:47
**130,000** [1] - 3060:33
**14** [1] - 3076:19
**140,000** [1] - 3047:28
**15** [2] - 3077:13, 3096:43
**16** [5] - 3058:39, 3059:13, 3059:14, 3076:23, 3076:41
**17** [2] - 3015:23, 3100:10
**17th** [1] - 3055:24
**18** [4] - 3020:1, 3038:40, 3038:41, 3083:28
**19** [3] - 3038:41, 3083:28, 3084:26
**19(2** [8] - 3029:5, 3029:6, 3029:10, 3029:22, 3030:30, 3030:33, 3031:14, 3031:19
**1997** [1] - 3076:44

## 2

**2** [2] - 3027:15, 3073:2
**2.7** [1] - 3061:14
**20** [6] - 3042:18, 3053:24, 3065:14, 3079:34, 3088:7, 3089:2
**200** [4] - 3027:10, 3058:13, 3058:26, 3059:3
**2007** [2] - 3075:16, 3082:30
**2008** [2] - 3046:28, 3051:10
**2009** [5] - 3087:3, 3096:33, 3096:42, 3099:9, 3099:28
**2016** [2] - 3076:3, 3076:8
**2017** [1] - 3046:41
**2019** [2] - 3076:9, 3095:46
**2024** [3] - 3015:23, 3100:10, 3101:6
**21** [4] - 3023:21, 3026:30, 3026:36, 3058:10
**21st** [1] - 3081:22
**22** [7] - 3026:35, 3026:39, 3065:36, 3091:28, 3092:19, 3092:40, 3101:6
**23** [4] - 3023:42, 3024:44, 3032:30, 3065:44
**24** [4] - 3043:7, 3061:12, 3095:27, 3095:28
**240,000** [1] - 3063:40
**25** [4] - 3020:11, 3033:15, 3033:32, 3087:19
**26** [1] - 3070:26
**27** [1] - 3090:14
**279,000** [1] - 3063:29
**28** [2] - 3031:37, 3049:7
**280,000** [1] - 3063:33

## 3

**3** [3] - 3027:16, 3056:10, 3062:24
**3.8** [2] - 3060:44, 3061:41
**30** [2] - 3034:43, 3042:19
**31** [2] - 3041:16, 3041:18
**32** [2] - 3041:16, 3044:11
**35** [2] - 3029:27, 3079:33
**38** [5] - 3016:47, 3023:45, 3024:19, 3026:1, 3077:6

## 4

**4** [6] - 3016:40, 3024:6, 3025:26, 3046:26, 3046:27, 3069:1
**40** [2] - 3077:5, 3095:42
**400** [1] - 3061:29
**43** [1] - 3079:25
**45,000** [2] - 3024:10, 3024:14
**47Ks** [1] - 3084:7

## 5

**5** [6] - 3017:19, 3019:9, 3024:6, 3025:26, 3048:3, 3078:13
**53** [1] - 3076:15
**56** [1] - 3058:22

## 6

**6** [4] - 3027:18, 3100:6, 3100:9, 3100:12
**60** [1] - 3077:9

## 7

**7** [4] - 3019:45, 3027:18, 3053:33, 3058:20
**7(b** [1] - 3020:2

## 8

**8** [1] - 3100:9

## 9

**9.30** [3] - 3100:39, 3100:41, 3100:45
**9.30am** [2] - 3015:23, 3016:7
**9.30AM** [1] - 3101:6
**90** [2] - 3047:39, 3047:43

## A

**abandon** [2] - 3019:27, 3061:36
**Aberdeen** [5] - 3063:39, 3063:40, 3063:41, 3063:43
**ABF** [2] - 3027:24, 3040:47
**ability** [5] - 3045:21, 3049:31, 3076:21, 3087:21, 3094:30
**able** [19] - 3021:36, 3027:42, 3032:42, 3038:27, 3039:25, 3047:35, 3049:25, 3050:27, 3050:29, 3060:33, 3061:3, 3072:46, 3079:40, 3083:20, 3091:16, 3091:44, 3091:45, 3092:42
**Aboriginal** [1] - 3052:32
**absolute** [1] - 3056:8
**absolutely** [15] - 3043:8, 3048:12, 3052:40, 3054:28, 3063:18, 3067:9, 3068:1, 3069:36, 3082:3, 3083:13, 3085:16, 3087:23, 3092:24, 3093:5, 3097:30
**absorb** [2] - 3038:37, 3041:10
**absorbed** [1] - 3040:35
**academic** [1] - 3099:44
**accelerating** [1] - 3077:36
**accent** [1] - 3063:36
**accept** [2] - 3068:12, 3095:19
**accepted** [1] - 3049:10
**access** [45] - 3017:5, 3020:12, 3020:31, 3020:35, 3020:38, 3020:45, 3025:20, 3025:37, 3026:5, 3026:13, 3028:11, 3029:24, 3034:21, 3039:25, 3040:22, 3042:3, 3045:2, 3050:33, 3050:34, 3057:3, 3057:40, 3057:42, 3059:12, 3059:27, 3059:33, 3060:13, 3060:34, 3061:28, 3064:10, 3064:28, 3064:32, 3065:13, 3076:20, 3076:21, 3076:36, 3076:38, 3080:22, 3081:14, 3084:19, 3084:24, 3087:21, 3087:23, 3087:26
**accessible** [1] - 3057:39
**accessing** [2] - 3025:33, 3057:33
**ACCHOs** [1] - 3080:31
**accommodate** [1] - 3049:18
**accompanied** [1] - 3099:36
**accompany** [1] - 3019:10
**account** [1] - 3045:19
**accountability** [1] - 3045:14
**accountable** [2] - 3018:5, 3087:8
**accounting** [1] - 3052:28
**accreditation** [10] - 3047:17, 3048:13, 3048:15, 3048:17, 3049:37, 3049:39, 3051:2, 3051:8, 3051:23, 3052:6
**accredited** [3] - 3048:26, 3071:14, 3071:15
**accurate** [2] - 3027:5, 3031:3
**achievable** [3] - 3058:2, 3060:35, 3071:11
**achieve** [15] - 3035:6, 3041:4, 3044:39, 3056:43, 3057:3, 3057:7, 3057:24,

3058:42, 3059:5, 3067:8, 3069:6, 3083:46, 3083:47, 3092:37
**achieved** [2] - 3069:25, 3094:42
**achievement** [1] - 3094:10
**acknowledge** [8] - 3023:43, 3024:47, 3046:21, 3046:23, 3054:36, 3060:4, 3068:11, 3070:2
**acknowledged** [1] - 3060:38
**acknowledging** [2] - 3022:30, 3066:20
**acknowledgment** [3] - 3029:2, 3037:47, 3068:26
**acquired** [2] - 3021:14, 3073:28
**actively** [1] - 3082:44
**activity** [20] - 3025:3, 3025:5, 3025:7, 3025:15, 3027:25, 3030:38, 3030:42, 3030:45, 3030:46, 3031:13, 3033:42, 3037:45, 3040:38, 3040:39, 3040:41, 3041:2, 3042:30, 3044:25, 3044:33
**Activity** [1] - 3037:45
**activity-based** [1] - 3030:46
**actual** [1] - 3057:47
**acute** [35] - 3016:46, 3017:14, 3018:6, 3019:25, 3021:14, 3024:38, 3025:20, 3028:40, 3029:41, 3029:42, 3029:44, 3030:9, 3032:40, 3033:19, 3041:23, 3043:3, 3044:3, 3047:18, 3047:31, 3047:35, 3048:16, 3048:25, 3050:34, 3053:37, 3054:1, 3057:34, 3061:11, 3062:34, 3067:34, 3069:18, 3071:10, 3083:11, 3094:44
**acute/acute** [1] - 3067:24
**ad** [1] - 3088:28
**add** [2] - 3054:7, 3064:29
**added** [2] - 3099:5, 3099:21
**addition** [6] - 3028:17, 3030:30, 3034:15, 3075:47, 3090:19, 3095:39
**additional** [1] - 3067:8
**address** [12] - 3023:15, 3054:42, 3056:47, 3073:12, 3073:42, 3074:7, 3076:18, 3077:26, 3078:41, 3090:8, 3093:28, 3100:34
**addressed** [2] - 3043:38, 3092:43
**addressing** [2] - 3042:10, 3087:46
**adequate** [1] - 3060:11
**adequately** [1] - 3023:43
**ADHD** [2] - 3038:41, 3044:28
**adjourn** [5] - 3053:25, 3098:40, 3100:36, 3100:45, 3101:3
**adjust** [1] - 3020:42
**adjusting** [1] - 3044:38
**administered** [1] - 3097:18
**administration** [1] - 3089:43
**administrative** [1] - 3089:42
**admission** [1] - 3061:8
**admissions** [1] - 3077:23
**admit** [1] - 3099:24
**admitted** [2] - 3069:31, 3100:2
**admitting** [2] - 3063:5, 3066:17
**adopted** [1] - 3092:40
**Adrian** [1] - 3080:15
**advanced** [6] - 3048:8, 3048:14, 3048:15, 3048:17, 3048:23, 3071:6
**advantageous** [1] - 3080:5
**adverse** [3] - 3073:4, 3073:22, 3073:23
**advertisement** [1] - 3052:47
**advertisements** [1] - 3039:17
**adverts** [1] - 3053:10
**advice** [3] - 3052:43, 3067:42, 3084:9
**Advisory** [1] - 3047:12
**advocate** [1] - 3082:45
**advocates** [1] - 3055:33
**advocating** [1] - 3071:32
**affirmed** [1] - 3046:1
**afraid** [1] - 3054:47
**afternoon** [2] - 3066:31, 3070:23
**aged** [13] - 3017:4, 3017:6, 3019:12, 3019:16, 3019:19, 3019:23, 3019:27, 3034:23, 3041:24, 3042:16, 3042:25, 3042:30, 3043:42
**ageing** [2] - 3019:9, 3019:30
**agencies** [1] - 3020:37
**agency** [8] - 3025:33, 3055:21, 3073:25, 3073:30, 3073:47, 3074:22, 3083:26
**ago** [2] - 3080:16, 3095:41
**agree** [11] - 3022:42, 3023:11, 3025:29, 3025:34, 3028:30, 3030:23, 3041:9, 3044:8, 3045:15, 3085:47, 3088:18
**agreed** [1] - 3034:13
**agreement** [3] - 3044:12, 3068:34, 3079:29
**agreements** [1] - 3068:24
**Ahpra** [1] - 3062:28
**aim** [4] - 3048:24, 3048:34, 3094:11, 3094:42
**aiming** [2] - 3048:25, 3050:2
**airlifting** [1] - 3081:45
**albeit** [2] - 3037:29, 3039:12
**Alfred** [6] - 3048:5, 3048:11, 3048:37, 3050:8, 3050:16, 3068:4
**Alice** [1] - 3049:4
**aligned** [1] - 3022:29
**aligning** [1] - 3038:15
**alleviated** [1] - 3034:30
**Alliance** [1] - 3076:2
**allied** [8] - 3052:29, 3052:30, 3076:33, 3082:7, 3094:32, 3095:11, 3095:12
**allocated** [2] - 3048:42, 3097:29
**allocation** [1] - 3049:23
**allocations** [1] - 3089:1
**allow** [4] - 3044:16, 3080:2, 3083:1, 3083:13
**allowed** [1] - 3067:45
**allows** [1] - 3062:37
**alluded** [1] - 3066:13
**almost** [3] - 3019:47, 3055:20, 3059:15
**alone** [1] - 3048:27
**alternative** [4] - 3025:19, 3026:19, 3029:3, 3031:9
**ambulances** [2] - 3025:31, 3083:5
**amount** [2] - 3028:18, 3057:23
**amounts** [1] - 3086:10
**analysis** [5] - 3059:30, 3065:8, 3068:47, 3073:24, 3080:21
**anatomical** [1] - 3070:21
**ancillary** [1] - 3043:45
**annoys** [1] - 3053:43
**annual** [3] - 3036:20, 3048:6, 3048:39
**annualised** [1] - 3061:43
**answer** [20] - 3025:40, 3035:4, 3040:30, 3042:10, 3051:37, 3059:4, 3059:5, 3063:26, 3063:27, 3065:31, 3067:43, 3074:10, 3079:1, 3079:9, 3081:32, 3082:18, 3085:43, 3087:14, 3087:19, 3094:39
**answerable** [1] - 3096:24
**answered** [1] - 3031:5
**answering** [1] - 3051:35
**answers** [4] - 3037:10, 3059:9, 3091:30, 3096:30
**anticipation** [1] - 3075:29
**apnoea** [3] - 3056:7, 3056:19, 3056:23
**apologise** [1] - 3095:16
**application** [1] - 3057:9
**applied** [2] - 3054:12, 3072:47
**applies** [1] - 3089:11
**apply** [5] - 3018:30, 3018:37, 3052:47, 3061:11, 3088:35
**appoint** [2] - 3053:14, 3067:13
**appointed** [5] - 3021:9, 3052:42, 3056:5, 3062:27, 3095:3
**appointment** [3] - 3017:9, 3062:40, 3090:25
**Appointments** [1] - 3047:12
**appreciate** [1] - 3051:3
**approach** [12] - 3018:3, 3022:19, 3028:47, 3042:9, 3065:39, 3079:15, 3080:30, 3081:12, 3091:36, 3092:39, 3094:27, 3095:41
**approaches** [3] - 3038:11, 3038:23, 3044:18
**appropriate** [11] - 3025:36, 3026:43, 3029:28, 3029:43, 3040:10, 3042:1, 3042:7, 3044:27, 3045:3, 3045:23, 3061:20
**appropriately** [1] - 3021:18
**approved** [1] - 3056:14
**area** [26] - 3016:42, 3019:37, 3021:8, 3022:43, 3028:9, 3051:4, 3056:25, 3058:28, 3059:28, 3065:12, 3066:12, 3067:22, 3068:7, 3071:31, 3071:32, 3072:32, 3073:33, 3074:19, 3074:27, 3076:12, 3076:15, 3086:44, 3091:20, 3092:11, 3095:43
**areas** [22] - 3017:42, 3018:10, 3018:20, 3019:2, 3020:8, 3020:21, 3022:22,

3022:28, 3048:15, 3052:30, 3056:42, 3064:32, 3067:1, 3067:3, 3072:15, 3074:17, 3074:21, 3084:15, 3085:19, 3092:43, 3093:33, 3098:2
**arena** [1] - 3018:26
**argue** [4] - 3022:5, 3022:23, 3031:2, 3037:17
**argument** [3] - 3036:45, 3037:22, 3058:31
**arise** [1] - 3053:40
**arithmetic** [1] - 3061:13
**arm** [2] - 3081:20, 3082:43
**arms** [1] - 3096:24
**Arnold** [5] - 3035:1, 3035:2, 3051:2, 3052:10, 3052:11
**arrangement** [5] - 3027:23, 3032:43, 3037:44, 3038:45, 3039:28
**arrangements** [9] - 3025:12, 3025:20, 3027:24, 3032:31, 3032:39, 3033:14, 3033:16, 3034:1, 3039:39
**arrive** [1] - 3025:31
**arrived** [1] - 3060:43
**arriving** [2] - 3060:46, 3070:5
**aside** [4] - 3027:47, 3038:9, 3038:19, 3066:43
**aspect** [3] - 3042:42, 3073:30, 3074:7
**aspects** [4] - 3051:39, 3057:11, 3065:34, 3074:8
**assess** [1] - 3065:24
**assessment** [5] - 3017:41, 3018:18, 3019:34, 3019:41, 3041:9
**asset** [1] - 3042:6
**assist** [2] - 3028:39, 3029:1
**assistance** [1] - 3017:41
**Assisting** [4] - 3015:27, 3015:28, 3015:29, 3015:30
**assists** [1] - 3023:1
**associated** [5] - 3036:18, 3036:20, 3042:27, 3044:13, 3072:41
**associates** [2] - 3079:23, 3080:10
**Association** [1] - 3057:30
**assume** [8] - 3024:13, 3024:14, 3024:19, 3031:43, 3052:33, 3058:47, 3085:8, 3096:36
**assumed** [2] - 3037:2, 3081:4
**assumes** [1] - 3043:17
**assuming** [2] - 3083:32, 3089:19
**assumption** [2] - 3023:38, 3023:40
**assure** [1] - 3063:15
**AT** [2] - 3101:5, 3101:6
**attack** [1] - 3057:37
**attempt** [1] - 3039:14
**attempted** [1] - 3020:42
**attempting** [1] - 3027:1
**attempts** [2] - 3051:21, 3085:44
**attend** [1] - 3081:35
**attended** [2] - 3057:31, 3071:45
**attending** [1] - 3047:8
**attention** [3] - 3036:14, 3044:12, 3082:21
**attitude** [1] - 3069:44
**attitudes** [1] - 3078:1
**attract** [3] - 3032:42, 3036:27, 3044:36
**attracting** [2] - 3023:10, 3067:11
**attractive** [1] - 3033:9
**attribute** [1] - 3068:20
**Australia** [3] - 3063:12, 3077:3, 3077:11
**Australian** [2] - 3057:30, 3076:47
**authority** [9] - 3065:12, 3083:40, 3084:44, 3087:13, 3096:19, 3096:22, 3097:7, 3097:27, 3098:1
**autonomy** [5] - 3050:28, 3050:33, 3094:12, 3094:30, 3095:9
**availability** [1] - 3019:35
**available** [8] - 3028:27, 3042:6, 3049:3, 3059:32, 3066:11, 3066:42, 3084:16, 3088:46
**avenue** [1] - 3040:14
**avenues** [2] - 3029:4, 3037:16
**average** [1] - 3027:16
**aware** [9] - 3019:40, 3020:8, 3024:6, 3026:12, 3042:36, 3042:38, 3051:28, 3064:24, 3072:7

## B

**b)** [1] - 3026:46
**back-up** [1] - 3065:19
**backgrounds** [4] - 3052:25, 3052:26, 3052:28, 3052:29
**balance** [1] - 3044:31
**balanced** [1] - 3054:34
**ball** [1] - 3080:46
**bandaid** [1] - 3081:12
**bar** [1] - 3069:39
**barometer** [1] - 3054:29
**barriers** [1] - 3094:41
**base** [2] - 3021:41, 3027:38
**based** [31] - 3017:2, 3017:12, 3017:34, 3023:1, 3025:3, 3030:38, 3030:42, 3030:46, 3031:13, 3032:11, 3032:18, 3032:19, 3032:42, 3037:45, 3039:36, 3040:41, 3042:5, 3044:25, 3044:33, 3052:39, 3056:9, 3056:28, 3057:38, 3065:27, 3066:35, 3069:22, 3078:25, 3080:25, 3088:23, 3089:41
**baseline** [1] - 3025:8
**basic** [14] - 3048:8, 3048:11, 3048:21, 3048:46, 3049:1, 3049:20, 3049:37, 3049:39, 3050:7, 3050:44, 3051:22, 3051:40, 3057:40, 3065:8
**basis** [9] - 3025:14, 3029:12, 3029:20, 3029:23, 3031:23, 3036:45, 3040:5, 3040:34, 3066:2
**Bathurst** [20] - 3019:22, 3020:16, 3023:30, 3023:32, 3024:16, 3027:19, 3044:35, 3050:4, 3050:6, 3051:3, 3051:16, 3051:39, 3052:19, 3064:45, 3072:6, 3076:32, 3083:4, 3089:3, 3089:24
**beach** [1] - 3089:15
**bearing** [2] - 3066:7, 3091:2
**Beasley** [1] - 3015:14
**beaten** [1] - 3063:26
**become** [5] - 3020:29, 3054:41, 3079:11, 3089:8, 3096:18
**becomes** [2] - 3064:38, 3081:9
**becoming** [4] - 3042:11, 3050:46, 3063:22, 3092:13
**bed** [4] - 3021:40, 3061:9, 3061:11, 3061:39
**beds** [9] - 3019:19, 3021:15, 3024:39, 3029:44, 3029:45, 3042:16, 3042:25, 3094:45, 3095:5
**beginning** [2] - 3079:18, 3079:30
**behaviours** [1] - 3057:18
**belief** [5] - 3047:24, 3051:39, 3051:45, 3061:11, 3070:41
**below** [1] - 3073:38
**benefit** [13] - 3028:10, 3028:30, 3033:11, 3037:11, 3039:28, 3061:22, 3079:39, 3081:42, 3082:12, 3085:13, 3085:34, 3097:8
**benefits** [5] - 3028:33, 3035:24, 3050:14, 3084:4, 3094:6
**best** [12] - 3021:41, 3023:9, 3025:45, 3053:3, 3053:11, 3069:16, 3071:9, 3085:38, 3091:42, 3094:11, 3094:26
**Better** [2] - 3061:17, 3061:38
**better** [13] - 3025:26, 3053:5, 3053:14, 3056:46, 3057:1, 3065:12, 3067:14, 3078:24, 3085:22, 3087:31, 3094:22, 3095:10, 3095:31
**between** [11] - 3021:10, 3021:20, 3034:29, 3047:28, 3050:6, 3060:23, 3069:17, 3080:44, 3082:28, 3082:31, 3087:5
**beyond** [4] - 3024:28, 3047:38, 3059:27, 3061:19
**biased** [1] - 3049:45
**big** [4] - 3019:22, 3076:29, 3077:44, 3090:10
**bigger** [1] - 3084:47
**biggest** [1] - 3055:23
**bill** [3] - 3063:3, 3065:15
**billed** [2] - 3034:17, 3069:24
**billing** [2] - 3077:43, 3087:30
**billion** [1] - 3053:18
**biopsies** [1] - 3070:20
**biopsy** [1] - 3070:22
**bit** [11] - 3016:40, 3017:22, 3048:45, 3052:24, 3059:19, 3063:13, 3063:22, 3063:29, 3069:26, 3071:4, 3086:36
**blah** [3] - 3067:45
**blame** [4] - 3068:20, 3068:25, 3082:31, 3096:31
**blanket** [1] - 3086:41
**Blayney** [5] - 3018:27, 3019:7, 3019:11, 3019:14, 3019:21
**blended** [1] - 3078:21
**block** [4] - 3036:25, 3036:27, 3037:15, 3078:21
**blockades** [1] - 3090:41
**blocks** [1] - 3064:22
**blowing** [2] - 3064:35
**blue** [1] - 3091:26
**board** [40] - 3046:39,

3046:40, 3047:2, 3047:6, 3047:7, 3052:7, 3052:23, 3052:25, 3052:43, 3052:45, 3053:2, 3053:11, 3053:15, 3053:32, 3053:34, 3053:36, 3053:39, 3053:43, 3053:47, 3054:5, 3054:13, 3054:23, 3054:25, 3054:26, 3054:41, 3055:22, 3063:46, 3067:30, 3067:39, 3072:1, 3076:2, 3076:8, 3080:42, 3080:43, 3082:8, 3085:16, 3085:18, 3090:26, 3092:28
**boards** [3] - 3052:42, 3085:18, 3089:43
**body** [1] - 3058:5
**boil** [1] - 3042:47
**bombastic** [1] - 3070:45
**boots** [3] - 3054:5, 3054:19, 3089:38
**born** [1] - 3063:40
**bothering** [1] - 3090:43
**bottom** [1] - 3044:31
**boundary** [1] - 3027:14
**Bourke** [2] - 3064:9, 3069:3
**bow** [1] - 3071:18
**bow-tie** [1] - 3071:18
**box** [2] - 3016:4, 3037:44
**BPT** [1] - 3048:20
**BPTs** [2] - 3051:5, 3051:40
**brainstorming** [1] - 3057:32
**break** [8] - 3036:34, 3045:13, 3046:19, 3053:22, 3053:24, 3053:31, 3067:32, 3077:30
**breed** [1] - 3064:26
**Brewarrina** [13] - 3058:14, 3058:19, 3058:22, 3058:24, 3058:36, 3058:40, 3058:43, 3059:18, 3059:34, 3059:39, 3060:13, 3064:9, 3083:47
**briefly** [5] - 3034:42, 3076:1, 3091:28, 3097:2, 3097:6
**bring** [6] - 3019:1, 3019:5, 3052:21, 3053:10, 3072:9, 3092:27
**bringing** [2] - 3067:10, 3082:7
**brings** [1] - 3016:44
**Brisbane** [1] - 3015:19
**broad** [3] - 3017:46, 3025:7, 3053:8
**broader** [3] - 3017:31, 3019:41, 3022:5
**broadly** [3] - 3018:10, 3059:4, 3067:35
**broke** [1] - 3087:28
**broken** [1] - 3059:17
**Broken** [6] - 3076:32, 3083:4, 3098:41, 3100:22, 3100:37, 3100:46
**brought** [2] - 3016:23, 3025:41
**buck** [1] - 3083:35
**budget** [9] - 3037:26, 3041:11, 3044:13, 3044:15, 3044:39, 3055:29, 3055:41, 3077:40, 3095:7
**build** [3] - 3039:35, 3056:4, 3093:7
**build-up** [1] - 3039:35
**building** [5] - 3026:35, 3059:36, 3062:3, 3067:15, 3078:47
**built** [5] - 3019:20, 3058:41, 3086:16, 3086:17, 3086:18
**bulk** [4] - 3046:36, 3065:15, 3069:24, 3077:43
**bulk-billed** [1] - 3069:24
**bullous** [2] - 3069:32, 3069:37
**bunch** [1] - 3071:20
**bundle** [1] - 3099:17
**burden** [1] - 3044:3
**burning** [1] - 3081:16
**business** [11] - 3017:22, 3018:4, 3019:12, 3022:24, 3036:16, 3037:18, 3041:3, 3056:12, 3078:9, 3079:11, 3080:8
**busy** [1] - 3032:44
**buy** [1] - 3091:45
**BY** [4] - 3016:9, 3046:3, 3075:7, 3097:4
**by-laws** [1] - 3047:9
**by-product** [1] - 3030:5

## C

**calendar** [1] - 3049:7
**calibre** [1] - 3033:8
**Camperdown** [1] - 3048:43
**campus** [1] - 3018:2
**capabilities** [1] - 3084:5
**capacity** [9] - 3021:40, 3041:10, 3042:21, 3056:4, 3058:41, 3059:36, 3062:2, 3067:15, 3071:8
**capita** [1] - 3093:32
**capital** [7] - 3018:26, 3036:16, 3036:37, 3036:39, 3037:18, 3038:15, 3038:16
**capture** [1] - 3040:38
**capturing** [1] - 3030:45
**cardiologist** [4] - 3062:13, 3062:18, 3062:33, 3062:45
**cardiology** [7] - 3020:46, 3060:28, 3062:23, 3071:3, 3071:6, 3071:10, 3071:16
**Cardiovascular** [1] - 3057:30
**cardiovascular** [1] - 3083:21
**care** [149] - 3017:4, 3017:6, 3017:36, 3019:12, 3019:19, 3019:28, 3020:13, 3020:34, 3025:37, 3028:11, 3028:42, 3029:31, 3029:38, 3030:26, 3030:34, 3032:8, 3034:23, 3034:32, 3038:11, 3041:23, 3041:24, 3041:32, 3042:16, 3042:25, 3042:30, 3043:9, 3043:25, 3043:39, 3043:42, 3044:18, 3047:31, 3047:38, 3047:41, 3050:24, 3050:34, 3052:3, 3054:46, 3055:3, 3055:32, 3055:34, 3056:26, 3056:30, 3056:39, 3057:2, 3057:3, 3057:5, 3057:6, 3057:10, 3057:40, 3058:40, 3058:43, 3059:6, 3059:12, 3059:13, 3059:16, 3059:23, 3059:27, 3059:28, 3059:38, 3059:40, 3059:45, 3059:46, 3059:47, 3060:3, 3060:10, 3060:11, 3060:13, 3060:16, 3060:22, 3060:36, 3060:37, 3061:3, 3061:11, 3061:17, 3061:19, 3061:38, 3062:5, 3065:13, 3066:39, 3066:42, 3066:45, 3067:24, 3067:26, 3067:34, 3069:10, 3069:43, 3071:26, 3071:30, 3073:14, 3076:20, 3076:21, 3076:23, 3076:28, 3076:29, 3076:30, 3076:31, 3076:42, 3077:18, 3077:26, 3078:5, 3078:10, 3078:34, 3078:37, 3078:40, 3079:3, 3079:4, 3079:30, 3080:25, 3081:5, 3081:8, 3081:12, 3081:18, 3081:26, 3081:29, 3081:33, 3081:36, 3081:39, 3082:3, 3082:9, 3082:33, 3082:42, 3083:9, 3083:12, 3083:13, 3083:24, 3083:27, 3084:1, 3084:19, 3084:43, 3085:2, 3085:33, 3086:7, 3086:10, 3087:14, 3093:2, 3093:3, 3093:46, 3094:6, 3095:18, 3096:19, 3096:37, 3097:21, 3097:29, 3097:34, 3098:2
**care"** [1] - 3082:45
**care/primary** [1] - 3067:26
**career** [4] - 3055:47, 3090:42, 3091:10, 3092:3
**careful** [1] - 3082:47
**Carey** [10] - 3016:4, 3016:11, 3016:13, 3016:39, 3017:19, 3026:29, 3032:30, 3041:14, 3044:11, 3045:28
**CAREY** [1] - 3016:7
**carriage** [2] - 3084:45, 3085:2
**carry** [1] - 3080:8
**case** [13] - 3021:24, 3022:9, 3036:16, 3036:35, 3037:18, 3056:12, 3056:40, 3070:16, 3073:45, 3074:3, 3082:7, 3088:38, 3088:47
**cases** [2] - 3037:32, 3041:38
**CAT** [1] - 3083:47
**catastrophe** [3] - 3051:21, 3064:38, 3064:39
**catchment** [7] - 3047:24, 3047:26, 3047:28, 3060:33, 3068:7
**categories** [1] - 3066:44
**category** [1] - 3024:6
**causing** [1] - 3057:19
**CEC's** [1] - 3072:2
**cent** [12] - 3027:16, 3027:18, 3033:15, 3042:19, 3042:21, 3047:39, 3047:43, 3058:22, 3061:29, 3076:15, 3077:9, 3077:13
**central** [3] - 3046:31, 3058:14, 3064:31
**centre** [6] - 3018:19, 3027:31, 3035:14, 3067:40, 3068:3, 3089:29
**centres** [5] - 3019:22, 3020:22, 3044:46, 3060:27, 3084:47
**centric** [1] - 3071:19
**century** [1] - 3081:22
**CEO** [1] - 3056:21
**certain** [6] - 3021:15, 3029:38, 3050:38, 3059:33, 3086:27, 3088:36
**certainly** [32] - 3018:37, 3018:38, 3019:14, 3019:24, 3019:41, 3021:10, 3021:27, 3024:4, 3025:13, 3033:28,

3034:34, 3035:2, 3042:38, 3052:16, 3054:15, 3055:24, 3076:39, 3077:35, 3078:14, 3078:34, 3079:13, 3079:17, 3082:29, 3083:42, 3086:9, 3086:43, 3090:29, 3091:4, 3091:11, 3094:16, 3094:43, 3097:33
**CEs** [1] - 3085:19
**cetera** [8] - 3017:22, 3066:44, 3083:6, 3084:33, 3094:46, 3095:34
**chain** [2] - 3094:23, 3095:9
**chair** [7] - 3046:43, 3052:43, 3053:2, 3071:26, 3076:2, 3076:8, 3081:6
**chaired** [1] - 3071:46
**chairman** [1] - 3097:9
**chairmanship** [1] - 3097:13
**chairs** [2] - 3058:23, 3085:18
**challenge** [3] - 3026:35, 3026:37, 3027:41
**challenged** [1] - 3040:25
**challenges** [11] - 3023:16, 3027:1, 3028:2, 3028:39, 3028:46, 3034:28, 3037:6, 3050:11, 3054:30, 3056:40, 3083:33
**challenging** [1] - 3090:15
**chance** [3] - 3016:26, 3046:13, 3075:33
**change** [21] - 3043:2, 3050:19, 3051:28, 3056:44, 3057:18, 3057:41, 3059:25, 3062:11, 3063:11, 3069:44, 3070:41, 3073:18, 3073:33, 3073:43, 3074:18, 3074:27, 3074:29, 3077:45, 3078:1, 3080:7, 3089:20
**changed** [6] - 3030:31, 3052:21, 3078:26, 3082:13, 3082:15
**changes** [6] - 3023:27, 3025:9, 3026:36, 3028:47, 3077:39, 3082:39
**charged** [1] - 3083:41
**Charles** [1] - 3090:21
**cheap** [1] - 3093:40
**cheaper** [3] - 3061:37, 3062:6, 3081:43
**Cheney** [5] - 3015:35, 3045:30, 3074:36, 3096:46, 3100:18
**CHENEY** [8] - 3045:32, 3074:39, 3097:2, 3097:4, 3097:6, 3097:47, 3098:6, 3100:20
**chief** [3] - 3051:1, 3052:11, 3055:16
**child** [1] - 3017:3
**children** [1] - 3040:23
**Children's** [3] - 3038:46, 3039:22, 3039:39
**children's** [3] - 3039:6, 3039:19, 3039:33
**choice** [2] - 3035:45, 3049:9
**choices** [1] - 3049:3
**chops** [1] - 3071:4
**chose** [1] - 3049:21
**chronic** [2] - 3058:40, 3081:39
**circulating** [1] - 3099:9
**circumstances** [2] - 3044:15, 3045:18
**city** [1] - 3090:44
**claiming** [1] - 3093:40
**clarify** [1] - 3048:7
**classified** [1] - 3058:21
**clean** [1] - 3040:37
**clear** [16] - 3022:10, 3031:10, 3032:4, 3036:27, 3038:14, 3038:19, 3040:31, 3042:44, 3043:8, 3067:27, 3094:45, 3095:4, 3095:28, 3096:29, 3097:21, 3097:47
**clearer** [2] - 3025:38, 3069:43
**clearly** [3] - 3019:15, 3022:29, 3071:41
**click** [2] - 3067:45, 3068:17
**cliff** [1] - 3043:29
**clinic** [2] - 3064:13, 3069:23
**clinical** [41] - 3017:32, 3017:44, 3018:2, 3018:8, 3021:45, 3022:3, 3022:12, 3022:15, 3022:18, 3022:26, 3022:27, 3022:31, 3022:37, 3022:41, 3023:1, 3038:35, 3039:1, 3039:15, 3039:22, 3039:37, 3048:32, 3049:32, 3053:35, 3055:47, 3061:1, 3061:31, 3061:35, 3067:38, 3071:14, 3071:44, 3072:1, 3072:8, 3072:12, 3072:14, 3072:19, 3072:24, 3072:30, 3078:10, 3079:25
**clinically** [1] - 3080:17
**clinician** [16] - 3022:36, 3047:7, 3052:27, 3053:42, 3055:25, 3056:33, 3058:39, 3059:17, 3067:38, 3068:7, 3073:4, 3074:16, 3082:23, 3084:16, 3086:37
**clinician's** [2] - 3073:3, 3087:20
**clinicians** [15] - 3018:44, 3022:11, 3023:8, 3033:8, 3033:12, 3040:18, 3069:5, 3084:18, 3088:45, 3089:10, 3090:17, 3093:34, 3094:11, 3094:27, 3094:31
**clinics** [1] - 3029:38
**close** [4] - 3035:8, 3035:12, 3082:21, 3094:1
**closed** [1] - 3024:30
**closely** [2] - 3050:22, 3086:45
**Cnr** [1] - 3015:19
**co** [1] - 3084:29
**co-design** [1] - 3084:29
**Cobonne** [2] - 3086:16, 3086:19
**coerced** [1] - 3064:4
**coexist** [1] - 3027:26
**cohort** [3] - 3050:28, 3077:9, 3078:17
**coinciding** [1] - 3076:12
**COLIN** [1] - 3046:1
**Colin** [2] - 3046:7, 3089:10
**collaborate** [1] - 3018:41
**collaboration** [1] - 3086:16
**collapse** [1] - 3083:20
**colleague** [2] - 3071:46, 3080:15
**colleagues** [1] - 3068:31
**collectively** [1] - 3079:24
**college** [2] - 3051:2, 3092:20
**College** [5] - 3047:17, 3048:13, 3062:27, 3070:42, 3070:43
**colleges** [1] - 3090:1
**collocated** [2] - 3078:34, 3086:43
**collocation** [1] - 3041:39
**combination** [2] - 3023:35, 3057:41
**comfortable** [2] - 3046:32, 3080:3
**comforting** [1] - 3092:3
**coming** [17] - 3023:33, 3034:16, 3055:34, 3062:38, 3064:11, 3067:31, 3068:42, 3068:45, 3070:12, 3070:32, 3071:5, 3071:18, 3078:8, 3078:18, 3085:14, 3095:32, 3096:10
**command** [2] - 3066:11, 3066:22
**commenced** [1] - 3046:41
**comment** [3] - 3019:29, 3019:38, 3027:4
**Commission** [4] - 3015:7, 3096:33, 3099:1, 3099:27
**commissioner** [1] - 3016:34
**Commissioner** [24] - 3015:13, 3016:3, 3028:1, 3041:16, 3041:29, 3045:32, 3045:43, 3046:35, 3053:21, 3055:47, 3059:44, 3062:12, 3074:33, 3074:39, 3075:41, 3088:6, 3098:11, 3099:13, 3099:14, 3099:30, 3100:14, 3100:20, 3100:43, 3101:1
**COMMISSIONER** [55] - 3016:1, 3016:37, 3023:21, 3023:26, 3026:27, 3031:17, 3031:46, 3032:3, 3035:36, 3035:42, 3042:47, 3045:30, 3045:34, 3053:24, 3053:29, 3055:38, 3060:9, 3065:4, 3065:29, 3074:36, 3074:41, 3074:46, 3075:44, 3082:37, 3088:9, 3092:46, 3093:16, 3093:37, 3096:29, 3096:46, 3097:39, 3098:8, 3098:13, 3098:18, 3098:22, 3098:26, 3098:30, 3098:35, 3098:40, 3098:46, 3099:8, 3099:17, 3099:24, 3099:33, 3099:38, 3100:2, 3100:8, 3100:17, 3100:22, 3100:30, 3100:36, 3100:41, 3100:45, 3101:3, 3101:5
**Commissioner's** [1] - 3065:33
**commissioners** [1] - 3084:43
**commitment** [3] - 3040:4, 3049:27, 3066:40
**commitments** [2] - 3038:16, 3052:34
**committed** [1] - 3056:1
**committee** [7] - 3046:44, 3047:1, 3071:3, 3071:26, 3071:27, 3073:8, 3074:6
**Committee** [1] - 3047:12
**committees** [1] - 3070:42
**common** [7] - 3029:24, 3054:14, 3054:47, 3067:15, 3068:28, 3085:19, 3085:20
**commonsense** [1] -

3071:4
**Commonwealth** [24] - 3029:9, 3030:38, 3030:40, 3030:43, 3030:46, 3034:29, 3042:15, 3042:37, 3042:43, 3043:13, 3057:33, 3080:44, 3081:5, 3082:28, 3082:31, 3082:33, 3083:37, 3085:29, 3087:29, 3096:36, 3097:23, 3097:28, 3097:31, 3097:35
**communications** [1] - 3025:44
**communities** [25] - 3019:39, 3019:41, 3020:11, 3020:36, 3026:5, 3028:12, 3028:14, 3029:21, 3030:1, 3030:3, 3031:5, 3041:36, 3041:45, 3059:7, 3080:26, 3083:44, 3085:35, 3085:36, 3087:14, 3089:4, 3092:30, 3092:35, 3094:6, 3094:26
**community** [57] - 3017:2, 3017:3, 3017:12, 3018:22, 3018:39, 3018:42, 3019:22, 3019:31, 3021:19, 3025:35, 3025:36, 3025:40, 3026:9, 3026:12, 3026:16, 3026:19, 3027:9, 3028:5, 3028:8, 3028:10, 3028:13, 3028:17, 3028:19, 3028:22, 3028:30, 3028:34, 3028:42, 3029:6, 3029:12, 3031:22, 3033:11, 3033:27, 3042:2, 3042:5, 3042:17, 3045:1, 3046:30, 3054:14, 3060:2, 3061:3, 3061:23, 3066:34, 3076:34, 3078:35, 3081:34, 3081:38, 3082:2, 3084:31, 3086:7, 3086:42, 3086:45, 3087:5, 3088:36, 3088:45, 3092:29, 3093:1, 3094:20
**community-based** [3] - 3017:2, 3017:12, 3042:5
**compare** [1] - 3027:15
**competing** [1] - 3097:17
**complaints** [1] - 3046:44
**complement** [1] - 3019:6
**complementary** [1] - 3060:35
**complements** [2] - 3030:8, 3059:38
**complete** [2] - 3055:47, 3066:22
**completely** [4] - 3026:18, 3030:41, 3064:29, 3087:4
**completes** [1] - 3100:14
**complex** [6] - 3037:34, 3040:40, 3047:45, 3060:18, 3066:8
**complexity** [1] - 3066:20
**complicated** [3] - 3031:8, 3059:44, 3059:45
**complication** [1] - 3072:41
**complications** [2] - 3073:29, 3074:5
**component** [9] - 3019:12, 3019:28, 3025:7, 3037:16, 3042:30, 3045:8, 3047:32, 3089:46, 3090:5
**components** [2] - 3044:26, 3045:10
**composite** [1] - 3089:2
**compounding** [1] - 3038:31
**concept** [6] - 3034:38, 3034:39, 3083:12, 3083:30, 3085:12, 3091:31
**concepts** [2] - 3077:30, 3078:47
**concern** [4] - 3026:18, 3033:32, 3033:34, 3039:44
**concerning** [2] - 3073:17, 3074:5
**condition** [5] - 3069:28, 3069:31, 3069:34, 3082:11, 3082:24
**conducting** [1] - 3035:42
**conference** [1] - 3082:7
**confidential** [2] - 3100:5, 3100:8
**CONFIDENTIAL** [1] - 3100:12
**confusion** [1] - 3026:7
**congregate** [2] - 3076:37, 3088:37
**connect** [1] - 3022:4
**connected** [4] - 3019:21, 3041:46, 3042:39, 3042:43
**connecting** [1] - 3022:11
**connection** [2] - 3033:17, 3040:46
**conscript** [1] - 3063:12
**consequently** [2] - 3078:17, 3081:10
**consider** [2] - 3023:4, 3034:40
**considerable** [1] - 3037:11
**considerably** [1] - 3082:15
**consideration** [6] - 3033:26, 3037:13, 3041:5, 3041:43, 3045:6, 3045:10
**considered** [5] - 3028:21, 3029:31, 3030:26, 3036:6, 3040:47
**considers** [2] - 3025:7, 3027:13
**consistency** [1] - 3022:12
**consistent** [2] - 3033:20, 3035:10
**constrained** [1] - 3021:15
**constraints** [1] - 3037:25
**construct** [1] - 3048:33
**consult** [2] - 3018:10, 3018:41
**consultation** [4] - 3028:18, 3064:14, 3064:24, 3069:18
**consultative** [1] - 3067:24
**consulting** [1] - 3064:34
**consumables** [1] - 3036:20
**consuming** [1] - 3074:28
**contemplate** [1] - 3098:1
**contemporary** [1] - 3078:33
**content** [1] - 3046:17
**contents** [2] - 3016:30, 3099:43
**context** [2] - 3019:36, 3076:28
**continue** [8] - 3027:26, 3031:8, 3040:28, 3040:36, 3041:47, 3044:4, 3064:34, 3086:21
**continued** [1] - 3042:3
**continuing** [2] - 3070:12, 3074:30
**contract** [5] - 3029:46, 3030:5, 3030:18, 3095:26, 3095:35
**contracted** [4] - 3030:5, 3033:16, 3048:47, 3095:36
**contractor** [1] - 3055:35
**contractors** [1] - 3071:31
**contracts** [3] - 3049:1, 3049:35, 3067:27
**contrast** [1] - 3024:9
**contribute** [1] - 3030:39
**contributing** [1] - 3074:18
**control** [8] - 3060:47, 3061:2, 3061:22, 3061:31, 3066:11, 3066:22, 3082:27, 3086:3
**controlled** [1] - 3059:15
**convened** [1] - 3074:12
**convention** [1] - 3046:19
**conventionally** [1] - 3047:33
**conversation** [4] - 3026:16, 3028:4, 3068:13, 3085:47
**conversations** [2] - 3018:14, 3018:45
**convert** [1] - 3087:28
**convinced** [1] - 3031:14
**convincing** [1] - 3057:44
**cooperation** [3] - 3021:10, 3021:20, 3021:24
**cope** [2] - 3027:32, 3044:46
**copy** [4] - 3016:24, 3016:25, 3046:9, 3075:42
**core** [3] - 3019:24, 3043:1, 3092:33
**corporate** [2] - 3019:42, 3029:18
**correct** [40] - 3016:31, 3017:10, 3024:17, 3024:24, 3026:24, 3028:17, 3028:27, 3028:35, 3029:31, 3030:13, 3032:28, 3033:2, 3036:36, 3036:40, 3039:2, 3043:4, 3043:10, 3043:14, 3043:18, 3043:22, 3043:26, 3043:35, 3043:46, 3044:4, 3046:10, 3046:16, 3046:40, 3047:16, 3054:16, 3060:24, 3068:35, 3075:17, 3075:30, 3075:37, 3076:3, 3082:2, 3088:24, 3093:9, 3096:12, 3098:38
**corridor** [2] - 3086:46, 3086:47
**cost** [38] - 3023:44, 3025:1, 3025:8, 3027:9, 3027:10, 3027:29, 3027:30, 3027:33, 3030:21, 3033:46, 3036:18, 3036:29, 3037:3, 3038:15, 3039:37, 3039:39, 3040:16, 3042:24, 3042:29, 3042:45, 3044:38, 3044:43, 3044:47, 3045:8, 3055:20, 3055:29, 3055:30, 3061:14, 3061:25, 3061:26, 3061:31, 3061:32, 3061:33, 3062:1, 3070:4, 3070:5, 3074:8, 3093:43
**costing** [1] - 3043:2
**costs** [6] - 3027:43, 3031:4, 3033:37, 3037:19, 3038:34, 3042:27
**cottage** [1] - 3078:5

**council** [2] - 3086:16, 3090:24
**Counsel** [4] - 3015:27, 3015:28, 3015:29, 3015:30
**counterpart** [1] - 3039:19
**counterparts** [1] - 3042:37
**counting** [1] - 3046:28
**country** [10] - 3025:13, 3048:32, 3051:44, 3059:31, 3060:14, 3071:20, 3073:5, 3085:23, 3086:34, 3089:16
**couple** [5] - 3060:41, 3065:34, 3071:24, 3080:15, 3093:46
**course** [29] - 3016:35, 3023:16, 3033:41, 3046:36, 3048:47, 3049:5, 3050:12, 3050:35, 3050:43, 3051:32, 3051:46, 3052:13, 3053:8, 3054:24, 3055:6, 3055:13, 3056:6, 3056:15, 3057:6, 3057:10, 3066:47, 3070:13, 3070:16, 3070:43, 3072:31, 3073:1, 3073:42, 3075:40, 3090:31
**cover** [7] - 3036:29, 3037:3, 3039:39, 3040:16, 3042:29, 3072:22, 3074:16
**covered** [4] - 3032:33, 3041:29, 3065:32, 3076:1
**covering** [2] - 3026:31, 3042:45
**covers** [4] - 3042:24, 3047:26, 3076:11, 3080:22
**COVID** [4] - 3070:21, 3082:15, 3084:4
**COVID-19** [1] - 3070:17
**craft** [1] - 3092:12
**crazy** [1] - 3082:23
**create** [4] - 3031:12, 3036:17, 3037:34, 3064:5
**created** [3] - 3028:21, 3064:10, 3069:23
**creating** [2] - 3017:16, 3027:19
**crisis** [5] - 3077:7, 3077:15, 3084:31, 3084:40, 3095:19
**critical** [3] - 3064:40, 3065:22, 3082:1
**CSU** [2] - 3090:23, 3090:24
**CT** [3] - 3035:20, 3038:9, 3038:21
**Cudal** [1] - 3086:20
**cure** [1] - 3081:44
**current** [18] - 3018:12, 3026:41, 3027:13, 3030:16, 3032:39, 3036:7, 3036:22, 3037:14, 3038:31, 3045:19, 3049:37, 3050:20, 3055:18, 3057:2, 3057:9, 3061:11, 3068:22, 3069:3
**cut** [1] - 3053:45
**CV** [1] - 3080:36
**CVA** [1] - 3081:45

## D

**Das** [1] - 3052:17
**dashboard** [1] - 3057:38
**dastardly** [1] - 3051:45
**data** [9] - 3017:34, 3018:15, 3018:30, 3019:6, 3023:39, 3024:19, 3073:13, 3074:18, 3087:7
**data-based** [1] - 3017:34
**date** [1] - 3080:16
**dated** [1] - 3100:10
**days** [8] - 3021:13, 3046:28, 3069:22, 3084:8, 3084:14, 3090:45, 3091:1, 3100:33
**deafening** [1] - 3094:24
**deal** [6] - 3055:7, 3057:20, 3077:22, 3079:35, 3083:21, 3099:13
**dealing** [2] - 3047:24, 3077:31
**dear** [1] - 3087:35
**death** [1] - 3088:34
**decade** [1] - 3061:19
**decide** [1] - 3066:14
**decides** [1] - 3085:30
**deciding** [2] - 3065:42, 3065:44
**decision** [7] - 3017:15, 3028:20, 3038:2, 3061:21, 3066:1, 3070:47, 3072:1
**decision-making** [1] - 3070:47
**decisions** [1] - 3089:9
**decks** [1] - 3095:4
**decrease** [1] - 3077:31
**decreased** [1] - 3061:39
**deescalate** [1] - 3045:8
**default** [2] - 3081:8, 3081:13
**deficit** [1] - 3055:17
**deficits** [1] - 3070:2
**define** [3] - 3060:25, 3060:32, 3067:17
**defined** [6] - 3020:27, 3050:15, 3063:34, 3068:3, 3068:12, 3069:12
**defining** [1] - 3069:1
**definitely** [9] - 3017:43, 3019:30, 3021:39, 3022:43, 3025:29, 3025:34, 3070:11, 3100:26
**definitions** [1] - 3026:8
**degree** [2] - 3065:37, 3094:12
**delayed** [1] - 3038:10
**deliver** [6] - 3056:26, 3056:30, 3057:40, 3059:37, 3062:5, 3069:45
**deliverable** [1] - 3060:27
**deliverables** [1] - 3060:37
**delivered** [7] - 3019:35, 3056:29, 3057:22, 3060:1, 3069:44, 3076:30, 3079:4
**delivering** [3] - 3042:25, 3059:46, 3061:2
**delivery** [24] - 3016:15, 3016:41, 3016:44, 3017:17, 3021:7, 3021:29, 3022:38, 3027:2, 3028:45, 3034:31, 3036:43, 3044:18, 3053:38, 3056:40, 3058:43, 3059:6, 3059:38, 3066:7, 3067:27, 3082:20, 3083:9, 3083:27, 3085:2, 3086:7
**delivery's** [1] - 3020:2
**demand** [15] - 3018:12, 3019:13, 3019:16, 3019:30, 3021:14, 3026:42, 3027:20, 3027:25, 3028:40, 3031:11, 3032:43, 3042:22, 3044:47, 3059:30, 3065:7
**demands** [2] - 3019:8, 3097:17
**demographic** [1] - 3023:27
**demographics** [1] - 3026:37
**Dental** [1] - 3047:11
**department** [7] - 3064:39, 3072:40, 3073:47, 3077:23, 3081:35, 3082:40, 3093:41
**departments** [4] - 3041:31, 3070:5, 3081:13, 3082:42
**dependable** [1] - 3059:6
**dependent** [3] - 3073:47, 3078:36, 3080:10
**deployed** [1] - 3023:15
**derive** [1] - 3034:28
**dermatologist** [1] - 3067:41
**dermatology** [12] - 3060:31, 3065:1, 3065:6, 3067:34, 3068:15, 3068:47, 3069:2, 3069:15, 3069:21, 3069:29, 3069:31, 3069:37
**describe** [14] - 3016:42, 3017:24, 3018:19, 3019:46, 3020:2, 3020:25, 3026:36, 3026:37, 3034:31, 3034:44, 3038:20, 3041:15, 3066:4, 3083:30
**described** [9] - 3019:1, 3022:18, 3030:27, 3042:9, 3045:20, 3084:38, 3090:8, 3091:3, 3094:5
**describing** [4] - 3020:20, 3038:6, 3040:32, 3085:43
**design** [4] - 3025:47, 3084:29, 3088:2, 3094:35
**designed** [2] - 3036:34, 3082:19
**desperately** [1] - 3044:46
**desperation** [1] - 3067:13
**despite** [1] - 3068:6
**detail** [3] - 3056:34, 3058:34, 3083:29
**detecting** [1] - 3064:20
**deteriorating** [1] - 3073:9
**deterioration** [2] - 3073:32, 3074:20
**determinants** [1] - 3056:37
**detrimental** [1] - 3070:6
**develop** [15] - 3037:27, 3048:27, 3056:24, 3061:23, 3066:41, 3072:32, 3081:21, 3081:39, 3082:4, 3083:28, 3090:30, 3090:33, 3091:2, 3091:36, 3094:20
**developed** [5] - 3020:26, 3025:6, 3059:31, 3079:1, 3082:20
**developing** [3] - 3066:39, 3079:38, 3090:27
**development** [4] - 3017:21, 3018:24, 3038:22, 3070:13
**devolution** [6] - 3066:29, 3070:33, 3072:13, 3085:30, 3085:32
**devolve** [1] - 3070:32
**devolved** [1] - 3070:40
**diabetes** [3] - 3058:27, 3082:10, 3083:21
**dialogue** [3] - 3080:31, 3086:14, 3086:33
**dialyse** [1] - 3061:37
**dialysing** [2] - 3061:25, 3061:34
**dialysis** [7] - 3058:14,

3058:23, 3061:21, 3061:30, 3061:34, 3064:5, 3064:10
**dictated** [1] - 3095:8
**diet** [3] - 3058:30, 3058:32, 3058:35
**difference** [4] - 3062:5, 3077:41, 3077:44, 3088:29
**different** [29] - 3016:47, 3017:11, 3017:35, 3018:5, 3018:9, 3021:16, 3025:12, 3025:27, 3025:47, 3026:14, 3029:19, 3042:28, 3047:33, 3049:32, 3050:29, 3051:14, 3052:29, 3052:30, 3052:38, 3052:40, 3055:27, 3065:10, 3082:24, 3086:41, 3087:12, 3093:8, 3095:29, 3095:41, 3096:24
**difficult** [7] - 3027:26, 3037:1, 3042:26, 3068:21, 3089:47, 3090:41, 3090:43
**difficulties** [1] - 3038:9
**difficulty** [2] - 3038:47, 3043:13
**digital** [1] - 3087:41
**diligently** [1] - 3087:33
**dip** [1] - 3047:4
**direct** [4] - 3044:11, 3054:7, 3056:22, 3070:27
**directed** [1] - 3041:23
**directing** [1] - 3041:32
**direction** [4] - 3070:9, 3070:41, 3093:8, 3096:5
**directly** [5] - 3052:17, 3062:25, 3063:4, 3076:18, 3096:10
**director** [17] - 3016:15, 3017:15, 3018:7, 3035:32, 3048:4, 3051:9, 3051:16, 3051:17, 3051:38, 3052:14, 3052:15, 3052:18, 3052:19, 3067:38, 3071:13, 3074:12, 3074:15
**directorate** [4] - 3016:44, 3017:17, 3072:14, 3072:21
**directors** [1] - 3051:15
**disagree** [1] - 3021:35
**disappear** [1] - 3040:8
**disbelief** [1] - 3050:36
**discharge** [1] - 3087:34
**disciplines** [2] - 3023:6, 3038:35
**discrete** [6] - 3017:14, 3018:4, 3036:47, 3037:11, 3038:3, 3040:33
**discuss** [3] - 3054:26, 3054:33, 3054:36
**discussed** [9] - 3027:7, 3028:1, 3044:19, 3050:32, 3053:34, 3054:45, 3058:4, 3078:32, 3081:7
**discussion** [4] - 3019:5, 3052:20, 3054:38, 3070:16
**discussions** [1] - 3052:13
**disease** [6] - 3064:31, 3070:4, 3073:35, 3073:45, 3081:39, 3083:22
**disinvestment** [1] - 3026:20
**disruption** [1] - 3050:20
**distance** [1] - 3059:33
**distant** [1] - 3044:7
**distinct** [1] - 3020:8
**distinction** [1] - 3065:18
**distinguishing** [1] - 3060:22
**distress** [1] - 3093:42
**district** [73] - 3016:46, 3016:47, 3017:11, 3017:23, 3017:26, 3017:33, 3017:42, 3017:46, 3018:20, 3018:32, 3020:7, 3020:21, 3020:47, 3021:17, 3021:36, 3022:8, 3023:11, 3024:35, 3027:1, 3027:13, 3027:22, 3027:38, 3027:44, 3029:11, 3029:30, 3029:37, 3029:39, 3030:12, 3030:17, 3030:24, 3030:32, 3031:20, 3033:2, 3033:15, 3033:22, 3034:4, 3034:21, 3035:29, 3036:44, 3037:7, 3038:24, 3039:35, 3040:19, 3041:10, 3041:44, 3042:15, 3042:19, 3044:17, 3044:39, 3044:44, 3045:6, 3045:11, 3045:21, 3045:22, 3045:23, 3050:13, 3052:38, 3055:19, 3055:25, 3057:36, 3062:22, 3063:34, 3063:43, 3063:46, 3066:7, 3066:23, 3066:24, 3066:27, 3066:30, 3070:38, 3071:40, 3076:13, 3077:22
**district's** [3] - 3036:46, 3046:29, 3058:19
**district-wide** [3] - 3016:47, 3018:32, 3027:13
**districts** [7] - 3022:9, 3070:34, 3071:8, 3079:46, 3084:28, 3085:13, 3088:42
**divorce** [1] - 3058:46
**doctor** [6] - 3026:10, 3074:41, 3080:1, 3088:10, 3090:5, 3098:14
**doctors** [10] - 3063:12, 3070:37, 3071:21, 3084:14, 3088:37, 3088:43, 3091:46, 3092:8, 3092:13
**document** [2] - 3099:20, 3099:41
**documentary** [2] - 3098:43, 3100:15
**documents** [1] - 3099:25
**dollar** [2] - 3053:18, 3097:18
**dollars** [1] - 3061:44
**done** [34] - 3022:25, 3022:44, 3024:42, 3026:1, 3029:11, 3030:12, 3031:22, 3033:42, 3035:29, 3042:27, 3042:40, 3043:3, 3044:40, 3046:20, 3050:21, 3053:13, 3054:2, 3055:28, 3055:35, 3055:36, 3055:39, 3055:44, 3059:2, 3065:23, 3068:46, 3080:21, 3084:17, 3085:31, 3086:32, 3089:40, 3089:44, 3095:46, 3096:43
**dot** [1] - 3079:16
**double** [2] - 3034:24, 3046:20
**dovetail** [1] - 3056:13
**down** [18] - 3026:39, 3041:6, 3042:47, 3066:34, 3069:38, 3073:1, 3073:18, 3073:24, 3077:4, 3077:12, 3077:21, 3081:29, 3081:42, 3081:45, 3083:38, 3084:25, 3084:26, 3092:28
**downside** [2] - 3085:28, 3085:29
**downward** [1] - 3077:33
**DPE** [1] - 3051:11
**Dr** [17] - 3015:29, 3045:41, 3045:43, 3046:5, 3046:39, 3052:17, 3052:18, 3058:9, 3065:5, 3075:3, 3075:9, 3087:35, 3093:45, 3095:15, 3096:27, 3097:6, 3098:6
**DR** [8] - 3045:43, 3046:3, 3046:5, 3046:35, 3053:21, 3053:31, 3065:31, 3074:33
**drain** [1] - 3097:28
**draw** [1] - 3044:12
**drawing** [1] - 3036:13
**drawn** [2] - 3053:36, 3054:21
**dream** [1] - 3087:2
**DRG** [1] - 3061:8
**drill** [2] - 3073:17, 3073:24
**drive** [4] - 3064:2, 3079:34, 3096:22
**driven** [1] - 3058:30
**driver** [1] - 3034:3
**drivers** [1] - 3026:41
**driving** [1] - 3038:35
**dropped** [1] - 3073:38
**drops** [1] - 3064:18
**dual** [4] - 3047:17, 3047:18, 3048:23, 3048:25
**Dubbo** [74] - 3015:18, 3015:20, 3020:10, 3020:12, 3020:32, 3020:43, 3021:13, 3021:16, 3023:30, 3023:32, 3024:15, 3027:19, 3027:32, 3044:35, 3046:27, 3047:25, 3048:4, 3048:13, 3048:40, 3048:42, 3048:44, 3049:4, 3049:8, 3049:15, 3049:23, 3049:31, 3049:36, 3049:38, 3049:45, 3050:27, 3050:42, 3050:45, 3051:6, 3051:10, 3052:3, 3052:39, 3056:1, 3059:37, 3060:39, 3060:45, 3060:47, 3061:8, 3061:43, 3062:13, 3062:18, 3062:24, 3062:45, 3063:1, 3064:5, 3064:11, 3064:16, 3064:39, 3064:41, 3065:27, 3066:15, 3066:35, 3067:42, 3068:31, 3068:47, 3069:2, 3069:21, 3071:6, 3071:11, 3071:45, 3073:37, 3074:12, 3076:32, 3076:45, 3084:14, 3089:3, 3089:24, 3091:9, 3093:41
**Dubbo's** [1] - 3060:33
**Dubbos** [1] - 3083:4
**due** [5] - 3023:16, 3030:26, 3046:36, 3075:40, 3077:37
**during** [1] - 3016:35

## E

**E.001** [2] - 3099:19, 3099:25
**E.086** [2] - 3099:19, 3099:25
**E.087** [2] - 3099:20, 3099:26
**early** [3] - 3057:11, 3088:19, 3091:1
**earn** [4] - 3062:40, 3079:16, 3079:17, 3090:45
**earth** [1] - 3071:20
**ease** [1] - 3090:39
**easier** [7] - 3029:4, 3029:26, 3034:34,

3070:18, 3084:6, 3090:33, 3091:43
**easily** [1] - 3036:6
**ECG** [1] - 3095:32
**economically** [1] - 3032:14
**ED** [9] - 3024:38, 3025:30, 3027:8, 3027:32, 3029:43, 3042:3, 3045:2, 3081:13, 3093:41
**Ed** [1] - 3015:27
**EDs** [11] - 3023:44, 3023:45, 3023:46, 3024:9, 3024:19, 3024:24, 3024:30, 3025:25, 3025:27, 3026:1, 3026:22
**education** [7] - 3048:4, 3051:10, 3051:17, 3051:47, 3052:1, 3052:18, 3070:15
**effect** [2] - 3050:18, 3051:31
**effective** [6] - 3052:44, 3053:34, 3061:32, 3070:4, 3071:37
**effectively** [4] - 3034:22, 3057:22, 3069:35, 3088:17
**efficient** [3] - 3029:23, 3033:44, 3041:21
**efficiently** [1] - 3021:36
**either** [7] - 3025:18, 3025:27, 3029:22, 3033:1, 3043:9, 3048:47, 3049:13
**Elders** [1] - 3046:23
**elect** [1] - 3037:15
**elected** [1] - 3082:29
**electing** [2] - 3032:40, 3077:32
**electronically** [1] - 3075:44
**element** [2] - 3017:35, 3054:40
**elevation** [1] - 3071:7
**eligible** [1] - 3040:16
**emails** [1] - 3099:9
**emerged** [1] - 3098:8
**emergency** [12] - 3041:23, 3041:31, 3064:39, 3070:5, 3072:40, 3073:47, 3077:23, 3081:11, 3081:35, 3082:42, 3091:18, 3095:29
**emerging** [1] - 3046:24
**emigrated** [1] - 3088:30
**employ** [1] - 3028:13
**employing** [1] - 3033:39
**employment** [2] - 3036:19, 3066:43
**EMR** [3] - 3087:24, 3087:28, 3087:29
**encourage** [6] - 3038:22, 3057:17, 3061:23, 3083:14, 3089:22, 3091:11
**end** [9] - 3050:23, 3051:24, 3055:32, 3067:34, 3077:22, 3079:20, 3083:24, 3092:4, 3092:14
**ended** [2] - 3077:10, 3091:25
**endovascular** [2] - 3064:26, 3064:29
**ends** [1] - 3064:39
**energy** [1] - 3053:4
**engage** [6] - 3029:14, 3029:19, 3031:26, 3031:34, 3081:40, 3085:44
**engaged** [7] - 3023:8, 3028:8, 3029:37, 3029:40, 3029:41, 3029:42, 3070:15
**engagement** [8] - 3022:36, 3023:2, 3028:16, 3029:9, 3046:30, 3052:7, 3054:2, 3066:40
**enhanced** [1] - 3084:4
**enjoyable** [1] - 3090:16
**enjoyed** [1] - 3090:14
**ensure** [10] - 3021:21, 3021:29, 3043:39, 3052:44, 3063:14, 3065:9, 3071:36, 3072:15, 3072:26, 3072:46
**ensuring** [4] - 3021:35, 3028:40, 3041:46, 3073:11
**enter** [2] - 3039:5, 3063:2
**entire** [2] - 3049:24, 3049:36
**entirely** [4] - 3038:13, 3050:9, 3052:8, 3063:1
**entity** [4] - 3076:6, 3083:26, 3083:36, 3097:33
**envelope** [4] - 3037:26, 3041:11, 3044:16, 3045:22
**environment** [1] - 3068:22
**envisage** [1] - 3084:28
**EOI** [2] - 3053:1, 3053:9
**EOIs** [1] - 3052:46
**equal** [1] - 3048:40
**equally** [9] - 3018:1, 3018:29, 3020:16, 3020:34, 3021:16, 3027:31, 3028:11, 3032:43, 3037:19
**equals** [2] - 3037:45
**equation** [1] - 3092:12
**equipment** [3] - 3036:21, 3036:40, 3037:34
**equivalent** [3] - 3060:44, 3061:41, 3072:5
**error** [1] - 3058:12
**errors** [1] - 3046:26
**escalate** [1] - 3045:8
**escalating** [1] - 3033:37
**essentially** [4] - 3029:46, 3034:18, 3036:25, 3042:5
**establish** [2] - 3021:29, 3041:1
**established** [6] - 3017:8, 3018:9, 3021:1, 3022:24, 3025:10, 3039:10
**establishing** [1] - 3031:4
**establishment** [1] - 3036:35
**estimate** [1] - 3088:13
**et** [8] - 3017:22, 3066:44, 3083:6, 3084:33, 3094:46, 3095:34
**ether** [1] - 3082:34
**ethical** [2] - 3061:20, 3061:22
**ethically** [1] - 3061:24
**evaluation** [4] - 3035:29, 3035:30, 3035:39, 3099:35
**EVALUATION** [1] - 3100:12
**event** [1] - 3073:4
**events** [3] - 3073:22, 3073:23, 3073:35
**eventual** [1] - 3048:34
**everywhere** [4] - 3035:7, 3086:41, 3088:36, 3092:15
**evidence** [29] - 3016:19, 3016:20, 3016:27, 3017:23, 3018:15, 3018:38, 3019:6, 3024:5, 3024:13, 3032:23, 3034:27, 3038:25, 3040:9, 3041:40, 3043:8, 3044:35, 3046:9, 3046:22, 3051:1, 3055:16, 3059:35, 3075:29, 3075:30, 3075:34, 3094:5, 3095:17, 3096:35, 3098:24, 3100:2
**evolution** [2] - 3019:47, 3022:12
**evolve** [5] - 3018:14, 3021:45, 3022:38, 3022:44, 3031:6
**evolved** [2] - 3020:28, 3025:18
**ex** [1] - 3079:22
**exactly** [7] - 3027:45, 3034:36, 3043:33, 3054:38, 3064:41, 3068:32, 3069:15
**examining** [1] - 3050:21
**example** [32] - 3017:43, 3018:18, 3018:28, 3020:32, 3028:6, 3028:7, 3028:25, 3028:45, 3038:14, 3040:26, 3042:14, 3053:37, 3054:3, 3055:46, 3056:3, 3057:29, 3066:12, 3066:14, 3069:3, 3069:28, 3070:20, 3070:24, 3071:42, 3071:43, 3072:10, 3073:35, 3074:11, 3083:8, 3089:40, 3092:47
**examples** [8] - 3017:4, 3024:34, 3040:10, 3041:44, 3042:3, 3055:43, 3055:45, 3060:41
**excel** [1] - 3048:31
**excellent** [4] - 3050:42, 3055:31, 3055:32, 3071:30
**excessively** [1] - 3052:2
**excused** [3] - 3045:35, 3074:46, 3098:18
**executive** [7] - 3016:15, 3017:11, 3017:13, 3052:9, 3054:5, 3054:16, 3055:16
**executive's** [1] - 3054:44
**exempt** [1] - 3047:8
**exemption** [3] - 3029:5, 3029:22, 3029:27
**exemptions** [4] - 3029:7, 3029:10, 3030:30, 3031:20
**exhibit** [2] - 3100:6, 3100:9
**EXHIBIT** [1] - 3100:12
**exhibits** [1] - 3099:24
**exist** [7] - 3020:37, 3025:12, 3044:24, 3057:42, 3060:16, 3063:23, 3067:21
**existence** [1] - 3023:5
**existent** [1] - 3043:10
**existing** [7] - 3023:43, 3026:44, 3040:35, 3041:10, 3042:11, 3092:27, 3097:28
**exists** [3] - 3021:27, 3026:7, 3064:16
**exit** [1] - 3026:18
**expand** [3] - 3032:15, 3047:46, 3070:30
**expanded** [3] - 3032:26, 3033:29, 3048:12
**expansion** [3] - 3019:28, 3019:32, 3027:32
**expect** [5] - 3025:8, 3026:10, 3040:21, 3061:3, 3069:45
**expectation** [1] - 3069:42
**expected** [2] - 3072:5, 3073:11
**expecting** [1] - 3059:32
**expeditiously** [1] - 3095:7
**expense** [2] - 3056:29, 3063:4
**expenses** [1] - 3036:6
**expensive** [3] - 3033:47, 3034:5, 3060:20
**experience** [9] - 3018:11, 3038:12,

3038:24, 3049:47, 3057:36, 3067:47, 3068:1, 3089:41, 3091:40
**experienced** [2] - 3027:18, 3044:44
**experiences** [2] - 3049:32, 3050:26
**experiencing** [1] - 3019:13
**expert** [1] - 3059:28
**expertise** [1] - 3081:25
**experts** [2] - 3017:31, 3019:1
**expires** [1] - 3040:6
**explain** [2] - 3020:6, 3044:23
**explore** [6] - 3037:16, 3037:19, 3041:31, 3041:44, 3083:30, 3088:16
**expose** [1] - 3062:8
**exposed** [2] - 3038:38, 3089:32
**exposure** [4] - 3048:30, 3050:37, 3062:33, 3071:10
**extension** [1] - 3066:28
**extensive** [1] - 3020:7
**extent** [1] - 3054:8
**external** [1] - 3035:44
**extract** [1] - 3027:33
**extrapolate** [1] - 3062:1
**extreme** [2] - 3025:33, 3058:27
**eyeball** [1] - 3078:31
**eyes** [1] - 3059:16

## F

**face** [5] - 3043:7, 3054:31, 3059:41, 3073:15
**face-to-face** [1] - 3059:41
**faced** [2] - 3038:9, 3047:27
**faces** [1] - 3028:40
**facilitated** [1] - 3094:11
**facilities** [9] - 3016:47, 3021:37, 3024:35, 3024:40, 3044:3, 3045:20, 3072:31, 3073:38, 3076:33
**facility** [6] - 3018:31, 3027:34, 3054:1, 3073:43, 3086:17, 3087:9
**facing** [1] - 3055:19
**fact** [7] - 3031:9, 3042:10, 3049:20, 3055:17, 3072:33, 3089:35, 3092:4
**factor** [4] - 3019:10, 3054:42, 3074:4
**factors** [3] - 3029:20, 3029:24, 3044:43
**failed** [2] - 3097:35, 3098:3
**failing** [7] - 3043:9, 3043:39, 3076:24, 3076:42, 3077:18, 3079:3
**fails** [1] - 3081:8
**failure** [7] - 3030:27, 3053:38, 3056:13, 3062:8, 3082:42, 3093:38, 3095:17
**fair** [2] - 3038:13, 3093:29
**fairly** [3] - 3037:22, 3063:8, 3067:37
**fall** [1] - 3043:29
**falling** [1] - 3064:44
**falls** [1] - 3074:20
**familiar** [2] - 3087:41, 3097:17
**families** [2] - 3040:22, 3049:19
**family** [4] - 3017:4, 3033:12, 3049:16, 3049:24
**fantastic** [1] - 3049:26
**Far** [2] - 3076:13, 3084:40
**far** [7] - 3019:22, 3027:32, 3047:38, 3085:18, 3089:28, 3093:33, 3096:35
**fashioned** [1] - 3078:26
**fear** [1] - 3090:12
**feature** [1] - 3040:42
**features** [2] - 3025:5, 3045:20
**February** [2] - 3017:9, 3046:27
**fed** [1] - 3072:3
**fee** [8] - 3025:14, 3029:47, 3032:42, 3033:47, 3034:10, 3078:20, 3095:25, 3095:35
**feed** [2] - 3020:12, 3074:26
**feedback** [1] - 3074:17
**feet** [2] - 3059:20, 3095:2
**fell** [1] - 3087:6
**fellowship** [4] - 3047:23, 3048:25, 3056:6, 3056:10
**fellowships** [1] - 3047:18
**fenced** [1] - 3084:46
**few** [5] - 3026:30, 3038:27, 3080:40, 3084:4, 3089:4
**fields** [1] - 3047:45
**figure** [1] - 3090:39
**figures** [1] - 3077:11
**filling** [1] - 3069:13
**final** [1] - 3099:26
**finally** [3] - 3041:14, 3044:11, 3093:45
**finances** [1] - 3095:36
**financial** [13] - 3021:38, 3038:31, 3038:35, 3045:14, 3052:27, 3053:35, 3055:18, 3055:40, 3063:7, 3078:11, 3079:28, 3081:42, 3083:2
**financially** [3] - 3032:41, 3070:38, 3086:21
**fine** [1] - 3080:8
**finish** [2] - 3062:44, 3088:10
**finished** [3] - 3076:45, 3077:2, 3091:14
**firming** [1] - 3035:46
**firmly** [1] - 3077:17
**first** [15] - 3016:3, 3022:20, 3037:32, 3039:10, 3048:7, 3060:42, 3065:42, 3067:41, 3076:44, 3077:31, 3088:19, 3089:10, 3092:36, 3098:44, 3099:14
**firstly** [2] - 3039:9, 3044:15
**fistula** [2] - 3064:7, 3064:10
**fistulas** [1] - 3064:5
**fit** [9] - 3037:14, 3037:44, 3040:40, 3078:4, 3081:21, 3081:22, 3096:8, 3097:35, 3097:39
**five** [7] - 3057:8, 3057:28, 3057:38, 3060:46, 3061:44, 3069:5, 3078:15
**five-year** [2] - 3057:28, 3057:38
**fix** [2] - 3054:12, 3089:19
**fixed** [10] - 3023:44, 3025:1, 3025:8, 3027:9, 3027:29, 3027:43, 3042:20, 3044:47, 3045:7, 3091:44
**fixes** [1] - 3070:3
**flag** [1] - 3073:17
**flat** [2] - 3094:27, 3095:30
**fledgling** [1] - 3056:13
**flexibility** [3] - 3038:6, 3038:10, 3038:21
**flourish** [1] - 3083:14
**flown** [1] - 3072:39
**fly** [11] - 3064:3, 3069:10, 3069:17, 3069:22, 3069:24, 3071:29
**fly-in** [5] - 3064:3, 3069:10, 3069:17, 3069:22, 3071:29
**fly-out** [6] - 3064:3, 3069:10, 3069:17, 3069:22, 3069:24, 3071:29
**focus** [10] - 3017:14, 3019:2, 3021:12, 3021:34, 3022:2, 3041:37, 3055:22, 3055:23, 3091:8, 3092:12
**focused** [4] - 3041:22, 3079:19, 3081:27, 3091:20
**focusing** [2] - 3021:9, 3094:28
**folder** [1] - 3099:31
**follow** [2] - 3059:39, 3061:35
**follow-up** [1] - 3061:35
**following** [2] - 3072:42, 3076:19
**follows** [1] - 3020:30
**food** [2] - 3094:23, 3095:9
**foot** [1] - 3080:45
**footprint** [4] - 3021:1, 3027:7, 3030:36, 3045:7
**forecast** [2] - 3034:3, 3055:17
**forefront** [1] - 3022:37
**form** [6] - 3018:44, 3023:2, 3035:28, 3039:23, 3046:35, 3054:8
**formal** [4] - 3020:42, 3033:30, 3035:30, 3035:39
**formalised** [1] - 3020:29
**formed** [1] - 3073:41
**former** [1] - 3033:47
**fortunate** [3] - 3079:13, 3079:32, 3091:14
**forward** [9] - 3018:16, 3021:32, 3026:17, 3032:36, 3034:14, 3042:12, 3077:28, 3079:5, 3079:36
**foul** [1] - 3087:6
**foundational** [3] - 3034:6, 3034:9, 3050:20
**Four** [7] - 3028:7, 3029:5, 3029:34, 3031:37, 3033:29, 3099:33, 3099:35
**FOUR** [1] - 3100:12
**four** [4] - 3028:14, 3061:10, 3062:23, 3073:41
**fracture** [1] - 3094:45
**fragmentation** [4] - 3034:28, 3082:19, 3085:45, 3092:32
**fragmented** [1] - 3092:32
**frame** [3] - 3060:46, 3068:10, 3069:6
**framework** [3] - 3025:6, 3035:46, 3073:9
**Fraser** [1] - 3015:30
**free** [3] - 3016:25, 3055:6, 3056:34
**freebie** [1] - 3084:10
**freely** [1] - 3057:39
**freeze** [2] - 3055:40, 3077:38
**frequent** [1] - 3097:12
**Friday** [1] - 3015:23
**friends** [1] - 3099:42
**frightened** [1] - 3062:2
**froing** [1] - 3082:28
**front** [4] - 3016:45, 3019:7, 3054:33, 3100:3
**fruit** [1] - 3091:2
**frustrating** [1] - 3087:33
**frustration** [1] -

3064:20
**FTE** [3] - 3062:23, 3062:24, 3069:1
**fulfil** [1] - 3090:42
**full** [15] - 3016:11, 3018:2, 3036:46, 3046:6, 3046:27, 3047:7, 3048:35, 3052:27, 3053:41, 3056:5, 3060:44, 3061:41, 3063:9, 3075:9, 3100:33
**full-time** [6] - 3047:7, 3052:27, 3053:41, 3056:5, 3061:41, 3063:9
**fully** [3] - 3055:38, 3081:29, 3089:26
**function** [4] - 3017:23, 3017:25, 3019:43, 3022:15
**functioning** [1] - 3047:6
**fund** [9] - 3027:2, 3027:43, 3037:27, 3041:6, 3060:5, 3067:7, 3069:4, 3097:31, 3097:32
**fundamental** [2] - 3077:40, 3092:7
**fundamentally** [3] - 3077:27, 3078:20, 3080:6
**funded** [11] - 3034:2, 3036:46, 3040:5, 3040:32, 3043:40, 3056:28, 3078:4, 3081:4, 3081:10, 3093:4, 3097:27
**Funding** [1] - 3015:9
**funding** [103] - 3023:43, 3024:47, 3025:4, 3025:16, 3025:35, 3026:38, 3026:41, 3026:44, 3027:13, 3027:17, 3027:22, 3027:23, 3027:24, 3027:25, 3027:27, 3027:36, 3027:39, 3027:42, 3028:46, 3028:47, 3029:3, 3029:25, 3030:16, 3030:20, 3030:32, 3030:35, 3030:36, 3030:38, 3030:40, 3030:42, 3031:6, 3031:9, 3031:14, 3033:33, 3034:6, 3034:9, 3034:29, 3036:7, 3036:16, 3036:22, 3036:24, 3036:27, 3036:28, 3036:37, 3036:39, 3036:43, 3036:47, 3037:3, 3037:12, 3037:13, 3037:15, 3037:43, 3037:45, 3037:47, 3038:3, 3038:20, 3038:21, 3039:12, 3039:17, 3039:31, 3039:43, 3039:47, 3040:6, 3040:8, 3040:11, 3040:14, 3040:34, 3040:35, 3040:41, 3041:1, 3041:6, 3041:7, 3042:14, 3042:42, 3042:44, 3043:3, 3043:14, 3043:17, 3043:21, 3044:24, 3044:32, 3044:33, 3044:36, 3057:23, 3057:33, 3066:40, 3068:37, 3077:37, 3077:46, 3078:38, 3082:21, 3082:24, 3083:10, 3086:26, 3087:47, 3095:25, 3095:39, 3096:38, 3097:22, 3097:34, 3097:39
**funds** [5] - 3018:26, 3025:45, 3034:32, 3034:35, 3097:28
**funnel** [2] - 3037:36, 3037:39
**funny** [1] - 3063:36
**future** [19] - 3017:38, 3018:13, 3022:4, 3022:12, 3023:4, 3030:23, 3044:8, 3046:23, 3048:31, 3050:2, 3078:38, 3080:6, 3080:11, 3080:19, 3080:23, 3081:18, 3093:17, 3093:21, 3096:17


## G


**gain** [3] - 3060:47, 3079:44, 3083:14
**gains** [1] - 3057:21
**game** [4] - 3055:46, 3082:31, 3082:41, 3096:31
**gap** [1] - 3069:13
**gaps** [1] - 3093:24
**gastroenterologist** [1] - 3066:14
**gastroenterology** [1] - 3060:29
**gee** [1] - 3093:40
**general** [59] - 3016:41, 3018:5, 3022:46, 3029:40, 3030:6, 3030:7, 3032:38, 3033:6, 3041:39, 3041:45, 3047:16, 3047:18, 3047:21, 3047:32, 3047:34, 3047:35, 3047:38, 3047:44, 3047:45, 3048:16, 3048:25, 3060:42, 3060:45, 3062:19, 3064:13, 3064:23, 3064:25, 3064:42, 3067:33, 3068:28, 3071:43, 3072:3, 3072:7, 3075:13, 3076:33, 3077:6, 3077:10, 3077:14, 3077:32, 3078:3, 3078:14, 3078:19, 3078:28, 3080:7, 3081:4, 3081:14, 3086:42, 3087:6, 3087:10, 3087:27, 3088:1, 3088:3, 3089:40, 3090:28, 3090:35, 3091:12, 3091:18, 3094:17, 3094:31
**Generalist** [2] - 3033:7, 3072:21
**generalists** [2] - 3033:22, 3033:26
**generally** [1] - 3032:8
**generational** [4] - 3056:44, 3057:9, 3059:25, 3069:44
**geographical** [1] - 3076:12
**geography** [3] - 3037:6, 3079:32, 3079:39
**given** [16] - 3018:38, 3019:20, 3019:38, 3027:16, 3033:26, 3037:10, 3037:25, 3040:27, 3052:6, 3065:31, 3070:28, 3095:16, 3095:17, 3095:40, 3099:19, 3099:26
**glad** [1] - 3070:31
**Glover** [1] - 3015:28
**GLOVER** [44] - 3016:3, 3016:9, 3016:11, 3016:34, 3016:39, 3023:24, 3026:29, 3032:1, 3032:30, 3035:39, 3036:5, 3044:2, 3045:27, 3045:41, 3075:3, 3075:7, 3075:9, 3075:40, 3075:47, 3088:6, 3088:12, 3093:7, 3093:20, 3093:45, 3096:27, 3098:11, 3098:24, 3098:28, 3098:33, 3098:38, 3098:43, 3099:4, 3099:12, 3099:19, 3099:30, 3099:35, 3099:41, 3100:5, 3100:14, 3100:26, 3100:33, 3100:39, 3100:43, 3101:1
**glue** [1] - 3022:4
**goal** [4] - 3067:15, 3069:6, 3071:15, 3087:38
**goods** [1] - 3020:35
**governance** [8] - 3053:9, 3053:35, 3053:44, 3054:36, 3071:35, 3072:1, 3072:14, 3087:9
**governing** [2] - 3067:39, 3090:24
**government** [18] - 3020:37, 3028:23, 3029:9, 3036:17, 3038:2, 3038:16, 3052:31, 3063:45, 3063:46, 3065:12, 3066:12, 3070:44, 3080:44, 3081:20, 3082:43, 3085:38, 3086:11, 3096:25
**GP** [15] - 3026:10, 3028:12, 3030:1, 3032:35, 3034:16, 3042:11, 3072:22, 3076:45, 3077:2, 3080:14, 3091:16, 3091:43, 3096:11, 3096:16, 3096:20
**GPs** [7] - 3032:40, 3079:4, 3080:23, 3092:27, 3095:43, 3096:11
**gradually** [1] - 3059:19
**graduates** [5] - 3077:13, 3078:8, 3078:17, 3090:34, 3090:40
**grant** [3] - 3042:15, 3042:24, 3042:29
**granted** [2] - 3029:11, 3030:20
**grants** [1] - 3078:22
**grateful** [4] - 3045:35, 3074:42, 3086:22, 3098:14
**great** [9] - 3040:46, 3043:7, 3055:45, 3057:7, 3057:20, 3057:24, 3060:14, 3062:46, 3079:35
**greater** [2] - 3020:44, 3029:2
**greatly** [1] - 3056:38
**grew** [1] - 3063:39
**groomed** [2] - 3048:28, 3048:29
**ground** [13] - 3026:32, 3032:33, 3054:6, 3054:19, 3059:32, 3066:46, 3069:2, 3084:21, 3085:9, 3087:10, 3089:38, 3093:13, 3096:11
**group** [5] - 3029:8, 3064:30, 3073:41, 3074:11, 3074:14
**groups** [5] - 3018:9, 3018:11, 3029:15, 3031:27, 3031:30
**grow** [1] - 3044:4
**growing** [5] - 3019:15, 3023:31, 3023:32, 3027:6, 3044:35
**growth** [4] - 3040:42, 3044:34, 3044:36, 3045:9
**guaranteed** [3] - 3079:21, 3091:42, 3092:5
**guess** [14] - 3018:42, 3019:29, 3042:19, 3051:20, 3052:26, 3052:46, 3053:41, 3054:7, 3056:33, 3059:28, 3071:13, 3071:18, 3074:18, 3092:27
**guide** [2] - 3053:11, 3094:18
**guided** [1] - 3019:46
**Gulgong** [3] - 3075:20, 3086:15, 3086:18

## H

**haematologist** [1] - 3074:13
**haematology** [1] - 3060:30
**half** [1] - 3061:8
**halfway** [2] - 3026:39, 3084:25
**halve** [1] - 3057:34
**halving** [1] - 3057:37
**hamstrung** [1] - 3044:45
**hand** [2] - 3099:2, 3099:13
**handed** [1] - 3099:31
**hands** [2] - 3054:28, 3083:18
**happy** [2] - 3047:46, 3099:38
**hard** [8] - 3016:24, 3016:25, 3067:13, 3067:35, 3067:36, 3070:1, 3075:44, 3078:23
**harder** [1] - 3078:24
**harm** [2] - 3073:2, 3073:10
**HCQC** [3] - 3047:3, 3071:47, 3072:14
**head** [4] - 3037:27, 3038:26, 3050:36, 3085:45
**heading** [3] - 3041:15, 3076:20, 3096:5
**headline** [1] - 3022:35
**Health** [16] - 3015:36, 3017:45, 3018:6, 3018:26, 3018:27, 3029:39, 3044:3, 3063:45, 3076:2, 3076:7, 3083:8, 3086:17, 3087:7, 3096:33, 3099:1, 3099:27
**health** [106] - 3016:45, 3017:1, 3017:3, 3017:28, 3018:1, 3018:7, 3018:40, 3018:41, 3019:11, 3020:34, 3021:21, 3022:6, 3024:36, 3026:6, 3028:34, 3034:21, 3034:23, 3039:39, 3041:35, 3042:7, 3043:29, 3045:3, 3050:13, 3050:24, 3052:29, 3052:30, 3053:14, 3054:30, 3055:25, 3055:34, 3056:37, 3056:39, 3056:42, 3056:44, 3057:8, 3057:11, 3057:14, 3057:15, 3057:22, 3057:36, 3058:37, 3059:16, 3059:25, 3059:31, 3061:17, 3061:38, 3062:22, 3063:34, 3063:42, 3063:46, 3065:13, 3066:6, 3066:23, 3066:24, 3066:27, 3066:30, 3070:6, 3070:33, 3070:34, 3070:38, 3071:8, 3071:26, 3076:12, 3076:23, 3076:32, 3076:33, 3076:42, 3077:21, 3077:25, 3078:35, 3079:2, 3080:33, 3081:17, 3081:25, 3081:41, 3081:42, 3082:2, 3082:7, 3082:40, 3083:3, 3083:15, 3084:5, 3084:28, 3084:29, 3084:42, 3085:14, 3086:7, 3086:42, 3086:45, 3087:5, 3087:10, 3091:5, 3091:7, 3091:8, 3091:31, 3092:23, 3092:34, 3093:1, 3093:2, 3093:3, 3094:32, 3095:11, 3095:13, 3096:37
**Health's** [1] - 3087:41
**healthcare** [7] - 3026:13, 3046:43, 3063:16, 3068:30, 3082:20, 3088:17, 3097:18
**Healthcare** [1] - 3015:9
**HealthOne** [5] - 3078:35, 3086:16, 3086:36, 3086:37, 3086:40
**hear** [3] - 3023:47, 3026:9, 3050:43
**heard** [12] - 3017:22, 3026:11, 3028:6, 3030:35, 3032:22, 3035:1, 3041:40, 3051:1, 3056:20, 3062:41, 3083:3, 3086:36
**hearing** [1] - 3059:8
**hearings** [3] - 3046:21, 3066:13, 3098:41
**heart** [1] - 3057:37
**held** [4] - 3044:43, 3045:4, 3045:13, 3045:18
**help** [6] - 3058:9, 3058:42, 3068:27, 3084:11, 3085:20, 3090:26
**helped** [3] - 3079:35, 3086:39, 3089:35
**helping** [1] - 3086:33
**hence** [2] - 3061:38, 3099:46
**Hernan** [1] - 3015:35
**hesitate** [1] - 3055:30
**high** [21] - 3031:4, 3033:8, 3033:43, 3033:46, 3052:32, 3053:14, 3055:29, 3055:30, 3056:7, 3056:18, 3056:21, 3056:22, 3056:35, 3056:47, 3062:25, 3067:12, 3067:16, 3070:5, 3070:47, 3071:21, 3071:38
**high-cost** [2] - 3033:46, 3055:29
**high-quality** [1] - 3071:21
**higher** [4] - 3029:46, 3089:37, 3094:11
**highest** [2] - 3062:34, 3064:31
**highlight** [2] - 3042:26, 3042:41
**highlighted** [2] - 3032:21, 3042:29
**highlights** [1] - 3073:14
**highly** [2] - 3022:38, 3040:17
**HILL** [1] - 3075:5
**Hill** [6] - 3075:11, 3076:32, 3098:41, 3100:23, 3100:37, 3100:46
**Hills** [1] - 3083:4
**historical** [1] - 3042:11
**historically** [2] - 3022:44, 3050:7
**history** [1] - 3075:47
**hit** [1] - 3034:24
**hmm** [2] - 3065:40, 3065:46
**hoc** [1] - 3088:28
**hold** [2] - 3047:17, 3085:12
**holistic** [2] - 3029:8, 3078:36
**home** [7] - 3034:19, 3049:25, 3078:13, 3084:9, 3086:28, 3087:24, 3094:47
**hone** [1] - 3063:13
**honestly** [1] - 3058:37
**hope** [2] - 3038:38, 3074:10
**horizon** [2] - 3095:19, 3096:15
**horrendous** [1] - 3090:12
**hospital** [50] - 3016:46, 3017:2, 3017:46, 3018:27, 3021:3, 3022:5, 3022:45, 3025:4, 3025:16, 3027:8, 3027:23, 3027:27, 3037:47, 3042:39, 3042:43, 3044:25, 3044:32, 3047:25, 3047:36, 3048:4, 3048:13, 3048:42, 3049:8, 3050:30, 3051:3, 3051:6, 3051:26, 3051:42, 3056:28, 3061:8, 3062:41, 3063:6, 3063:7, 3064:6, 3066:17, 3066:23, 3067:25, 3069:46, 3071:6, 3071:11, 3071:42, 3071:45, 3073:28, 3073:34, 3076:29, 3076:36, 3082:33, 3087:23, 3087:25, 3088:2
**Hospital** [3] - 3048:5, 3048:37, 3068:4
**hospital"** [1] - 3087:36
**hospital-acquired** [1] - 3073:28
**hospitals** [21] - 3020:11, 3021:41, 3022:8, 3022:29, 3022:46, 3022:47, 3024:14, 3024:15, 3026:22, 3027:38, 3032:41, 3043:4, 3050:12, 3068:36, 3068:43, 3076:30, 3076:37, 3077:22, 3081:27, 3082:34, 3083:20
**Hospitals** [4] - 3038:46, 3096:33, 3099:1, 3099:27
**hot** [1] - 3075:41
**hours** [6] - 3061:12, 3066:33, 3072:25, 3087:25, 3095:27, 3095:28
**house** [1] - 3091:45
**hub** [2] - 3059:35, 3084:13
**hub-and-spoke** [1] - 3084:13
**huge** [10] - 3028:18, 3057:21, 3061:25, 3077:14, 3077:15, 3081:10, 3082:41, 3083:21, 3086:9, 3093:42
**hugely** [1] - 3057:21
**hybridised** [2] - 3067:1, 3069:17
**hypertension** [2] - 3058:28, 3082:10
**hypothetical** [1] - 3058:47
**hypoventilation** [1] - 3056:8

## I

**Ian** [1] - 3015:30
**iceberg** [1] - 3069:25
**idea** [8] - 3033:38, 3068:45, 3078:25, 3078:27, 3079:15, 3083:26, 3087:8, 3088:35
**ideal** [1] - 3084:37
**idealist** [1] - 3056:23
**identification** [1] - 3021:5
**identified** [3] - 3073:35, 3073:37, 3090:19
**identify** [7] - 3073:16, 3073:31, 3088:19, 3093:9, 3093:12, 3093:24, 3093:27
**identifying** [1] - 3073:9
**idiots** [1] - 3071:20
**imagine** [4] - 3032:41, 3053:42, 3064:8, 3066:17
**immediately** [1] - 3099:41
**impact** [3] - 3027:36, 3032:8, 3058:35
**impacting** [1] - 3073:14

**impending** [1] - 3064:38
**implement** [2] - 3017:36, 3044:17
**implementation** [2] - 3038:11, 3038:23
**important** [23] - 3021:19, 3021:36, 3021:42, 3022:13, 3022:38, 3022:41, 3023:10, 3033:17, 3041:47, 3042:41, 3045:14, 3068:45, 3079:21, 3080:31, 3085:37, 3086:11, 3086:12, 3090:40, 3092:16, 3092:29, 3093:30, 3094:16, 3096:21
**impression** [1] - 3024:5
**improve** [7] - 3022:36, 3022:39, 3023:3, 3055:28, 3056:2, 3056:47, 3083:16
**improved** [1] - 3021:28
**improvement** [2] - 3054:8, 3057:28
**improving** [3] - 3032:46, 3051:18, 3095:12
**inasmuch** [2] - 3077:37, 3087:3
**incentives** [2] - 3077:43, 3088:42
**incentivise** [1] - 3078:23
**incidents** [1] - 3074:5
**include** [5] - 3048:8, 3051:47, 3052:1, 3061:33, 3092:20
**includes** [3] - 3016:46, 3017:1, 3076:33
**including** [1] - 3082:33
**income** [3] - 3078:12, 3079:21, 3092:5
**incorporates** [1] - 3018:3
**increase** [3] - 3027:14, 3030:21, 3040:42
**increased** [4] - 3025:1, 3061:28, 3073:10, 3077:34
**increases** [1] - 3038:34
**increasing** [1] - 3074:4
**incredibly** [1] - 3047:45
**incumbent** [1] - 3081:20
**incumbents** [1] - 3070:39
**independent** [1] - 3030:7
**indicator** [1] - 3073:31
**Indigenous** [3] - 3058:21, 3058:35, 3060:15
**individual** [8] - 3018:11, 3029:12, 3031:22, 3039:36, 3048:45, 3049:23, 3050:1, 3078:6
**individual's** [1] - 3070:6
**individuals** [5] - 3021:30, 3048:28, 3048:31, 3062:38, 3085:23
**induce** [1] - 3074:27
**industry** [1] - 3078:5
**inevitably** [1] - 3091:21
**infarction** [3] - 3057:34, 3071:7, 3081:38
**infirmary** [1] - 3063:41
**inflating** [1] - 3044:38
**influencing** [1] - 3029:21
**information** [2] - 3087:18, 3087:36
**infrastructure** [3] - 3018:24, 3026:23, 3086:12
**initial** [1] - 3040:33
**initiative** [1] - 3091:1
**initiatives** [2] - 3037:12, 3057:17
**innovation** [4] - 3018:13, 3037:14, 3037:35, 3037:39
**innovations** [1] - 3038:29
**innovative** [6] - 3033:5, 3037:6, 3037:28, 3038:11, 3038:23, 3044:18
**inpatient** [1] - 3068:10
**input** [20] - 3017:20, 3018:39, 3021:6, 3025:20, 3028:19, 3028:22, 3029:10, 3029:41, 3029:42, 3031:2, 3033:16, 3035:44, 3053:2, 3053:14, 3056:22, 3063:45, 3078:36, 3084:31, 3088:1, 3092:30
**inputting** [1] - 3058:37
**INQUIRY** [1] - 3101:5
**Inquiry** [2] - 3015:7, 3096:35
**inside** [1] - 3076:37
**instance** [1] - 3042:18
**Institute** [1] - 3031:41
**institute** [1] - 3074:29
**insurmountable** [1] - 3054:17
**integrate** [1] - 3017:15
**integrated** [8] - 3042:25, 3078:40, 3079:15, 3079:30, 3082:3, 3087:30, 3093:46, 3094:6
**integration** [3] - 3041:38, 3042:1, 3082:17
**intent** [1] - 3022:35
**interact** [2] - 3018:33, 3022:31
**interaction** [1] - 3097:12
**interest** [2] - 3039:20, 3074:13
**interested** [3] - 3065:38, 3071:36, 3078:9
**interesting** [1] - 3095:22
**interests** [1] - 3092:33
**interfering** [1] - 3099:46
**interim** [6] - 3067:5, 3067:19, 3068:25, 3069:7, 3069:8, 3069:11
**intern** [3] - 3091:6, 3091:16, 3091:41
**internal** [5] - 3023:30, 3023:33, 3027:5, 3035:43, 3036:2
**internally** [1] - 3038:30
**interplay** [1] - 3066:8
**interrupt** [1] - 3058:8
**intervening** [1] - 3077:5
**intervention** [2] - 3029:44, 3033:20
**interventional** [1] - 3064:28
**intra** [3] - 3056:44, 3057:9, 3059:25
**intra-generational** [3] - 3056:44, 3057:9, 3059:25
**introduced** [2] - 3022:21, 3033:43
**introduction** [1] - 3090:7
**invest** [2] - 3027:37, 3044:45
**investigation** [1] - 3057:43
**investment** [1] - 3026:19
**invoiced** [1] - 3039:38
**involve** [2] - 3068:42, 3070:8
**involved** [18] - 3019:34, 3048:6, 3051:5, 3051:7, 3052:12, 3053:17, 3054:40, 3055:5, 3055:6, 3055:8, 3061:36, 3062:26, 3073:3, 3074:16, 3083:33, 3085:24, 3086:6
**involvement** [9] - 3046:29, 3047:2, 3052:5, 3052:12, 3052:13, 3054:45, 3055:10, 3069:30, 3090:20
**involves** [5] - 3018:18, 3025:44, 3043:45, 3048:20, 3048:21
**irrespective** [2] - 3055:4, 3055:8
**issue** [24] - 3032:45, 3034:42, 3036:13, 3038:17, 3042:33, 3043:7, 3044:14, 3052:7, 3054:1, 3054:38, 3059:1, 3070:36, 3074:22, 3076:22, 3076:38, 3077:15, 3077:26, 3081:3, 3084:24, 3085:45, 3090:10, 3099:43
**issues** [16] - 3026:46, 3029:21, 3038:20, 3043:40, 3054:21, 3054:36, 3064:22, 3065:37, 3073:12, 3076:18, 3077:19, 3081:6, 3087:7, 3087:18, 3090:9, 3092:42
**items** [1] - 3044:26
**itself** [1] - 3059:38

## J

**January** [2] - 3046:41, 3062:22
**jaw** [1] - 3064:18
**jerk** [1] - 3067:12
**JMO** [1] - 3091:6
**job** [7] - 3055:35, 3078:15, 3082:37, 3088:35, 3090:44, 3092:5, 3092:10
**jobs** [7] - 3048:37, 3062:45, 3088:46, 3091:6, 3091:16, 3091:42
**John** [1] - 3077:1
**join** [3] - 3054:5, 3054:13, 3072:26
**joined** [1] - 3080:13
**joining** [1] - 3024:37
**joint** [1] - 3085:44
**Josh** [1] - 3016:4
**JOSHUA** [1] - 3016:7
**Joshua** [1] - 3016:13
**journalism** [1] - 3055:14
**July** [1] - 3090:25
**jump** [2] - 3030:41, 3070:23
**June** [3] - 3051:10, 3099:9, 3099:28
**justify** [1] - 3050:23

## K

**keep** [5] - 3025:25, 3050:42, 3063:27, 3063:28, 3070:4
**Kensington** [1] - 3088:37
**kept** [2] - 3025:9, 3025:21
**Kevin** [1] - 3082:29
**key** [15] - 3019:46, 3044:12, 3044:15, 3054:42, 3064:22, 3065:18, 3065:44, 3067:1, 3069:8, 3072:15, 3073:16, 3073:31, 3074:17, 3074:19, 3080:32
**kicking** [1] - 3080:46
**kicks** [1] - 3077:21
**kilometres** [2] - 3065:14, 3079:33
**kind** [5] - 3037:12, 3049:26, 3057:5, 3057:27, 3092:39
**Kingdom** [1] - 3075:25

**KINGSLEY** [1] - 3046:1
**Kingsley** [1] - 3046:7
**knee** [1] - 3067:12
**knee-jerk** [1] - 3067:12
**knock** [1] - 3051:31
**knock-on** [1] - 3051:31
**knowing** [2] - 3091:44, 3092:2
**knowledge** [2] - 3025:24, 3084:18
**known** [3] - 3019:29, 3022:4, 3023:39
**knows** [1] - 3080:11
**KPI** [1] - 3045:22

## L

**lab** [1] - 3056:12
**laboratories** [2] - 3056:25, 3064:28
**laboratory** [1] - 3056:9
**labour** [6] - 3055:22, 3071:25, 3071:38, 3073:14, 3074:3, 3074:8
**lack** [6] - 3028:42, 3038:6, 3038:10, 3038:21, 3050:37, 3065:25
**lament** [2] - 3054:25, 3057:23
**land** [2] - 3046:23, 3076:15
**language** [1] - 3088:24
**large** [6] - 3017:1, 3017:45, 3027:38, 3028:34, 3043:3, 3048:21
**largely** [8] - 3017:31, 3019:39, 3023:1, 3038:30, 3041:38, 3049:25, 3077:11, 3079:38
**larger** [7] - 3018:19, 3024:15, 3027:31, 3035:14, 3044:45, 3063:43, 3089:29
**last** [17] - 3017:9, 3017:20, 3019:47, 3022:16, 3022:25, 3024:44, 3034:44, 3037:38, 3039:42, 3046:47, 3054:3, 3064:43, 3073:41, 3077:40, 3079:1, 3081:34, 3091:29
**lastly** [1] - 3095:15
**late** [4] - 3046:47, 3070:23, 3077:36, 3086:9
**laws** [1] - 3047:9
**layers** [2] - 3026:14, 3028:23
**lead** [4] - 3017:26, 3056:35, 3077:45, 3077:47
**lead-in** [2] - 3077:45, 3077:47
**leaders** [3] - 3017:32, 3048:32
**leadership** [2] - 3018:8, 3022:37
**Leading** [2] - 3061:17, 3061:38
**leading** [4] - 3022:11, 3051:8, 3073:18, 3073:33
**leads** [5] - 3017:32, 3018:5, 3018:31, 3018:43, 3033:1
**learn** [4] - 3089:26, 3089:28, 3090:2, 3090:3
**learned** [3] - 3067:6, 3067:13, 3099:42
**learning** [2] - 3051:47, 3092:12
**learnings** [1] - 3072:46
**least** [8] - 3028:41, 3038:10, 3040:31, 3043:41, 3063:13, 3088:19, 3089:23, 3097:22
**leave** [5] - 3049:13, 3059:21, 3062:46, 3065:4, 3096:16
**leaving** [1] - 3038:19
**led** [3] - 3051:14, 3051:27, 3073:44
**left** [4] - 3073:5, 3092:28, 3095:43, 3098:22
**legally** [1] - 3067:44
**legislative** [1] - 3083:32
**length** [1] - 3072:25
**lens** [1] - 3071:25
**less** [11] - 3022:19, 3023:47, 3024:27, 3025:25, 3031:8, 3041:22, 3042:11, 3042:12, 3060:1, 3077:12, 3093:33
**letters** [1] - 3087:34
**level** [47] - 3018:40, 3019:42, 3020:13, 3022:45, 3025:6, 3025:26, 3025:37, 3027:9, 3040:37, 3046:21, 3047:31, 3048:17, 3049:15, 3050:1, 3050:14, 3050:22, 3050:39, 3052:8, 3054:1, 3056:10, 3058:20, 3059:47, 3060:37, 3061:24, 3063:42, 3067:30, 3068:2, 3069:30, 3070:47, 3072:19, 3072:22, 3072:24, 3072:30, 3073:24, 3080:26, 3083:43, 3083:44, 3085:17, 3085:35, 3085:47, 3086:13, 3086:14, 3086:32, 3088:23, 3090:7
**levels** [5] - 3024:23, 3060:11, 3071:42, 3073:39, 3085:37
**LGA** [10] - 3047:25, 3058:20, 3058:23, 3058:41, 3059:30, 3080:26, 3083:43, 3083:44, 3085:35, 3086:13
**LHD** [33] - 3016:16, 3020:27, 3023:34, 3023:45, 3024:29, 3025:24, 3028:17, 3028:25, 3028:40, 3031:19, 3032:18, 3040:36, 3043:1, 3043:9, 3056:19, 3056:36, 3063:29, 3063:30, 3066:28, 3070:39, 3080:42, 3080:43, 3081:6, 3081:9, 3082:5, 3085:18, 3085:29, 3086:6, 3092:47, 3097:9, 3097:13, 3097:18, 3097:29
**LHDs** [3] - 3066:29, 3082:5, 3085:22
**life** [7] - 3057:12, 3061:19, 3061:20, 3061:21, 3069:34, 3082:15, 3091:43
**lifestyle** [3] - 3057:18, 3057:41, 3082:8
**lift** [1] - 3062:4
**likely** [4] - 3030:24, 3035:44, 3058:13, 3079:44
**limb** [1] - 3064:40
**limitations** [1] - 3095:39
**Limited** [1] - 3076:3
**limited** [3] - 3032:32, 3039:18, 3068:41
**line** [2] - 3016:45, 3044:32
**linkage** [1] - 3050:14
**list** [7] - 3025:33, 3040:23, 3064:35, 3099:5, 3099:13, 3099:14, 3099:22
**listed** [1] - 3099:25
**listen** [1] - 3085:35
**listening** [2] - 3083:43, 3085:36
**literature** [1] - 3057:21
**live** [6] - 3033:10, 3034:20, 3043:26, 3079:33, 3088:32, 3092:10
**living** [5] - 3019:39, 3058:14, 3061:42, 3062:40, 3063:7
**LLOYD** [1] - 3075:5
**Lloyd** [1] - 3075:11
**local** [37] - 3019:39, 3020:36, 3032:35, 3034:20, 3050:13, 3052:31, 3055:25, 3057:36, 3062:22, 3063:34, 3063:42, 3063:46, 3065:11, 3065:17, 3066:6, 3066:12, 3066:22, 3066:23, 3066:24, 3066:27, 3066:30, 3070:34, 3070:38, 3071:8, 3076:12, 3077:21, 3080:44, 3084:3, 3084:28, 3084:31, 3085:47, 3086:11, 3086:14, 3086:32, 3094:19, 3094:31, 3097:9
**locality** [4] - 3023:9, 3091:42, 3093:32, 3094:36
**locally** [8] - 3029:14, 3031:26, 3058:42, 3090:35, 3094:12, 3094:22, 3094:37, 3095:10
**located** [1] - 3018:1
**location** [1] - 3049:29
**locations** [3] - 3043:9, 3076:22, 3084:30
**locum** [9] - 3033:37, 3033:40, 3033:46, 3051:38, 3071:29, 3072:39, 3073:3, 3073:4, 3073:30
**locums** [5] - 3025:18, 3033:2, 3055:20, 3073:25, 3092:15
**logistics** [1] - 3021:19
**London** [3] - 3075:26, 3077:10, 3091:15
**long-gone** [1] - 3051:38
**long-term** [1] - 3083:14
**longer"** [1] - 3068:9
**longer-term** [2] - 3017:28, 3041:6
**longest** [1] - 3063:26
**longevity** [2] - 3040:15, 3061:20
**longitudinal** [2] - 3058:40, 3059:6
**longstanding** [1] - 3051:11
**look** [47] - 3017:35, 3019:9, 3022:26, 3029:23, 3030:45, 3031:9, 3034:34, 3042:28, 3050:22, 3051:36, 3054:2, 3054:6, 3057:37, 3060:34, 3060:41, 3061:29, 3061:30, 3062:2, 3062:14, 3062:20, 3063:19, 3066:8, 3066:43, 3066:45, 3067:4, 3068:20, 3068:44, 3069:15, 3069:36, 3073:24, 3073:29, 3073:32, 3073:46, 3074:10, 3074:21, 3078:22, 3078:36, 3080:1, 3084:6, 3084:16, 3085:19, 3087:13, 3090:43, 3091:39, 3092:33, 3093:30, 3094:43
**looked** [3] - 3053:1, 3080:36, 3085:34
**looking** [14] - 3026:18, 3032:44, 3036:26, 3057:29, 3057:33, 3078:18, 3078:37, 3080:24, 3080:26, 3083:43, 3089:5, 3089:17, 3093:17, 3093:31
**looks** [3] - 3046:33, 3059:43, 3080:46
**loop** [1] - 3074:17

**Lopez** [1] - 3015:35
**lose** [2] - 3065:22, 3090:45
**loss** [6] - 3032:21, 3032:23, 3032:25, 3036:31, 3040:27
**losses** [1] - 3038:37
**lost** [3] - 3065:17, 3082:34, 3082:37
**love** [1] - 3071:2
**low** [1] - 3055:30

## M

**M&M** [2] - 3071:37, 3072:3
**Machiavellian** [1] - 3050:22
**MADAAC** [2] - 3047:6, 3047:11
**magical** [2] - 3054:11, 3067:7
**maintain** [2] - 3027:43, 3052:32
**maintaining** [2] - 3027:8, 3031:5
**maintenance** [3] - 3028:34, 3036:21, 3082:1
**major** [5] - 3020:16, 3020:22, 3054:43, 3060:1, 3062:41
**majoritively** [1] - 3070:14
**majority** [2] - 3064:25, 3077:13
**make-up** [1] - 3017:11
**maldistributed** [1] - 3062:32
**maldistribution** [2] - 3062:35, 3090:9
**manage** [2] - 3029:19, 3082:6
**managed** [7] - 3017:13, 3021:17, 3029:16, 3031:28, 3031:30, 3052:8, 3052:9
**management** [3] - 3022:47, 3052:8, 3081:40
**manager** [1] - 3018:6
**manner** [3] - 3021:18, 3027:47, 3035:9
**mannered** [1] - 3040:45
**Marco** [1] - 3052:18
**mark** [3] - 3040:8, 3040:25, 3099:20
**Mark** [2] - 3052:10, 3081:7
**marked** [2] - 3100:5, 3100:8
**market** [14] - 3019:23, 3019:31, 3019:36, 3030:19, 3030:27, 3043:17, 3043:21, 3076:23, 3076:42, 3079:3, 3079:4, 3093:38, 3095:17, 3098:2
**markets** [2] - 3097:36
**married** [1] - 3091:22
**marry** [2] - 3091:44, 3092:4
**masters** [2] - 3085:28, 3087:12
**matching** [2] - 3026:38, 3027:24
**mate** [1] - 3065:14
**material** [3] - 3027:14, 3031:46, 3040:42
**maternal** [1] - 3074:21
**matter** [4] - 3017:30, 3019:1, 3096:21, 3097:2
**matters** [8] - 3035:28, 3052:23, 3053:37, 3053:43, 3053:45, 3054:23, 3098:44, 3100:15
**maturation** [1] - 3021:25
**MAY** [1] - 3101:6
**MBS** [6] - 3078:25, 3081:4, 3087:29, 3093:32, 3093:33, 3097:43
**McClintock** [6] - 3045:41, 3045:43, 3046:5, 3046:7, 3046:39, 3089:11
**MCCLINTOCK** [1] - 3046:1
**mean** [29] - 3020:6, 3024:33, 3025:36, 3027:1, 3031:30, 3032:3, 3032:26, 3054:22, 3055:38, 3057:14, 3058:12, 3061:2, 3061:6, 3076:42, 3077:46, 3079:13, 3080:9, 3081:2, 3084:39, 3085:16, 3087:23, 3089:24, 3091:44, 3093:37, 3094:15, 3094:30, 3094:43, 3095:24, 3097:30
**meaning** [1] - 3068:36
**means** [11] - 3023:14, 3033:19, 3050:23, 3061:7, 3061:9, 3068:4, 3069:36, 3076:31, 3082:26, 3083:35, 3095:30
**meant** [1] - 3031:18
**meantime** [1] - 3085:12
**measure** [1] - 3069:11
**measures** [2] - 3067:5, 3068:25
**mechanism** [1] - 3036:27
**media** [11] - 3053:39, 3054:40, 3054:42, 3054:43, 3054:45, 3055:4, 3055:5, 3055:8, 3055:14, 3083:5
**media's** [1] - 3055:10
**medical** [34] - 3025:12, 3025:20, 3025:45, 3029:18, 3029:41, 3029:42, 3029:43, 3030:9, 3032:31, 3032:40, 3034:45, 3035:3, 3047:35, 3048:7, 3050:46, 3051:1, 3051:13, 3051:16, 3051:38, 3052:11, 3052:19, 3055:20, 3057:20, 3057:40, 3058:2, 3060:30, 3066:5, 3077:9, 3084:15, 3087:4, 3089:42, 3090:22, 3090:28, 3090:31
**Medical** [1] - 3047:11
**medically** [1] - 3067:44
**Medicare** [12] - 3030:35, 3030:36, 3030:39, 3030:42, 3034:18, 3034:22, 3036:28, 3037:2, 3040:15, 3040:16, 3063:3, 3077:38
**medicine** [29] - 3047:19, 3047:23, 3047:32, 3047:37, 3047:39, 3047:40, 3047:44, 3047:45, 3048:16, 3048:17, 3048:25, 3056:6, 3060:29, 3060:30, 3060:45, 3061:4, 3061:8, 3061:10, 3065:39, 3067:39, 3071:13, 3071:44, 3072:3, 3072:7, 3089:26, 3089:28, 3090:15, 3091:18
**meet** [2] - 3028:46, 3045:21
**meeting** [10] - 3028:39, 3046:22, 3047:8, 3070:22, 3071:44, 3072:12, 3072:23, 3085:17, 3093:13
**meetings** [3] - 3070:16, 3071:39, 3072:5
**meets** [1] - 3072:24
**Melbourne** [1] - 3065:11
**member** [11] - 3046:39, 3046:40, 3047:1, 3047:3, 3047:6, 3047:7, 3052:32, 3052:35, 3053:16, 3060:2
**members** [9] - 3052:25, 3052:28, 3052:30, 3053:44, 3054:5, 3054:25, 3054:26, 3061:3, 3085:19
**mental** [4] - 3016:47, 3017:1, 3018:1, 3018:7
**mention** [1] - 3048:3
**mentioned** [7] - 3022:28, 3049:21, 3049:35, 3050:32, 3071:28, 3094:39, 3096:30
**mentions** [1] - 3046:30
**met** [2] - 3051:37, 3091:21
**Metelo** [1] - 3052:18
**method** [1] - 3057:37
**metric** [2] - 3044:12, 3044:15
**metro** [6] - 3027:15, 3060:1, 3064:28, 3065:13, 3071:19, 3093:34
**metro-centric** [1] - 3071:19
**MICHAEL** [1] - 3016:7
**Michael** [1] - 3016:13
**mid** [1] - 3091:41
**middle** [1] - 3041:18
**might** [49] - 3017:34, 3018:19, 3018:24, 3019:8, 3025:7, 3025:19, 3025:45, 3025:47, 3027:18, 3028:2, 3029:15, 3029:31, 3030:25, 3031:27, 3031:30, 3040:11, 3041:1, 3044:27, 3045:3, 3047:33, 3049:4, 3053:21, 3053:42, 3054:17, 3057:1, 3057:18, 3059:10, 3062:41, 3064:24, 3065:4, 3069:5, 3069:15, 3074:10, 3083:31, 3085:9, 3088:12, 3089:40, 3089:42, 3089:44, 3090:13, 3090:17, 3090:45, 3091:30, 3092:42, 3093:7, 3094:40, 3095:15, 3098:46, 3099:12
**migration** [3] - 3023:30, 3023:33, 3027:5
**million** [3] - 3055:17, 3061:14, 3061:44
**mind** [13] - 3027:26, 3034:25, 3039:23, 3066:7, 3070:8, 3076:28, 3085:5, 3091:35, 3091:39, 3096:32, 3096:38, 3097:7, 3097:27
**mindful** [1] - 3069:9
**mine** [3] - 3023:40, 3055:24, 3080:15
**minimum** [1] - 3043:41
**Minister** [2] - 3082:4, 3082:30
**minister** [3] - 3052:42, 3053:14, 3082:5
**ministerial** [1] - 3090:25
**ministers** [3] - 3082:13, 3082:38
**ministry** [19] - 3024:29, 3028:22, 3036:35, 3039:13, 3042:33, 3042:36, 3050:15, 3052:43, 3061:6, 3066:24, 3066:27, 3066:28, 3068:2, 3068:12, 3070:27, 3070:29, 3070:44, 3085:30
**Ministry** [1] - 3063:45
**ministry's** [1] - 3070:34

**ministry-level** [1] - 3068:2
**minor** [2] - 3046:18, 3046:26
**minute** [1] - 3066:38
**minutes** [3] - 3079:34, 3088:7, 3089:15
**miracle** [1] - 3099:4
**misquote** [1] - 3091:30
**missing** [2] - 3065:11, 3067:2
**mix** [2] - 3037:1, 3041:21
**mmm-hmm** [2] - 3065:40, 3065:46
**mobile** [3] - 3035:20, 3038:9, 3038:21
**model** [61] - 3019:20, 3022:39, 3025:5, 3025:10, 3025:16, 3025:21, 3026:41, 3026:44, 3027:13, 3027:17, 3027:28, 3028:47, 3030:32, 3031:6, 3031:40, 3032:35, 3033:8, 3033:9, 3034:20, 3036:22, 3037:15, 3038:22, 3039:23, 3041:19, 3041:32, 3041:36, 3041:37, 3041:46, 3042:5, 3042:7, 3042:11, 3042:39, 3042:40, 3042:44, 3045:19, 3048:23, 3057:39, 3066:9, 3066:10, 3066:39, 3066:42, 3066:45, 3069:15, 3078:5, 3078:18, 3078:33, 3079:25, 3079:38, 3079:44, 3080:4, 3080:8, 3080:18, 3084:13, 3095:20, 3095:22, 3095:35, 3095:39, 3096:7, 3096:16, 3099:33, 3099:35
**MODEL** [1] - 3100:12
**models** [10] - 3017:35, 3023:4, 3023:43, 3024:47, 3030:16, 3033:5, 3036:7, 3038:11, 3047:38, 3069:11
**modification** [1] - 3082:9
**Modified** [1] - 3058:20
**modified** [1] - 3095:23
**MOH.9999.1195.0001 ]** [1] - 3016:24
**MOH.9999.1197.0001 ]** [1] - 3046:37
**Molong** [15] - 3075:13, 3075:16, 3078:34, 3079:14, 3079:34, 3079:36, 3080:9, 3086:15, 3086:18, 3086:44, 3094:20, 3094:44, 3095:8, 3095:23
**moment** [15] - 3039:47, 3044:16, 3049:2, 3053:16, 3053:21, 3057:42, 3058:46, 3071:12, 3077:18, 3078:44, 3084:25, 3088:46, 3090:40, 3094:42, 3097:34
**Monash** [1] - 3058:20
**Monday** [2] - 3046:27, 3100:23
**money** [11] - 3025:26, 3039:34, 3044:28, 3044:29, 3059:1, 3079:17, 3083:15, 3084:46, 3090:45, 3092:10, 3093:41
**month** [5] - 3049:23, 3069:23, 3079:20, 3091:18, 3100:37
**monthly** [2] - 3058:44, 3072:25
**months** [12] - 3020:1, 3022:26, 3035:34, 3037:30, 3049:22, 3049:29, 3049:30, 3049:41, 3058:39, 3062:23, 3089:23, 3089:27
**morbid** [1] - 3083:22
**morbidity** [12] - 3071:35, 3071:39, 3071:44, 3072:2, 3072:9, 3072:11, 3072:15, 3072:19, 3072:23, 3083:16, 3089:33, 3089:36
**morbidity/mortality** [1] - 3072:30
**morning** [4] - 3016:1, 3028:1, 3057:32, 3090:20
**mortality** [11] - 3071:35, 3071:39, 3071:44, 3072:2, 3072:9, 3072:11, 3072:15, 3072:20, 3072:23, 3083:16, 3089:36
**mortgage** [1] - 3079:20
**most** [11] - 3021:13, 3024:5, 3026:5, 3038:29, 3041:35, 3042:3, 3042:20, 3056:27, 3056:31, 3085:22, 3088:17
**mother** [1] - 3051:41
**mouth** [1] - 3064:17
**move** [11] - 3032:45, 3049:19, 3050:45, 3052:23, 3054:35, 3062:36, 3066:15, 3072:18, 3077:28, 3078:19, 3095:4
**moved** [3] - 3049:24, 3086:15, 3086:17
**movement** [6] - 3020:41, 3021:21, 3027:31, 3044:31, 3080:43, 3081:2
**moves** [1] - 3077:20
**moving** [4] - 3017:5, 3049:1, 3062:30, 3079:36
**MPS** [11] - 3019:20, 3032:36, 3034:20, 3041:19, 3041:32, 3053:47, 3058:24, 3072:22, 3082:26, 3094:21, 3094:31
**MPSs** [2] - 3076:31, 3081:11
**Mudgee** [2] - 3023:30, 3023:32
**Multi** [1] - 3018:27
**multi** [8] - 3019:11, 3024:36, 3030:18, 3041:35, 3041:46, 3053:18, 3067:10, 3080:30
**multi-billion** [1] - 3053:18
**multi-pronged** [1] - 3080:30
**multi-purpose** [4] - 3019:11, 3024:36, 3041:35, 3041:46
**multi-year** [2] - 3030:18, 3067:10
**multiple** [15] - 3022:22, 3022:47, 3025:11, 3028:12, 3029:10, 3029:15, 3031:13, 3031:19, 3031:27, 3031:30, 3031:34, 3032:25, 3033:12, 3039:14, 3044:24
**multiplied** [1] - 3032:25
**must** [5] - 3049:43, 3049:44, 3051:46, 3052:1, 3057:10
**Muston** [1] - 3015:27
**myocardial** [3] - 3057:34, 3071:7, 3081:38

## N

**name** [3] - 3016:11, 3046:6, 3075:10
**napkin** [1] - 3066:32
**National** [3] - 3096:33, 3099:1, 3099:27
**national** [2] - 3025:6, 3025:11
**natural** [4] - 3020:2, 3020:25, 3020:40, 3040:46
**natural"** [1] - 3020:40
**naturally** [2] - 3037:36, 3037:39
**nature** [11] - 3020:34, 3022:7, 3027:28, 3030:34, 3034:35, 3038:14, 3039:16, 3040:12, 3040:39, 3041:37, 3042:25
**navigate** [2] - 3026:14, 3029:5
**near** [1] - 3043:32
**necessarily** [12] - 3022:9, 3026:6, 3027:42, 3030:16, 3032:46, 3033:11, 3033:28, 3045:22, 3060:23, 3084:22, 3085:40, 3089:15
**necessary** [2] - 3022:32, 3047:47
**necessity** [1] - 3047:46
**need** [69] - 3020:33, 3020:34, 3021:14, 3021:20, 3022:11, 3022:30, 3023:3, 3025:31, 3027:37, 3027:43, 3029:14, 3030:12, 3030:24, 3030:41, 3031:7, 3031:10, 3031:25, 3035:5, 3044:46, 3055:11, 3056:26, 3056:46, 3057:2, 3058:5, 3058:9, 3059:2, 3059:5, 3059:12, 3059:43, 3060:10, 3061:45, 3063:13, 3067:42, 3068:15, 3068:16, 3068:25, 3068:28, 3069:9, 3069:31, 3069:42, 3070:2, 3072:32, 3077:25, 3078:19, 3078:21, 3078:22, 3078:23, 3078:37, 3080:6, 3081:24, 3081:25, 3081:30, 3081:44, 3082:43, 3085:32, 3085:40, 3086:13, 3089:13, 3089:34, 3092:43, 3093:13, 3094:18, 3094:25, 3094:46, 3096:22, 3097:31
**needed** [11] - 3017:42, 3025:46, 3027:3, 3055:34, 3057:1, 3057:27, 3060:4, 3093:2, 3093:9, 3093:16, 3094:36
**needs** [22] - 3018:18, 3031:6, 3037:44, 3040:35, 3041:4, 3043:38, 3045:10, 3048:34, 3054:41, 3059:30, 3065:7, 3068:47, 3071:32, 3077:27, 3080:33, 3088:20, 3088:45, 3089:6, 3089:8, 3089:9, 3093:1, 3093:28
**negotiate** [2] - 3060:3, 3083:45
**Nepean** [2] - 3050:6, 3050:8
**net** [1] - 3053:10
**network** [28] - 3020:9, 3020:15, 3022:39, 3038:46, 3039:6, 3039:28, 3039:33, 3040:35, 3048:5, 3048:11, 3048:19, 3048:41, 3048:43, 3049:3, 3049:5, 3049:40, 3050:7, 3050:9, 3050:20, 3051:14, 3051:15, 3052:14, 3052:15, 3065:19, 3084:42, 3085:14
**Network** [1] - 3076:7
**networked** [1] -

3048:36
**networks** [11] - 3020:3, 3021:5, 3021:11, 3021:35, 3021:45, 3022:3, 3022:26, 3023:2, 3050:5, 3070:8, 3084:29
**neurology** [1] - 3060:29
**neurosurgery** [1] - 3065:26
**never** [8] - 3055:33, 3060:38, 3065:27, 3067:14, 3077:6, 3081:28, 3082:35, 3087:9
**New** [15] - 3015:20, 3025:13, 3048:22, 3051:11, 3056:25, 3056:42, 3057:35, 3061:12, 3071:11, 3076:11, 3076:15, 3076:44, 3089:1, 3090:15, 3091:25
**new** [9] - 3040:11, 3055:18, 3055:19, 3064:26, 3072:34, 3077:13, 3078:17, 3084:16, 3090:39
**newly** [1] - 3079:10
**next** [13] - 3019:9, 3020:13, 3025:37, 3032:4, 3032:12, 3045:41, 3052:15, 3069:40, 3075:3, 3080:47, 3090:25, 3100:45
**nine** [1] - 3078:15
**ninth** [1] - 3061:19
**nobody** [3] - 3080:45, 3093:39, 3093:40
**nods)** [4] - 3076:4, 3088:25, 3093:25, 3097:24
**nominally** [1] - 3100:36
**nominate** [1] - 3049:2
**nominated** [2] - 3049:8, 3054:4
**non** [5] - 3043:10, 3092:8, 3099:36, 3099:47, 3100:3
**non-doctors** [1] - 3092:8
**non-existent** [1] - 3043:10
**non-publication** [3] - 3099:36, 3099:47, 3100:3
**none** [1] - 3030:4
**nonsense** [1] - 3071:19
**normal** [2] - 3041:3, 3091:46
**north** [6] - 3020:10, 3029:17, 3031:32, 3088:32, 3091:22, 3091:23
**northern** [3] - 3020:9, 3021:1, 3046:31
**note** [1] - 3088:6
**notes** [2] - 3046:29, 3087:26
**nothing** [4] - 3053:15, 3063:38, 3071:23, 3098:8
**noticed** [1] - 3058:3
**notion** [1] - 3079:3
**notionally** [1] - 3097:22
**nowhere** [1] - 3043:32
**NSW** [10] - 3015:36, 3016:16, 3018:26, 3044:3, 3070:39, 3076:6, 3083:8, 3086:17, 3087:7, 3087:41
**number** [15] - 3018:8, 3021:15, 3021:40, 3029:30, 3035:5, 3040:31, 3045:2, 3068:4, 3068:5, 3077:31, 3077:38, 3079:14, 3080:17, 3088:36, 3088:45
**numbers** [2] - 3061:30, 3095:12
**nurse** [2] - 3086:27, 3091:21
**nurses** [4] - 3017:3, 3025:32, 3078:31, 3078:33
**nursing** [10] - 3023:1, 3055:21, 3074:12, 3074:15, 3074:22, 3074:28, 3076:34, 3084:9, 3086:28, 3094:47
**NWAU** [1] - 3037:45

## O

**o'clock** [1] - 3078:13
**oath** [1] - 3016:5
**obesity** [6] - 3056:7, 3056:21, 3056:35, 3057:1, 3057:19, 3083:22
**observation** [3] - 3032:31, 3032:34, 3077:33
**observe** [1] - 3033:32
**observed** [1] - 3033:1
**obstetrics** [3] - 3076:47, 3077:1, 3091:17
**obstructive** [3] - 3056:7, 3056:18, 3056:22
**obtain** [4] - 3029:6, 3029:22, 3029:27, 3043:41
**obvious** [1] - 3030:33
**obviously** [15] - 3018:14, 3019:9, 3019:27, 3024:40, 3025:11, 3025:44, 3028:8, 3028:22, 3030:8, 3032:11, 3036:18, 3066:22, 3071:41, 3072:7, 3074:26
**occasion** [1] - 3048:36
**occasionally** [1] - 3049:14
**occasions** [1] - 3040:31
**occupancy** [3] - 3042:19, 3061:10, 3061:39
**occur** [2] - 3018:22, 3054:27
**occurred** [2] - 3052:14, 3054:4
**occurring** [2] - 3018:34, 3072:6
**occurs** [1] - 3018:40
**Ochre** [1] - 3029:39
**OF** [1] - 3101:5
**offer** [1] - 3064:12
**offered** [1] - 3079:29
**offering** [2] - 3025:27, 3092:43
**offers** [1] - 3020:18
**officer** [4] - 3032:31, 3050:46, 3051:1, 3052:11
**oft** [1] - 3050:32
**often** [10] - 3026:9, 3053:36, 3063:18, 3077:47, 3086:11, 3087:34, 3091:46, 3094:24, 3094:25, 3094:46
**old** [4] - 3062:14, 3078:5, 3078:18, 3078:25
**on-call** [1] - 3067:40
**onboarded** [2] - 3052:10, 3071:47
**onboarding** [1] - 3067:11
**once** [3] - 3031:34, 3069:23, 3084:7
**oncology** [3] - 3020:45, 3060:30
**one** [52] - 3020:22, 3021:3, 3023:14, 3029:25, 3029:34, 3030:3, 3036:18, 3037:31, 3039:10, 3040:4, 3047:22, 3048:15, 3049:29, 3050:13, 3053:6, 3054:4, 3054:13, 3058:5, 3059:20, 3061:10, 3061:18, 3061:33, 3066:17, 3067:6, 3069:8, 3069:23, 3069:39, 3071:34, 3073:37, 3074:14, 3080:13, 3081:6, 3081:20, 3082:5, 3083:26, 3084:3, 3084:14, 3085:45, 3086:14, 3087:16, 3087:37, 3088:29, 3090:21, 3092:41, 3095:20, 3096:17, 3096:29, 3097:2, 3098:22, 3098:30, 3098:35
**one-third** [1] - 3061:33
**ongoing** [10] - 3033:33, 3036:6, 3036:24, 3036:43, 3037:19, 3038:20, 3039:43, 3040:5, 3040:25, 3040:34
**onsite** [1] - 3052:12
**open** [3] - 3025:25, 3026:17, 3028:4
**opened** [1] - 3086:20
**operate** [7] - 3017:37, 3019:40, 3024:35, 3029:38, 3035:9, 3039:31, 3098:2
**operated** [1] - 3024:38
**operates** [2] - 3027:23, 3076:6
**operating** [4] - 3036:6, 3036:18, 3037:19, 3039:24
**operation** [1] - 3035:33
**operational** [3] - 3053:36, 3053:43, 3053:45
**operations** [2] - 3016:42, 3017:15
**opinion** [5] - 3025:23, 3032:19, 3053:6, 3059:2
**opportunities** [5] - 3031:13, 3038:28, 3041:16, 3041:30, 3049:18
**opportunity** [8] - 3034:44, 3038:3, 3041:33, 3047:4, 3054:18, 3063:14, 3070:12, 3091:36
**opposed** [1] - 3081:34
**opposite** [1] - 3070:9
**optimised** [1] - 3021:35
**option** [3] - 3038:4, 3041:7, 3067:21
**Orange** [29] - 3017:2, 3017:45, 3018:6, 3018:40, 3020:16, 3020:17, 3020:47, 3023:31, 3023:32, 3024:16, 3027:19, 3044:35, 3050:4, 3050:9, 3064:42, 3064:44, 3068:31, 3072:6, 3076:32, 3079:32, 3079:33, 3079:39, 3083:4, 3089:3, 3089:24, 3094:45, 3095:4
**orange** [2] - 3019:23, 3091:9
**order** [12] - 3029:27, 3031:12, 3035:6, 3077:27, 3079:19, 3085:19, 3090:26, 3099:36, 3099:47, 3100:3, 3100:6, 3100:9
**organisation** [17] - 3017:29, 3022:17, 3022:21, 3022:25, 3024:34, 3024:38, 3024:42, 3029:16, 3030:6, 3031:28, 3031:31, 3032:21, 3033:20, 3033:37, 3037:31, 3040:24, 3054:30
**organisations** [1] - 3053:18
**organised** [1] - 3071:46
**oriented** [1] - 3051:42
**original** [1] - 3087:8

**originally** [1] - 3063:36
**OT** [1] - 3095:2
**otherwise** [11] - 3028:26, 3030:14, 3034:1, 3034:7, 3040:8, 3043:29, 3046:32, 3056:29, 3060:15, 3066:5, 3073:5
**ourselves** [1] - 3058:46
**out"** [1] - 3049:10
**out-of-hospital** [1] - 3082:33
**out-of-pocket** [2] - 3056:29, 3063:4
**outcome** [4] - 3018:28, 3019:18, 3070:6, 3074:18
**outcomes** [10] - 3032:9, 3040:21, 3043:29, 3056:42, 3057:8, 3057:25, 3058:37, 3059:26, 3073:10, 3074:21
**outlets** [1] - 3063:14
**outline** [17] - 3016:20, 3016:39, 3017:19, 3046:9, 3048:3, 3052:24, 3053:33, 3071:27, 3075:30, 3075:33, 3076:19, 3078:41, 3082:18, 3083:29, 3087:20, 3091:28, 3093:47
**outpatient** [4] - 3040:39, 3047:31, 3047:41, 3067:25
**outpatients** [1] - 3047:36
**outraged** [1] - 3090:1
**outreach** [3] - 3069:13, 3086:20, 3086:24
**outreaches** [1] - 3059:37
**outreaching** [1] - 3069:2
**outside** [10] - 3021:40, 3023:33, 3033:13, 3037:46, 3073:10, 3076:29, 3076:31, 3076:36, 3079:32, 3088:12
**outstanding** [1] - 3064:3
**outweighs** [1] - 3027:32
**overall** [1] - 3044:13
**overarching** [1] - 3070:28
**overcome** [4] - 3028:3, 3043:40, 3082:19, 3083:32
**overhauled** [1] - 3077:27
**overly** [1] - 3040:40
**overseas** [2] - 3062:24, 3088:43
**oversight** [1] - 3017:21
**overview** [1] - 3016:40
**overwhelmed** [2] - 3021:13, 3028:41
**overwhelming** [1] - 3044:7
**own** [7] - 3034:19, 3038:24, 3051:4, 3058:41, 3078:6, 3079:11, 3079:39
**owned** [1] - 3087:7
**owners** [1] - 3079:11

## P

**package** [2] - 3042:17, 3080:1
**paediatrician** [3] - 3039:1, 3039:15, 3039:37
**paediatrics** [1] - 3091:17
**page** [1] - 3076:27
**paid** [4] - 3029:47, 3061:46, 3084:8, 3095:27
**pandemic** [1] - 3033:36
**paper** [1] - 3066:34
**paragraph** [45] - 3016:40, 3017:19, 3019:45, 3019:46, 3020:2, 3023:21, 3023:42, 3024:44, 3026:30, 3026:35, 3026:36, 3026:39, 3032:30, 3032:34, 3033:32, 3034:43, 3035:17, 3035:24, 3035:37, 3036:5, 3038:40, 3039:42, 3041:18, 3044:11, 3044:14, 3046:26, 3046:29, 3048:3, 3053:33, 3058:10, 3065:36, 3065:44, 3070:26, 3071:27, 3071:34, 3073:8, 3076:23, 3076:41, 3082:22, 3084:26, 3087:19, 3091:28, 3092:19, 3092:40, 3094:2
**paragraphs** [7] - 3035:20, 3038:41, 3041:16, 3076:19, 3082:18, 3083:28, 3093:47
**parallel** [2] - 3056:40, 3057:10
**paramedics** [1] - 3094:32
**parking** [1] - 3066:38
**part** [42] - 3017:30, 3017:40, 3018:31, 3018:44, 3019:29, 3021:6, 3021:11, 3025:15, 3032:20, 3036:7, 3038:16, 3039:15, 3039:23, 3039:37, 3044:20, 3044:22, 3046:35, 3048:5, 3048:22, 3050:5, 3050:32, 3051:4, 3053:8, 3059:24, 3062:34, 3072:10, 3072:11, 3073:3, 3073:20, 3073:23, 3077:36, 3078:30, 3078:40, 3079:1, 3079:31, 3082:6, 3086:8, 3086:26, 3087:36, 3090:5, 3092:29, 3096:7
**part-time** [1] - 3039:37
**participate** [6] - 3017:30, 3017:33, 3018:7, 3018:32, 3018:45, 3033:12
**participating** [1] - 3033:8
**particular** [47] - 3017:27, 3018:29, 3018:31, 3018:47, 3019:16, 3019:31, 3021:3, 3022:2, 3025:34, 3026:46, 3028:10, 3028:20, 3029:6, 3029:21, 3029:25, 3030:6, 3030:31, 3030:47, 3032:22, 3033:40, 3034:43, 3036:13, 3036:30, 3036:47, 3037:20, 3037:29, 3038:13, 3038:34, 3039:20, 3039:32, 3040:13, 3040:45, 3041:33, 3042:14, 3042:31, 3042:42, 3042:45, 3044:29, 3050:26, 3054:40, 3069:12, 3072:38, 3073:23, 3073:33, 3074:7, 3078:4, 3094:41
**particularly** [7] - 3017:27, 3018:25, 3020:32, 3021:8, 3023:3, 3037:5, 3094:6
**parties** [2] - 3018:42, 3019:40
**partly** [2] - 3022:20, 3032:41
**partner** [2] - 3031:33, 3035:45
**partners** [1] - 3022:32
**partnership** [2] - 3039:6, 3039:9
**partnerships** [1] - 3086:33
**parts** [5] - 3029:38, 3050:24, 3052:38, 3052:40, 3079:45
**pass** [1] - 3051:24
**passed** [1] - 3099:20
**passionate** [1] - 3061:42
**past** [5] - 3024:33, 3046:23, 3046:40, 3053:24, 3081:27
**pastoral** [1] - 3052:3
**patch** [1] - 3093:43
**path** [3] - 3030:33, 3060:1, 3090:39
**pathologist** [1] - 3095:3
**pathology** [3] - 3050:33, 3070:21, 3089:32
**pathway** [9] - 3021:25, 3060:2, 3061:22, 3065:18, 3090:28, 3090:36, 3091:2, 3091:12, 3092:3
**pathways** [6] - 3020:20, 3020:30, 3025:38, 3069:43, 3089:46, 3090:8
**patient** [15] - 3021:21, 3032:8, 3061:22, 3063:3, 3068:10, 3068:13, 3068:15, 3072:41, 3078:36, 3082:23, 3087:22, 3087:23, 3087:36, 3087:42, 3095:33
**patients** [30] - 3017:5, 3020:20, 3021:17, 3021:42, 3024:23, 3034:17, 3034:19, 3057:43, 3057:47, 3059:39, 3061:36, 3064:5, 3064:33, 3064:36, 3078:32, 3079:19, 3080:2, 3081:35, 3081:40, 3082:7, 3082:8, 3084:6, 3084:7, 3086:29, 3087:24, 3090:4, 3094:28, 3094:44, 3094:46, 3095:7
**pausing** [1] - 3080:35
**pay** [4] - 3061:45, 3079:15, 3079:19, 3092:15
**paying** [2] - 3030:44, 3034:23
**payments** [1] - 3077:38
**pays** [2] - 3030:42, 3061:44
**peers** [2] - 3022:11, 3023:9
**pemphigoid** [1] - 3069:37
**pemphigoids** [1] - 3069:32
**pen** [1] - 3066:33
**people** [50] - 3020:30, 3020:33, 3021:37, 3023:33, 3024:39, 3025:37, 3033:10, 3043:26, 3043:41, 3049:9, 3049:14, 3049:18, 3052:47, 3053:11, 3053:15, 3055:10, 3056:26, 3056:30, 3057:17, 3058:13, 3058:23, 3058:36, 3058:42, 3060:13, 3060:15, 3060:33, 3060:35, 3061:25, 3062:10, 3063:11, 3063:29, 3063:33, 3063:41, 3067:12, 3068:42, 3070:9, 3071:28, 3078:23, 3081:12, 3084:21, 3085:24, 3085:40, 3086:1, 3086:2, 3088:46, 3089:34, 3090:1, 3090:10, 3091:46, 3095:4
**per** [18] - 3024:20,

3024:27, 3027:16, 3027:18, 3033:15, 3042:19, 3042:21, 3047:39, 3047:43, 3049:6, 3058:22, 3061:29, 3069:23, 3076:15, 3077:9, 3077:13, 3093:32, 3095:27
**perceive** [2] - 3028:38, 3029:1
**percentage** [1] - 3030:39
**perfectly** [1] - 3089:14
**perform** [2] - 3022:15, 3051:18
**performance** [4] - 3054:8, 3073:10, 3073:31, 3073:38
**performing** [1] - 3068:22
**perhaps** [19] - 3024:30, 3032:32, 3038:19, 3041:29, 3042:11, 3043:42, 3044:7, 3045:22, 3050:27, 3051:26, 3054:44, 3055:11, 3056:46, 3062:6, 3070:44, 3072:39, 3085:14, 3096:10, 3099:6
**period** [5] - 3048:47, 3049:27, 3059:17, 3069:7, 3070:17
**periods** [1] - 3084:22
**peripheral** [3] - 3064:31, 3084:15, 3095:5
**permanent** [1] - 3074:31
**person** [5] - 3049:8, 3052:16, 3052:33, 3065:15, 3065:17
**personal** [4] - 3046:21, 3047:23, 3057:18, 3085:25
**personalities** [1] - 3021:30
**personally** [4] - 3026:5, 3026:16, 3031:7, 3062:46
**perspective** [4] - 3018:47, 3022:42, 3086:37, 3087:20
**phase** [1] - 3040:33
**PHN** [10] - 3029:15, 3031:27, 3076:11, 3079:46, 3080:21, 3080:40, 3083:43, 3085:28, 3086:6, 3095:41
**PHNs** [1] - 3085:23
**phone** [2] - 3068:41, 3070:1
**physical** [2] - 3033:16, 3054:28
**physician** [26] - 3047:15, 3047:16, 3047:34, 3048:4, 3048:8, 3048:11, 3048:21, 3048:46, 3049:1, 3049:20, 3049:38, 3049:39, 3050:7, 3050:44, 3050:45, 3051:9, 3051:17, 3051:22, 3051:40, 3052:18, 3056:5, 3056:11, 3060:43, 3067:33, 3071:12
**physicians** [3] - 3057:22, 3061:42, 3062:25
**Physicians** [4] - 3047:17, 3048:13, 3062:28, 3070:42
**physio** [1] - 3095:1
**pick** [3] - 3057:43, 3088:23, 3090:44
**picked** [2] - 3053:39, 3087:19
**picking** [1] - 3069:2
**piece** [1] - 3066:33
**pilot** [7] - 3039:12, 3039:47, 3040:32, 3040:45, 3041:6, 3048:22, 3057:36
**Pintos** [1] - 3015:35
**Pintos-Lopez** [1] - 3015:35
**pipeline** [1] - 3035:10
**place** [10] - 3025:19, 3025:20, 3029:18, 3034:1, 3037:30, 3080:24, 3080:33, 3088:23, 3090:13, 3091:47
**place-based** [1] - 3088:23
**placed** [1] - 3051:47
**placements** [2] - 3092:43, 3094:47
**places** [2] - 3042:16, 3043:39
**plan** [8] - 3027:2, 3060:4, 3060:9, 3073:11, 3073:12, 3079:41, 3085:15
**planning** [32] - 3017:23, 3017:26, 3017:28, 3017:33, 3017:35, 3017:36, 3017:40, 3017:45, 3018:3, 3018:25, 3018:29, 3018:45, 3019:14, 3019:42, 3021:7, 3022:44, 3023:3, 3028:16, 3055:47, 3066:25, 3068:45, 3069:4, 3085:2, 3085:20, 3085:45, 3086:5, 3088:15, 3088:16, 3088:44, 3089:5, 3089:16
**plans** [3] - 3017:22, 3074:6, 3091:10
**platform** [2] - 3070:23, 3081:17
**platforms** [1] - 3070:17
**play** [2] - 3053:39, 3055:46
**played** [1] - 3021:31
**players** [3] - 3080:32, 3087:11, 3096:23
**playing** [1] - 3070:29
**plug** [1] - 3018:21
**plugs** [1] - 3017:25
**pocket** [2] - 3056:29, 3063:4
**point** [21] - 3020:47, 3027:36, 3030:11, 3030:44, 3033:45, 3034:3, 3034:4, 3034:30, 3042:13, 3044:42, 3045:4, 3054:44, 3055:27, 3067:23, 3067:26, 3069:29, 3083:8, 3088:47, 3092:36, 3094:1, 3096:10
**points** [4] - 3018:16, 3051:7, 3054:37, 3093:46
**policies** [1] - 3020:27
**policy** [3] - 3038:2, 3082:39, 3096:37
**political** [2] - 3025:46, 3083:32
**pompous** [1] - 3071:18
**pooled** [2] - 3034:32, 3034:35
**poor** [1] - 3058:37
**popped** [1] - 3022:22
**popular** [1] - 3049:5
**population** [16] - 3019:8, 3020:41, 3023:27, 3026:42, 3027:14, 3027:31, 3047:25, 3047:27, 3047:37, 3058:22, 3060:32, 3063:43, 3069:1, 3088:20, 3089:6, 3089:8
**populations** [2] - 3017:47, 3027:6
**portfolio** [5] - 3016:41, 3016:43, 3017:8, 3017:13, 3019:47
**portfolios** [1] - 3017:16
**position** [1] - 3063:9
**position's** [1] - 3052:35
**positions** [3] - 3039:32, 3039:36, 3048:27
**positive** [3] - 3028:33, 3032:8, 3051:28
**possible** [1] - 3074:1
**possibly** [4] - 3024:38, 3032:45, 3054:11, 3071:21
**post** [2] - 3017:36, 3094:44
**potential** [3] - 3048:31, 3057:24, 3074:4
**potentially** [3] - 3019:20, 3021:30, 3022:45
**power** [7] - 3070:40, 3084:18, 3085:32, 3089:19, 3089:21, 3091:6, 3091:31
**practical** [2] - 3026:47, 3090:7
**practice** [61] - 3022:13, 3027:29, 3029:18, 3029:40, 3030:6, 3032:38, 3041:39, 3047:24, 3050:2, 3075:13, 3075:16, 3075:20, 3076:1, 3076:33, 3077:4, 3077:6, 3077:10, 3077:14, 3077:32, 3078:3, 3078:9, 3078:14, 3078:19, 3078:30, 3079:11, 3079:14, 3079:22, 3079:23, 3079:39, 3079:41, 3080:7, 3080:13, 3081:4, 3081:14, 3083:31, 3086:18, 3086:26, 3086:38, 3086:39, 3086:43, 3086:46, 3087:6, 3087:11, 3087:27, 3087:28, 3088:1, 3088:3, 3088:31, 3088:32, 3089:41, 3090:29, 3090:35, 3091:12, 3091:23, 3091:24, 3092:7, 3094:17, 3094:21, 3094:31, 3097:13
**practices** [11] - 3029:19, 3030:7, 3031:34, 3032:44, 3032:45, 3041:45, 3078:6, 3078:22, 3080:28, 3090:37, 3091:19
**practise** [2] - 3047:29, 3080:3
**practised** [3] - 3047:21, 3075:24, 3075:26
**practising** [2] - 3076:43, 3094:17
**practitioner** [2] - 3075:13, 3078:28
**practitioners** [3] - 3059:14, 3077:32, 3079:10
**practitioners"** [1] - 3084:3
**pre** [1] - 3033:36
**predate** [2] - 3062:13, 3062:17
**predicted** [1] - 3095:42
**prediction** [1] - 3095:18
**predominantly** [3] - 3047:29, 3052:9, 3064:7
**preface** [1] - 3053:41
**prefer** [1] - 3051:32
**preferred** [1] - 3049:3
**preliminary** [1] - 3073:36
**premier** [1] - 3061:18
**premium** [6] - 3055:21, 3071:24, 3071:38, 3073:14, 3074:3, 3074:8
**preparation** [1] - 3016:19
**prepared** [2] - 3016:20, 3075:30
**presence** [2] - 3033:15, 3065:25
**present** [4] - 3015:33,

3046:23, 3078:27, 3081:12
**presentations** [8] - 3023:47, 3024:4, 3024:10, 3024:15, 3024:20, 3025:25, 3033:40, 3077:24
**presented** [1] - 3073:13
**presenting** [1] - 3024:24
**presently** [1] - 3077:7
**press** [1] - 3075:41
**pressure** [7] - 3021:2, 3025:47, 3040:23, 3074:20, 3077:24, 3081:11, 3092:14
**pressures** [4] - 3018:12, 3023:6, 3082:41, 3083:2
**pretty** [3] - 3057:44, 3067:36, 3070:45
**prevalent** [3] - 3071:40, 3071:41, 3072:30
**prevent** [3] - 3051:21, 3081:41, 3083:24
**preventative** [2] - 3057:40, 3081:39
**preventible** [1] - 3064:41
**prevention** [2] - 3081:43, 3083:15
**previous** [4] - 3032:23, 3041:40, 3048:30, 3061:18
**previously** [9] - 3021:31, 3024:37, 3028:7, 3028:9, 3029:47, 3038:37, 3047:1, 3047:5, 3084:10
**price** [2] - 3033:43, 3037:45
**primarily** [1] - 3055:21
**Primary** [1] - 3076:7
**primary** [67] - 3028:42, 3029:31, 3029:38, 3030:26, 3030:34, 3034:32, 3041:24, 3041:32, 3042:5, 3043:9, 3043:25, 3043:39, 3043:42, 3047:25, 3047:26, 3057:5, 3057:6, 3057:9, 3057:39, 3059:6, 3059:12, 3059:13, 3059:16, 3059:23, 3059:27, 3060:11, 3060:23, 3065:13, 3076:20, 3076:21, 3076:23, 3076:28, 3076:30, 3076:31, 3076:41, 3077:18, 3077:26, 3079:2, 3079:3, 3081:5, 3081:8, 3081:18, 3081:25, 3081:29, 3081:33, 3081:36, 3082:42, 3082:45, 3083:9, 3083:13, 3083:24, 3083:27, 3084:1, 3084:29, 3084:42, 3085:14, 3085:33, 3086:10, 3087:14, 3093:2, 3095:18, 3096:19, 3096:37, 3097:21, 3097:34, 3098:2
**Prime** [1] - 3082:30
**Prince** [6] - 3048:5, 3048:11, 3048:36, 3050:8, 3050:16, 3068:3
**principles** [3] - 3018:30, 3018:37, 3019:46
**priorities** [1] - 3038:16
**priority** [1] - 3040:12
**privacy** [1] - 3087:6
**private** [15] - 3019:23, 3019:35, 3019:40, 3034:19, 3037:1, 3056:24, 3063:3, 3063:6, 3063:7, 3064:13, 3066:10, 3066:15, 3066:21, 3079:4, 3089:14
**pro** [1] - 3086:31
**problem** [9] - 3043:38, 3054:9, 3054:16, 3055:7, 3069:26, 3073:20, 3074:23, 3084:42
**problems** [3] - 3056:35, 3058:36, 3069:19
**procedural** [3] - 3050:34, 3050:39, 3072:19
**process** [34] - 3017:25, 3017:36, 3017:40, 3018:21, 3018:24, 3018:25, 3018:29, 3019:15, 3019:18, 3019:29, 3021:7, 3028:19, 3029:6, 3029:13, 3030:20, 3031:24, 3035:31, 3037:30, 3046:30, 3048:10, 3048:40, 3052:46, 3053:3, 3053:16, 3054:3, 3055:5, 3066:29, 3067:10, 3072:42, 3073:6, 3082:14, 3086:8, 3090:34, 3093:8
**processes** [3] - 3060:36, 3071:36, 3071:37
**procurement** [1] - 3030:19
**produced** [1] - 3035:25
**product** [1] - 3030:5
**professional** [4] - 3023:9, 3052:25, 3062:3, 3070:13
**Professor** [5] - 3035:1, 3035:2, 3051:2, 3052:10, 3052:11
**profit** [1] - 3079:29
**program** [10] - 3038:2, 3039:12, 3039:34, 3044:26, 3048:33, 3082:13, 3086:38, 3086:40, 3091:20
**programmatic** [2] - 3017:12, 3022:24
**programs** [4] - 3035:3, 3035:15, 3040:32, 3040:46
**progress** [6] - 3033:30, 3059:20, 3063:19, 3063:20, 3072:36, 3080:25
**progressed** [2] - 3036:15, 3047:37
**progressing** [1] - 3062:20
**project** [10] - 3031:37, 3032:7, 3032:15, 3037:29, 3039:20, 3039:31, 3039:43, 3082:6, 3087:42, 3093:21
**projecting** [1] - 3019:8
**projection** [1] - 3096:3
**projects** [5] - 3028:38, 3037:28, 3040:34, 3057:12, 3057:17
**promotion** [3] - 3057:11, 3057:14, 3082:1
**prompts** [2] - 3057:47, 3058:1
**pronged** [1] - 3080:30
**proper** [2] - 3025:44, 3093:2
**proportion** [2] - 3060:12, 3090:11
**proposal** [1] - 3069:4
**proposed** [2] - 3099:36, 3099:47
**proposing** [1] - 3097:26
**proposition** [1] - 3045:24
**propping** [1] - 3044:47
**proudest** [2] - 3058:38
**provide** [31] - 3025:45, 3028:5, 3028:26, 3029:40, 3029:41, 3029:42, 3029:45, 3031:11, 3032:40, 3033:22, 3033:27, 3047:35, 3050:39, 3054:15, 3055:32, 3059:29, 3067:5, 3068:24, 3068:37, 3068:39, 3077:20, 3079:40, 3081:11, 3084:19, 3084:43, 3086:12, 3089:38, 3092:34, 3093:35, 3093:39, 3095:10
**provided** [9] - 3035:31, 3036:44, 3039:33, 3039:35, 3041:22, 3065:43, 3065:45, 3067:4, 3099:42
**provider** [4] - 3022:10, 3029:37, 3081:9, 3081:34
**providers** [1] - 3028:17
**provides** [1] - 3043:14
**providing** [9] - 3023:2, 3026:23, 3032:35, 3073:8, 3081:19, 3081:33, 3081:34, 3086:9, 3086:25
**provision** [4] - 3047:31, 3059:23, 3061:21, 3093:2
**proximity** [2] - 3035:8, 3035:12
**psychiatry** [1] - 3091:17
**psychologist** [2] - 3039:16, 3039:37
**psychologists** [1] - 3039:1
**public** [16] - 3034:23, 3043:4, 3056:9, 3056:12, 3056:27, 3057:15, 3057:22, 3062:19, 3062:40, 3064:27, 3066:17, 3066:23, 3068:28, 3089:13, 3092:23, 3099:45
**publication** [3] - 3099:36, 3099:47, 3100:3
**published** [1] - 3099:44
**pulled** [1] - 3073:6
**purchase** [1] - 3036:39
**purchasing** [1] - 3030:9
**purely** [1] - 3024:36
**Purpose** [1] - 3018:27
**purpose** [11] - 3019:11, 3022:18, 3024:36, 3041:35, 3041:46, 3078:4, 3081:22, 3085:8, 3086:17, 3096:8, 3097:35
**purpose-built** [1] - 3086:17
**purposes** [1] - 3058:47
**purse** [1] - 3086:3
**pursuant** [1] - 3100:9
**purview** [1] - 3091:7
**put** [10] - 3019:6, 3036:35, 3044:29, 3053:5, 3074:11, 3074:13, 3079:19, 3080:14, 3082:41, 3093:31
**puts** [3] - 3077:24, 3080:45, 3081:10
**putting** [3] - 3041:5, 3053:9, 3066:43

## Q

**qualified** [2] - 3077:9, 3079:10
**quality** [9] - 3046:43, 3061:20, 3062:25, 3067:12, 3067:16, 3071:21, 3071:26, 3073:14, 3074:9
**quantum** [1] - 3078:14
**quarantined** [3] - 3044:27, 3044:30, 3083:11
**quaternary** [2] - 3050:1, 3070:10
**querying** [1] - 3100:26

**questions** [11] - 3041:14, 3045:27, 3045:30, 3045:32, 3065:33, 3074:33, 3074:37, 3074:39, 3086:5, 3096:27, 3096:47
**quickly** [1] - 3068:16
**quid** [1] - 3086:31
**quite** [28] - 3019:13, 3019:21, 3020:8, 3026:17, 3028:4, 3029:7, 3032:44, 3033:13, 3033:19, 3038:28, 3038:37, 3039:18, 3039:23, 3042:17, 3044:27, 3053:44, 3066:36, 3071:41, 3072:24, 3077:47, 3086:11, 3087:33, 3090:3, 3090:12, 3094:24, 3094:25, 3094:46, 3100:33
**quo** [2] - 3083:19, 3086:31

## R

**RAC** [2] - 3029:45, 3034:17
**radiation** [1] - 3020:45
**radical** [2] - 3043:2, 3057:27
**raise** [4] - 3034:43, 3086:39, 3093:46, 3094:2
**raised** [3] - 3042:33, 3042:36, 3042:39
**raising** [1] - 3044:14
**ramping** [1] - 3083:5
**rapid** [2] - 3057:40, 3057:41
**rapidly** [4] - 3051:24, 3052:15, 3052:21, 3063:8
**rarity** [1] - 3054:47
**rate** [11] - 3025:33, 3029:47, 3042:19, 3057:34, 3061:8, 3061:10, 3071:7, 3074:5, 3095:27, 3095:29, 3095:30
**rates** [11] - 3056:7, 3056:18, 3056:21, 3056:22, 3056:35, 3056:47, 3057:37, 3058:27, 3064:31, 3089:36, 3089:37
**rather** [7] - 3016:25, 3025:24, 3031:8, 3031:34, 3040:34, 3063:8, 3088:10
**RDN** [1] - 3080:37
**re** [1] - 3059:19
**re-find** [1] - 3059:19
**reach** [1] - 3017:46
**reached** [2] - 3038:46, 3080:16
**read** [2] - 3016:26, 3075:33
**reads** [2] - 3046:33, 3058:12
**ready** [2] - 3053:29, 3077:2
**real** [10] - 3050:42, 3057:37, 3078:1, 3081:42, 3082:40, 3085:34, 3088:44, 3090:3, 3091:8, 3093:43
**real-time** [1] - 3057:37
**realign** [2] - 3041:30, 3054:8
**realigning** [1] - 3027:47
**realise** [2] - 3074:7, 3090:12
**realised** [1] - 3087:2
**realistic** [1] - 3071:15
**reality** [10] - 3053:19, 3054:17, 3054:27, 3058:44, 3058:46, 3059:26, 3059:47, 3066:16, 3067:21, 3067:31
**really** [44] - 3021:42, 3022:13, 3038:1, 3040:21, 3042:41, 3047:30, 3050:21, 3050:44, 3052:2, 3054:29, 3055:30, 3056:2, 3057:42, 3060:13, 3064:12, 3064:18, 3065:24, 3067:42, 3068:14, 3068:17, 3068:21, 3068:45, 3069:9, 3070:2, 3074:23, 3077:25, 3078:26, 3081:10, 3081:11, 3081:26, 3081:28, 3081:40, 3082:12, 3082:27, 3085:36, 3087:11, 3089:17, 3089:34, 3090:26, 3090:27, 3090:32, 3092:47, 3096:39, 3097:35
**reason** [10] - 3021:12, 3021:28, 3033:35, 3040:13, 3062:36, 3072:25, 3079:2, 3083:34, 3099:39, 3100:30
**reasonably** [1] - 3067:35
**reasons** [4] - 3049:16, 3070:35, 3079:14, 3086:15
**receive** [1] - 3057:23
**received** [2] - 3021:17, 3036:39
**receives** [1] - 3042:15
**receiving** [4] - 3032:1, 3060:15, 3068:37, 3073:12
**recent** [7] - 3017:43, 3020:30, 3020:44, 3024:31, 3047:22, 3077:34, 3089:1
**recently** [2] - 3031:40, 3086:20
**reception** [1] - 3086:44
**receptionist** [1] - 3086:26
**reckon** [1] - 3061:30
**recognise** [1] - 3030:17
**recommendation** [1] - 3096:36
**recommendations** [1] - 3096:34
**reconsider** [3] - 3022:26, 3035:3, 3042:40
**record** [6] - 3016:12, 3084:15, 3087:4, 3087:21, 3087:37, 3087:42
**records** [1] - 3084:24
**recruit** [2] - 3039:14, 3039:26
**recruiting** [1] - 3038:47
**recruitment** [7] - 3039:21, 3048:6, 3048:10, 3048:39, 3048:40, 3062:26, 3066:9
**redeploy** [1] - 3027:42
**redevelop** [1] - 3018:27
**redevelopment** [1] - 3020:44
**redirecting** [1] - 3051:18
**rediverted** [2] - 3024:41, 3025:35
**reduce** [4] - 3059:2, 3060:10, 3063:13, 3074:8
**reduced** [4] - 3027:30, 3061:7, 3061:9, 3061:13
**reducing** [1] - 3032:38
**refer** [6] - 3035:24, 3041:18, 3071:34, 3073:8, 3076:27, 3092:18
**reference** [1] - 3086:5
**referral** [20] - 3017:46, 3020:3, 3020:9, 3020:15, 3020:16, 3020:17, 3020:46, 3021:11, 3021:35, 3022:8, 3022:29, 3047:36, 3050:12, 3050:15, 3060:27, 3065:18, 3067:23, 3067:40, 3068:12, 3071:42
**referred** [5] - 3020:21, 3036:1, 3040:30, 3079:9, 3099:21
**referring** [7] - 3031:32, 3035:12, 3035:36, 3077:43, 3081:32, 3082:17, 3091:35
**reflect** [1] - 3027:17
**reflective** [1] - 3025:15
**reflexly** [1] - 3061:25
**refocus** [1] - 3057:2
**Reform** [3] - 3096:33, 3099:1, 3099:27
**refuse** [1] - 3068:6
**regard** [1] - 3059:25
**regarding** [3] - 3077:41, 3078:11, 3087:29
**regardless** [1] - 3080:2
**regards** [1] - 3085:16
**region** [9] - 3019:16, 3020:41, 3023:45, 3027:17, 3033:13, 3033:18, 3039:18, 3056:14, 3080:22
**regional** [25] - 3018:19, 3022:45, 3029:20, 3029:23, 3044:46, 3047:36, 3048:35, 3049:45, 3050:2, 3050:12, 3050:44, 3051:31, 3051:41, 3051:46, 3055:33, 3056:2, 3060:27, 3060:35, 3063:9, 3065:18, 3067:25, 3070:13, 3071:42, 3079:45, 3089:29
**regional/rural** [1] - 3056:27
**regions** [2] - 3095:18, 3096:17
**registrar** [5] - 3048:24, 3050:46, 3076:46, 3089:1, 3091:19
**registrars** [10] - 3048:7, 3049:6, 3051:13, 3078:8, 3079:15, 3079:22, 3080:14, 3089:2, 3089:22, 3090:23
**reintroduction** [1] - 3051:29
**related** [4] - 3032:32, 3052:23, 3056:8, 3058:10
**relation** [4] - 3026:1, 3039:32, 3087:18, 3087:21
**relationship** [1] - 3085:25
**relatively** [5] - 3070:3, 3072:34, 3075:41, 3088:23, 3091:1
**relayed** [1] - 3079:12
**relevant** [1] - 3018:41
**reliance** [1] - 3050:38
**rely** [1] - 3048:44
**relying** [2] - 3071:37, 3073:25
**remain** [2] - 3027:11, 3059:19
**remaining** [1] - 3070:15
**remains** [2] - 3027:9, 3077:39
**remember** [1] - 3082:30
**remit** [1] - 3019:36
**remote** [18] - 3018:20, 3019:2, 3020:21, 3052:31, 3055:33, 3056:41, 3058:21, 3059:7, 3059:30, 3064:32, 3065:19, 3069:13, 3076:22, 3079:45, 3093:33, 3095:18, 3096:17
**remotely** [2] - 3081:18, 3084:20
**remunerated** [2] - 3068:34, 3078:24
**remuneration** [4] -

3025:12, 3025:19, 3032:39, 3068:24
**renal** [24] - 3047:15, 3047:18, 3047:21, 3047:23, 3047:40, 3048:17, 3058:40, 3060:30, 3060:42, 3060:44, 3061:4, 3061:7, 3061:10, 3061:18, 3061:28, 3061:33, 3061:41, 3065:39, 3067:33, 3070:20, 3070:22, 3071:12, 3072:10, 3072:12
**renewed** [1] - 3040:9
**repair** [1] - 3074:31
**repeat** [1] - 3041:17
**repeated** [1] - 3072:12
**replicated** [1] - 3074:19
**report** [6] - 3096:31, 3096:32, 3096:34, 3099:2, 3099:26, 3099:35
**REPORT** [1] - 3100:12
**reporting** [1] - 3088:9
**representation** [3] - 3022:32, 3053:5, 3053:8
**representations** [1] - 3024:29
**representative** [1] - 3052:31
**requested** [2] - 3049:21, 3049:22
**require** [9] - 3020:35, 3020:43, 3028:11, 3050:21, 3053:7, 3056:31, 3058:14, 3068:23, 3069:30
**required** [4] - 3029:44, 3050:18, 3051:27, 3097:40
**requirement** [3] - 3047:29, 3049:47, 3056:9
**requirements** [2] - 3073:11, 3093:28
**requires** [3] - 3028:16, 3045:1, 3068:10
**reshaping** [1] - 3021:28
**resident** [11] - 3050:46, 3055:33, 3059:18, 3060:39, 3062:13, 3062:17, 3067:16, 3067:17, 3069:12, 3071:31, 3076:45
**residential** [4] - 3017:6, 3019:12, 3019:27, 3042:16
**resigned** [1] - 3052:33
**resolve** [1] - 3054:28
**resolved** [2] - 3039:5, 3083:10
**resort** [1] - 3081:35
**resources** [7] - 3021:37, 3053:4, 3053:13, 3093:12, 3093:20, 3093:21, 3093:31
**resourcing** [2] - 3093:27, 3093:28
**respects** [1] - 3036:26
**respiratory** [4] - 3056:5, 3056:11, 3056:13, 3060:28
**respond** [1] - 3020:28
**response** [5] - 3019:25, 3033:44, 3067:12, 3068:32, 3094:23
**responses** [1] - 3053:1
**responsibility** [21] - 3016:43, 3034:31, 3051:4, 3058:4, 3060:6, 3063:35, 3064:17, 3065:9, 3066:10, 3067:44, 3068:8, 3070:34, 3071:35, 3072:8, 3081:5, 3081:21, 3083:27, 3083:37, 3096:37, 3097:22, 3097:32
**responsible** [7] - 3035:32, 3053:34, 3058:6, 3082:29, 3082:32, 3083:9, 3083:39
**rest** [2] - 3048:41, 3078:14
**restaurants** [2] - 3062:47, 3063:1
**restrictive** [1] - 3038:29
**result** [4] - 3022:23, 3040:21, 3044:39, 3077:47
**resulting** [1] - 3053:38
**results** [1] - 3038:36
**resume** [1] - 3053:29
**retain** [1] - 3025:32
**retained** [2] - 3033:22, 3040:11
**retaining** [2] - 3023:10, 3033:26
**retire** [1] - 3079:24
**retired** [2] - 3064:43, 3080:15
**retirement** [1] - 3088:34
**retrench** [1] - 3019:24
**retrieving** [1] - 3064:40
**return** [2] - 3078:44, 3088:15
**returned** [2] - 3021:18, 3079:22
**revenue** [2] - 3037:2, 3042:20
**review** [9] - 3031:43, 3032:7, 3032:11, 3032:18, 3032:20, 3046:13, 3073:4, 3099:45
**reviewed** [1] - 3031:40
**RFDS** [2] - 3080:32, 3086:9
**Richard** [2] - 3015:14, 3015:35
**rights** [2] - 3063:5, 3066:18
**ring** [6] - 3065:13, 3067:39, 3068:9, 3069:39, 3069:40, 3084:46
**ring-fenced** [1] - 3084:46
**ringing** [1] - 3067:41
**risk** [3] - 3054:44, 3064:40, 3099:46
**risks** [1] - 3078:11
**Riton** [1] - 3052:17
**road** [2] - 3051:23, 3077:21
**ROBIN** [1] - 3075:5
**Robin** [1] - 3075:11
**robust** [4] - 3054:38, 3057:38, 3072:24, 3072:26
**rock** [2] - 3062:4, 3062:9
**rocky** [2] - 3059:19
**role** [23] - 3017:20, 3017:27, 3017:29, 3021:9, 3021:31, 3026:11, 3028:20, 3039:11, 3046:47, 3047:5, 3048:14, 3051:5, 3051:9, 3051:18, 3052:11, 3052:16, 3053:32, 3053:39, 3054:43, 3068:21, 3070:27, 3070:29, 3071:13
**roles** [4] - 3039:22, 3039:38, 3089:43, 3090:19
**rolled** [2] - 3041:2, 3073:13
**room** [3] - 3037:27, 3038:26, 3045:5
**rooms** [7] - 3063:3, 3064:13, 3066:10, 3066:15, 3066:21, 3082:25, 3086:25
**Ross** [1] - 3015:28
**rostered** [1] - 3049:14
**rotate** [4] - 3049:15, 3049:31, 3049:43, 3049:44
**rotated** [1] - 3050:8
**rotating** [2] - 3049:6, 3049:10
**rotation** [1] - 3091:17
**rotations** [1] - 3035:4
**round** [4] - 3068:2, 3089:1, 3093:45, 3095:28
**Royal** [7] - 3048:5, 3048:11, 3048:36, 3050:8, 3050:16, 3063:41, 3068:3
**RPA** [12] - 3048:19, 3048:43, 3049:5, 3049:8, 3050:6, 3050:36, 3051:15, 3051:41, 3052:15, 3064:10, 3068:5, 3068:36
**RSL** [1] - 3015:18
**Rudd** [2] - 3082:29, 3096:30
**run** [10] - 3044:3, 3058:23, 3061:1, 3062:6, 3062:10, 3070:22, 3079:11, 3080:7, 3086:2, 3096:19
**run-away** [1] - 3061:1
**rung** [1] - 3087:25
**running** [8] - 3030:7, 3031:33, 3032:43, 3036:19, 3036:29, 3041:45, 3072:2, 3078:9
**runs** [3] - 3023:45, 3085:33, 3085:45
**rural** [23] - 3018:20, 3019:2, 3020:11, 3020:21, 3022:32, 3033:38, 3045:7, 3047:27, 3049:27, 3049:45, 3053:47, 3068:43, 3072:18, 3072:31, 3076:21, 3089:26, 3089:46, 3090:4, 3090:14, 3090:22, 3091:10, 3095:18, 3096:16
**Rural** [2] - 3033:7, 3072:21
**rurally** [8] - 3078:15, 3085:40, 3089:27, 3090:1, 3090:10, 3090:29, 3090:36, 3092:28

## S

**safe** [1] - 3021:42
**salaried** [1] - 3079:38
**salaries** [1] - 3039:40
**salary** [3] - 3061:45, 3079:16, 3079:17
**sat** [1] - 3047:3
**satisfied** [2] - 3016:30, 3075:37
**save** [1] - 3083:15
**saving** [1] - 3061:43
**savings** [2] - 3036:1, 3062:2
**Sax** [1] - 3031:41
**SC** [2] - 3015:14, 3015:27
**scale** [2] - 3051:14, 3057:38
**scanner** [1] - 3083:47
**scared** [2] - 3062:7, 3062:10
**scenario** [2] - 3030:46, 3040:41
**schedules** [1] - 3097:44
**Scheme** [1] - 3072:22
**scheme** [2] - 3097:43
**school** [2] - 3077:10, 3090:28
**schooled** [1] - 3063:39
**schools** [1] - 3090:22
**scope** [2] - 3080:3, 3094:18
**score** [1] - 3073:2
**Scotland** [1] - 3063:36
**screen** [3] - 3016:23, 3016:25, 3046:36
**seamless** [1] - 3021:30
**seamlessly** [1] - 3021:22
**second** [3] - 3049:15, 3056:5, 3059:24
**secondary** [11] - 3047:26, 3057:6, 3057:10, 3057:39,

3059:28, 3060:23, 3066:3, 3066:4, 3081:28, 3089:9, 3097:29
**section** [1] - 3100:9
**sector** [2] - 3046:31, 3046:32
**security** [2] - 3092:9, 3092:10
**seduced** [1] - 3091:26
**see** [67] - 3019:15, 3019:24, 3019:28, 3020:3, 3021:46, 3022:39, 3022:43, 3023:1, 3023:14, 3024:44, 3025:25, 3027:6, 3030:31, 3032:46, 3036:10, 3037:5, 3037:11, 3038:42, 3039:44, 3040:21, 3041:26, 3041:32, 3045:13, 3046:10, 3049:26, 3051:17, 3056:2, 3058:28, 3059:15, 3059:40, 3062:9, 3065:14, 3065:24, 3065:37, 3066:41, 3067:19, 3067:20, 3070:29, 3072:41, 3073:22, 3073:30, 3076:24, 3080:2, 3080:5, 3082:23, 3082:25, 3083:34, 3084:6, 3084:44, 3085:13, 3085:33, 3086:28, 3087:24, 3088:16, 3088:28, 3089:45, 3090:27, 3090:30, 3090:32, 3090:33, 3091:1, 3092:41, 3094:41, 3095:34, 3096:15, 3097:30
**seed** [1] - 3041:1
**seeing** [2] - 3033:36, 3074:20
**seem** [3] - 3043:1, 3082:22, 3096:41
**seen"** [1] - 3064:36
**sees** [1] - 3030:12
**sell** [1] - 3080:16
**sell-by** [1] - 3080:16
**send** [3] - 3071:5, 3094:40, 3095:5
**sending** [1] - 3094:23
**Senior** [1] - 3015:27
**senior** [9] - 3017:31, 3017:32, 3018:44, 3022:10, 3048:24, 3067:37, 3071:14, 3074:16, 3074:28
**sensational** [1] - 3069:41
**sensationalism** [1] - 3055:13
**sense** [16] - 3020:29, 3020:42, 3022:7, 3031:35, 3032:20, 3034:24, 3037:46, 3038:32, 3038:38, 3040:43, 3042:17, 3042:20, 3048:28, 3048:41, 3070:11, 3096:3
**sent** [4] - 3091:47, 3094:44, 3094:46, 3099:10
**sentence** [6] - 3017:20, 3024:44, 3032:5, 3032:12, 3034:44, 3039:42
**sentences** [1] - 3032:4
**separate** [1] - 3050:5
**September** [2] - 3079:24, 3080:17
**series** [1] - 3091:29
**serious** [2] - 3069:34, 3073:4
**service** [156] - 3016:15, 3016:41, 3016:44, 3017:14, 3017:16, 3017:28, 3017:32, 3017:44, 3018:1, 3018:2, 3018:12, 3018:18, 3018:31, 3018:33, 3018:40, 3018:43, 3018:44, 3019:2, 3019:10, 3019:11, 3019:25, 3020:2, 3020:16, 3020:17, 3021:7, 3021:13, 3021:29, 3022:10, 3022:12, 3022:37, 3024:41, 3025:14, 3025:28, 3026:6, 3028:9, 3028:16, 3028:20, 3028:26, 3028:45, 3029:34, 3029:44, 3029:47, 3030:14, 3030:21, 3030:47, 3032:22, 3032:40, 3032:42, 3033:5, 3033:13, 3033:18, 3033:23, 3033:27, 3033:33, 3033:43, 3033:46, 3033:47, 3034:5, 3034:6, 3034:10, 3034:22, 3034:23, 3034:24, 3035:21, 3035:25, 3035:32, 3035:33, 3036:17, 3036:20, 3036:25, 3036:26, 3036:28, 3036:30, 3036:31, 3036:34, 3036:40, 3036:43, 3036:47, 3037:20, 3038:10, 3038:21, 3038:42, 3039:1, 3039:11, 3039:24, 3040:13, 3040:17, 3040:18, 3040:24, 3040:38, 3041:2, 3041:36, 3042:1, 3042:7, 3042:26, 3042:31, 3042:45, 3043:14, 3044:12, 3044:28, 3044:29, 3044:35, 3045:3, 3051:42, 3053:38, 3056:10, 3056:13, 3056:16, 3056:28, 3060:32, 3060:37, 3061:1, 3061:31, 3063:30, 3063:35, 3063:44, 3064:16, 3064:45, 3065:6, 3065:11, 3065:22, 3066:25, 3067:3, 3067:23, 3067:27, 3068:24, 3068:34, 3068:38, 3068:39, 3068:41, 3069:1, 3069:3, 3069:8, 3069:12, 3069:18, 3069:21, 3069:24, 3069:26, 3069:37, 3077:20, 3078:20, 3081:19, 3081:21, 3081:32, 3081:33, 3084:30, 3086:2, 3087:16, 3093:40, 3094:35, 3095:10, 3095:26, 3095:35, 3097:40
**Service** [4] - 3017:45, 3018:6, 3018:28, 3033:7
**serviceable** [1] - 3020:36
**serviced** [1] - 3063:41
**services** [101] - 3016:45, 3016:46, 3017:1, 3017:3, 3017:4, 3017:5, 3017:12, 3017:13, 3017:38, 3017:42, 3017:47, 3018:7, 3018:13, 3018:32, 3018:35, 3019:16, 3019:25, 3019:32, 3019:35, 3020:12, 3020:18, 3020:31, 3020:43, 3020:45, 3020:46, 3021:2, 3021:11, 3021:21, 3022:5, 3022:6, 3022:30, 3023:44, 3024:36, 3025:46, 3026:8, 3026:13, 3026:23, 3026:38, 3027:2, 3027:8, 3027:20, 3027:37, 3027:44, 3027:47, 3028:41, 3030:8, 3030:9, 3031:4, 3031:10, 3032:35, 3033:2, 3033:17, 3033:18, 3033:38, 3033:41, 3034:18, 3035:8, 3035:13, 3039:26, 3040:28, 3041:3, 3041:22, 3041:30, 3042:21, 3043:3, 3044:45, 3050:38, 3051:16, 3051:38, 3052:19, 3059:34, 3060:26, 3063:23, 3064:2, 3065:10, 3065:20, 3065:24, 3065:43, 3065:44, 3066:4, 3066:38, 3067:28, 3068:5, 3068:27, 3070:33, 3079:36, 3079:46, 3081:9, 3081:14, 3081:28, 3082:20, 3085:15, 3088:17, 3089:38, 3092:35, 3093:1, 3093:35, 3094:19, 3094:20
**session** [1] - 3057:32
**sessional** [1] - 3069:23
**set** [11] - 3016:1, 3026:46, 3030:6, 3035:28, 3039:18, 3052:45, 3062:37, 3063:2, 3066:15, 3069:9, 3095:37
**setting** [3] - 3076:36, 3083:12, 3092:6
**settings** [1] - 3097:16
**settled** [1] - 3077:4
**seven** [5] - 3023:46, 3024:27, 3046:40, 3049:6, 3097:8
**several** [1] - 3054:37
**severity** [1] - 3073:2
**shake** [1] - 3050:35
**share** [1] - 3079:29
**shared** [5] - 3028:12, 3086:44, 3087:4, 3087:5, 3087:8
**sharing** [1] - 3087:19
**sharp** [1] - 3083:24
**sheet** [1] - 3099:25
**shingle** [1] - 3092:6
**ship** [1] - 3051:41
**shire** [3] - 3063:40, 3063:43
**shock** [1] - 3051:26
**short** [1] - 3032:46
**shortage** [2] - 3053:38, 3088:43
**shorter** [1] - 3088:12
**shortly** [1] - 3032:1
**show** [1] - 3082:12
**shrinking** [1] - 3027:6
**shudder** [1] - 3070:43
**sick** [1] - 3068:14
**sicker** [1] - 3089:34
**side** [6] - 3017:34, 3038:1, 3079:28, 3079:30, 3086:45, 3086:46
**sifted** [1] - 3053:1
**signage** [1] - 3025:30
**significant** [9] - 3017:20, 3019:13, 3027:36, 3029:7, 3030:18, 3051:28, 3072:35, 3076:22, 3085:13
**significantly** [2] - 3034:30, 3059:2
**silence** [2] - 3094:25, 3094:40
**similar** [4] - 3036:30, 3041:34, 3055:26, 3065:38
**simple** [3] - 3054:29, 3061:12, 3066:36
**simplified** [1] - 3058:31
**simplify** [1] - 3066:30
**single** [7] - 3029:13, 3031:24, 3034:30, 3049:7, 3061:1, 3087:21, 3087:41
**sinusoidal** [1] - 3059:15
**siphoned** [1] - 3084:46
**sit** [9] - 3021:11, 3039:22, 3046:30, 3050:12, 3063:46, 3067:39, 3076:13,

3083:18, 3096:4
**site** [15] - 3018:34, 3019:21, 3048:22, 3048:35, 3049:40, 3050:16, 3051:46, 3057:36, 3058:20, 3063:9, 3073:23, 3073:29, 3073:32, 3100:23
**sites** [17] - 3021:16, 3035:4, 3044:38, 3044:44, 3050:40, 3051:31, 3059:37, 3060:35, 3068:43, 3069:13, 3070:10, 3071:37, 3072:19, 3072:22, 3073:32, 3095:5
**sits** [1] - 3058:22
**sitting** [3] - 3049:40, 3051:17, 3053:15
**situation** [6] - 3038:31, 3054:6, 3067:4, 3081:16, 3084:37, 3096:44
**situations** [1] - 3053:40
**six** [11] - 3049:23, 3049:41, 3052:36, 3058:23, 3060:46, 3062:23, 3084:8, 3089:23, 3089:27, 3091:18, 3097:8
**six-month** [2] - 3049:23, 3091:18
**six-year** [1] - 3060:46
**size** [2] - 3020:7, 3047:38
**sized** [1] - 3047:36
**skies** [1] - 3091:26
**skill** [2] - 3039:18, 3052:45
**skilled** [1] - 3067:35
**skin** [1] - 3082:40
**skinner** [1] - 3082:4
**slap** [1] - 3071:4
**sleep** [8] - 3056:6, 3056:7, 3056:9, 3056:10, 3056:12, 3056:19, 3056:22, 3056:24
**slightly** [3] - 3017:11, 3020:17, 3047:32
**small** [26] - 3018:22, 3020:11, 3022:32, 3022:46, 3022:47, 3024:35, 3025:4, 3025:15, 3027:9, 3027:23, 3027:27, 3027:34, 3033:38, 3037:47, 3041:36, 3042:39, 3042:43, 3044:25, 3044:32, 3044:38, 3044:44, 3045:2, 3057:21, 3057:23, 3079:11, 3080:8
**smaller** [15] - 3018:33, 3018:34, 3020:17, 3035:4, 3035:13, 3045:20, 3050:27, 3070:37, 3070:38, 3076:31, 3082:34, 3089:4, 3089:23, 3089:24, 3089:25
**soccer** [1] - 3080:45
**social** [3] - 3056:37, 3090:5, 3094:47
**socioeconomic** [1] - 3058:36
**software** [1] - 3087:27
**sole** [1] - 3031:15
**solid** [1] - 3024:19
**soliloquy** [1] - 3063:23
**solution** [6] - 3031:15, 3035:7, 3037:6, 3065:37, 3081:12
**solutions** [3] - 3084:30, 3084:41, 3094:22
**someone** [7] - 3049:16, 3059:18, 3061:37, 3064:9, 3068:6, 3069:30, 3098:47
**something's** [1] - 3096:43
**sometimes** [8] - 3026:7, 3030:37, 3048:29, 3050:36, 3055:10, 3063:17, 3069:39, 3094:39
**somewhat** [1] - 3032:32
**somewhere** [2] - 3082:35, 3092:6
**soon** [2] - 3025:30, 3087:39
**sorry** [7] - 3037:38, 3038:19, 3049:8, 3050:36, 3071:43, 3084:25, 3098:36
**sort** [13] - 3050:18, 3052:8, 3054:15, 3054:46, 3065:17, 3065:36, 3068:29, 3069:10, 3069:18, 3069:28, 3082:14, 3092:2, 3095:6
**sorted** [1] - 3051:40
**sound** [1] - 3069:40
**source** [5] - 3018:30, 3036:29, 3037:2, 3042:42, 3082:25
**sources** [5] - 3029:4, 3031:9, 3037:12, 3044:24, 3082:21
**South** [15] - 3015:20, 3025:13, 3048:22, 3051:11, 3056:25, 3056:42, 3057:35, 3061:12, 3071:11, 3076:11, 3076:15, 3076:44, 3089:1, 3090:15, 3091:25
**southern** [2] - 3020:15, 3021:1
**space** [18] - 3017:6, 3017:27, 3019:14, 3022:33, 3025:10, 3028:25, 3029:31, 3030:13, 3030:26, 3030:34, 3034:36, 3041:33, 3080:33, 3081:20, 3081:29, 3086:10, 3089:44, 3091:32
**span** [1] - 3057:28
**speaking** [1] - 3021:25
**SPECIAL** [1] - 3101:5
**Special** [1] - 3015:7
**specialised** [5] - 3020:18, 3020:33, 3021:2, 3022:7, 3040:17
**specialist** [18] - 3039:14, 3047:40, 3056:4, 3059:34, 3059:36, 3062:38, 3066:4, 3066:9, 3066:21, 3066:44, 3068:47, 3070:41, 3071:3, 3089:44, 3089:45, 3092:20, 3093:3
**specialists** [8] - 3066:42, 3066:45, 3070:14, 3076:36, 3076:37, 3089:11, 3089:12, 3096:20
**specialties** [2] - 3022:31, 3068:19
**specialty** [13] - 3018:10, 3022:22, 3022:27, 3047:30, 3047:40, 3048:26, 3049:30, 3049:33, 3062:18, 3062:34, 3068:5, 3072:9, 3074:13
**specific** [5] - 3036:45, 3055:45, 3055:46, 3056:3, 3084:30
**specifically** [3] - 3018:43, 3051:36, 3070:30
**speech** [2] - 3055:6, 3095:3
**spend** [4] - 3049:36, 3049:38, 3054:23, 3057:21
**spending** [2] - 3055:29, 3082:27
**spent** [1] - 3025:26
**Spittal** [4] - 3037:26, 3056:20, 3063:26, 3081:7
**split** [1] - 3050:6
**spoken** [4] - 3033:28, 3059:8, 3059:35, 3068:31
**sponsored** [1] - 3038:2
**sponsorship** [1] - 3029:8
**spouse** [1] - 3049:24
**Springs** [1] - 3049:4
**ST** [1] - 3071:7
**ST-elevation** [1] - 3071:7
**stability** [2] - 3092:2, 3092:16
**staff** [13] - 3036:19, 3042:6, 3055:21, 3066:8, 3066:21, 3066:44, 3073:47, 3078:35, 3086:45, 3088:9, 3095:13, 3096:20
**staff's** [1] - 3074:30
**staffing** [4] - 3053:37, 3054:1, 3054:9, 3073:25
**stage** [7] - 3016:35, 3048:2, 3049:46, 3057:43, 3098:47, 3099:8, 3100:31
**stages** [1] - 3048:30
**stand** [4] - 3036:26, 3045:44, 3047:11, 3048:27
**stand-alone** [1] - 3048:27
**standardisation** [2] - 3022:13, 3022:41
**standing** [1] - 3048:41
**start** [10] - 3026:8, 3046:20, 3048:46, 3052:24, 3055:45, 3062:8, 3069:9, 3076:20, 3088:30, 3093:31
**started** [11] - 3022:17, 3046:27, 3060:47, 3062:12, 3062:47, 3065:1, 3068:13, 3082:14, 3086:18, 3087:3, 3093:7
**starting** [6] - 3049:26, 3052:26, 3082:12, 3092:7, 3092:36, 3095:3
**starts** [1] - 3066:8
**state** [25] - 3016:11, 3031:2, 3032:23, 3034:29, 3046:5, 3056:28, 3056:41, 3075:9, 3077:24, 3080:33, 3080:44, 3081:14, 3081:17, 3081:24, 3082:28, 3082:31, 3082:40, 3083:3, 3083:37, 3087:10, 3091:5, 3091:7, 3091:8, 3091:31, 3093:42
**statement** [7] - 3023:22, 3031:38, 3058:10, 3060:43, 3083:1, 3097:21, 3098:36
**static** [2] - 3042:18, 3061:30
**stats** [1] - 3035:31
**status** [2] - 3081:41, 3083:19
**stay** [7] - 3026:29, 3083:19, 3090:11, 3090:17, 3091:10, 3092:10, 3092:11
**stayed** [1] - 3091:23
**staying** [2] - 3071:31, 3080:10
**STC** [1] - 3071:12
**steady** [2] - 3077:33, 3077:35
**step** [6] - 3030:12, 3044:32, 3080:33, 3081:20, 3082:44, 3088:19
**stepped** [2] - 3028:8, 3081:28
**stepping** [3] - 3028:25, 3030:25, 3030:34
**steps** [5] - 3029:30, 3033:30, 3035:5, 3035:30, 3044:2

**stick** [2] - 3047:39, 3053:44
**still** [13] - 3024:39, 3025:5, 3025:7, 3030:40, 3033:46, 3058:28, 3062:40, 3065:13, 3068:11, 3078:5, 3078:31, 3084:21, 3095:24
**stints** [1] - 3091:18
**stock** [1] - 3035:33
**stone** [1] - 3095:37
**stood** [2] - 3033:35, 3040:33
**stop** [2] - 3036:46, 3083:35
**stopping** [2] - 3082:31, 3096:31
**story** [2] - 3063:1, 3091:25
**straightforward** [1] - 3070:3
**strained** [1] - 3028:41
**strategic** [2] - 3017:21, 3017:28
**strategies** [1] - 3057:41
**strategy** [1] - 3070:28
**stream** [6] - 3042:20, 3043:14, 3043:17, 3043:22, 3072:11, 3072:12
**streams** [10] - 3021:45, 3022:3, 3022:15, 3022:18, 3026:38, 3030:41, 3072:8, 3072:10, 3072:13, 3083:10
**Street** [2] - 3015:19
**stretched** [1] - 3028:42
**strides** [1] - 3057:7
**strings** [1] - 3086:3
**strong** [7] - 3018:15, 3030:19, 3037:22, 3040:21, 3051:37, 3051:39, 3053:6
**strongly** [1] - 3068:23
**structure** [2] - 3022:47, 3029:18
**structured** [6] - 3020:26, 3021:32, 3022:19, 3028:14, 3033:14, 3037:43
**structures** [1] - 3031:12
**struggle** [1] - 3025:32
**struggling** [1] - 3064:27
**stuck** [1] - 3078:5
**stuff** [3] - 3068:26, 3068:29, 3091:45
**Sturt** [1] - 3090:21
**style** [2] - 3073:44, 3078:18
**sub** [14] - 3019:25, 3047:30, 3047:40, 3048:26, 3049:30, 3049:33, 3062:18, 3062:34, 3067:24, 3068:5, 3068:19, 3072:9, 3074:13, 3094:44
**sub-acute** [2] - 3019:25, 3094:44
**sub-acute/acute** [1] - 3067:24
**sub-specialties** [1] - 3068:19
**sub-specialty** [10] - 3047:30, 3047:40, 3048:26, 3049:30, 3049:33, 3062:18, 3062:34, 3068:5, 3072:9, 3074:13
**subcommittee** [2] - 3047:2, 3085:17
**subcommittees** [1] - 3047:5
**subject** [3] - 3017:30, 3019:1, 3099:43
**submission** [1] - 3027:5
**submitting** [1] - 3037:32
**subparagraph** [1] - 3021:44
**substantively** [2] - 3050:15, 3052:12
**subsumed** [1] - 3083:11
**subvert** [1] - 3051:45
**successful** [3] - 3033:7, 3033:19, 3039:23
**succession** [1] - 3079:40
**suck** [2] - 3054:35, 3083:3
**sufficient** [1] - 3044:16
**suggest** [5] - 3059:34, 3067:9, 3072:33, 3094:32, 3099:19
**suggested** [2] - 3019:19, 3034:27
**suggesting** [3] - 3029:14, 3031:25, 3043:1
**suggestion** [1] - 3027:27
**suit** [2] - 3048:34, 3062:46
**summarise** [1] - 3065:36
**summary** [1] - 3093:29
**summation** [1] - 3032:11
**supervised** [1] - 3051:13
**supervision** [2] - 3050:35, 3062:27
**supervisory** [1] - 3048:14
**support** [32] - 3019:32, 3021:5, 3027:39, 3028:22, 3029:45, 3030:20, 3030:32, 3031:7, 3034:17, 3036:35, 3038:22, 3039:25, 3039:43, 3040:14, 3040:22, 3040:26, 3044:36, 3052:1, 3052:3, 3052:17, 3054:16, 3067:5, 3067:25, 3067:37, 3068:24, 3068:26, 3072:2, 3080:28, 3084:3, 3085:34, 3086:10, 3090:4
**supported** [15] - 3018:14, 3026:14, 3034:7, 3036:16, 3036:21, 3038:30, 3039:11, 3039:21, 3040:9, 3056:11, 3080:4, 3086:21, 3086:24, 3089:25
**supporting** [2] - 3030:47, 3086:25
**supportive** [3] - 3029:7, 3061:18, 3086:19
**supports** [1] - 3017:47
**suppose** [1] - 3037:36
**surgeon** [3] - 3064:43, 3065:16
**Surgeons** [1] - 3070:43
**surgeons** [5] - 3064:4, 3064:21, 3064:26, 3064:27, 3064:45
**surgery** [2] - 3060:32, 3086:20
**surgical** [7] - 3063:30, 3063:34, 3063:35, 3063:42, 3063:44, 3064:30, 3066:5
**surprised** [3] - 3069:38, 3088:29, 3088:38
**suspect** [1] - 3053:3
**sustain** [2] - 3079:40, 3086:39
**sustainability** [2] - 3033:33, 3079:36
**sustainable** [6] - 3032:36, 3034:5, 3034:14, 3042:12, 3079:5, 3095:21
**swap** [1] - 3049:15
**sworn** [2] - 3016:7, 3075:5
**Sydney** [17] - 3038:46, 3039:19, 3039:22, 3039:38, 3049:13, 3058:15, 3060:12, 3062:39, 3062:41, 3062:46, 3062:47, 3064:32, 3065:11, 3071:8, 3081:45, 3089:2, 3089:12
**Sydney's** [2] - 3061:31, 3090:22
**system** [38] - 3029:3, 3037:33, 3037:36, 3037:40, 3038:4, 3038:27, 3043:25, 3044:7, 3044:37, 3055:5, 3059:31, 3061:25, 3061:34, 3061:37, 3061:43, 3062:1, 3062:8, 3062:31, 3062:37, 3063:2, 3064:27, 3066:29, 3068:30, 3077:17, 3077:25, 3078:21, 3083:19, 3087:30, 3087:37, 3089:13, 3089:14, 3091:31, 3091:36, 3092:18, 3092:23, 3092:31, 3092:32, 3092:39
**systems** [3] - 3060:3, 3060:36, 3063:16

## T

**tack** [1] - 3070:33
**tackling** [1] - 3070:36
**tailored** [1] - 3028:46
**Tamsin** [1] - 3015:29
**tapped** [1] - 3093:38
**targeted** [1] - 3022:27
**tasks** [1] - 3039:10
**teaching** [1] - 3091:19
**team** [15] - 3017:26, 3017:29, 3017:31, 3017:41, 3018:21, 3018:43, 3019:5, 3019:34, 3021:6, 3039:13, 3044:17, 3078:30, 3079:31, 3082:8, 3094:27
**teams** [1] - 3018:8
**tease** [1] - 3065:33
**technically** [1] - 3095:24
**technology** [1] - 3058:2
**telehealth** [2] - 3069:17, 3084:5
**temporary** [5] - 3039:16, 3039:17, 3039:18, 3039:26, 3072:39
**tend** [2] - 3076:37, 3089:8
**tended** [2] - 3018:25, 3085:38
**tender** [5] - 3046:36, 3098:47, 3099:1, 3099:15, 3099:17
**tendered** [4] - 3016:34, 3075:40, 3098:36, 3099:8
**tends** [1] - 3054:41
**tent** [1] - 3096:23
**tenure** [1] - 3024:42
**term** [10] - 3017:28, 3032:46, 3041:6, 3049:6, 3049:19, 3050:45, 3080:45, 3083:14, 3086:41, 3095:21
**terms** [23] - 3016:42, 3017:5, 3017:47, 3020:18, 3021:13, 3026:47, 3040:40, 3046:16, 3046:26, 3047:2, 3047:8, 3047:24, 3048:10, 3048:19, 3049:2, 3049:22, 3049:32, 3055:11, 3059:33, 3061:14, 3061:35, 3065:24, 3093:43
**terrible** [2] - 3048:29, 3056:42
**terrifying** [1] - 3050:38
**tertiary** [21] - 3022:10, 3049:47, 3050:15, 3050:30, 3059:47, 3060:10, 3060:23, 3060:38, 3063:42, 3067:23, 3067:28, 3067:40, 3068:12,

3068:36, 3068:43, 3069:37, 3069:45, 3070:10, 3070:15, 3081:28, 3097:29
**tertiary/quaternary** [2] - 3050:39, 3068:3
**thankful** [1] - 3072:20
**thankfully** [2] - 3064:6, 3071:40
**themselves** [2] - 3024:24, 3032:44
**theory** [1] - 3026:43
**therapy** [2] - 3051:27, 3058:2
**there"** [1] - 3083:40
**therefore** [13] - 3017:16, 3025:8, 3025:32, 3027:19, 3027:25, 3030:4, 3038:30, 3040:41, 3044:36, 3047:39, 3048:36, 3056:38, 3074:14
**they have** [10] - 3018:4, 3019:11, 3020:28, 3039:21, 3042:38, 3050:28, 3063:41, 3070:21, 3072:43, 3073:5
**thin** [1] - 3097:36
**thinking** [1] - 3022:16
**third** [3] - 3061:33, 3084:25, 3090:31
**thoroughly** [1] - 3090:14
**thoughts** [1] - 3018:11
**thousand** [2] - 3024:4, 3033:40
**thrash** [1] - 3094:22
**threatening** [1] - 3069:35
**three** [22] - 3022:7, 3022:29, 3039:34, 3040:8, 3040:25, 3049:1, 3049:22, 3049:29, 3049:30, 3049:35, 3049:36, 3050:12, 3061:43, 3071:7, 3072:35, 3079:21, 3080:10, 3082:5, 3090:45, 3091:16, 3091:19, 3091:42
**three-year** [5] - 3040:8, 3040:25, 3049:1, 3049:35, 3091:16
**thrombosis** [1] - 3074:14
**thrombotic** [2] - 3073:34, 3073:45
**through-put** [2] - 3079:19, 3080:14
**throughout** [1] - 3081:13
**thrust** [1] - 3053:45
**Thursday** [2] - 3057:32, 3070:23
**tie** [1] - 3071:18
**timely** [1] - 3021:18
**tip** [1] - 3069:25
**TO** [1] - 3101:6
**today** [15] - 3016:3, 3016:19, 3016:27, 3027:4, 3032:33, 3044:19, 3045:21, 3046:13, 3046:22, 3075:29, 3075:34, 3077:46, 3084:38, 3092:41, 3096:4
**together** [5] - 3016:45, 3060:43, 3074:11, 3085:15, 3094:35
**toilet** [1] - 3095:33
**toing** [1] - 3082:27
**tomorrow** [3] - 3077:47, 3087:28, 3089:19
**took** [5] - 3037:33, 3039:11, 3046:47, 3051:9, 3052:16
**tool** [1] - 3072:2
**tools** [2] - 3063:45, 3095:6
**tooth** [1] - 3077:1
**top** [3] - 3049:9, 3082:9, 3094:18
**topic** [3] - 3058:8, 3088:15, 3091:29
**torpedo** [1] - 3051:44
**torpedoed** [1] - 3056:15
**total** [1] - 3049:41
**touched** [4] - 3041:17, 3091:30, 3093:47, 3096:35
**towards** [5] - 3041:24, 3044:29, 3049:45, 3050:2, 3067:15
**town** [7] - 3020:37, 3026:10, 3032:38, 3062:14, 3065:14, 3080:8, 3081:8
**towns** [7] - 3031:11, 3047:27, 3080:21, 3089:23, 3089:24, 3089:25, 3095:42
**track** [4] - 3066:16, 3081:30, 3081:43, 3092:29
**tracking** [1] - 3096:3
**traction** [1] - 3079:44
**traditional** [2] - 3032:35, 3047:38
**traditionally** [5] - 3030:26, 3035:14, 3049:22, 3081:3, 3081:26
**train** [4] - 3048:24, 3061:1, 3071:21, 3090:34
**trained** [5] - 3025:31, 3047:34, 3062:24, 3075:24, 3075:26
**trainee** [6] - 3048:42, 3048:44, 3049:21, 3049:36, 3050:26, 3071:16
**trainees** [11] - 3048:8, 3048:9, 3048:46, 3049:12, 3050:7, 3050:37, 3050:45, 3051:29, 3051:40, 3052:21, 3071:6
**training** [41] - 3035:3, 3035:15, 3048:11, 3048:14, 3048:15, 3048:17, 3048:21, 3048:23, 3048:24, 3048:30, 3048:33, 3049:1, 3049:38, 3049:39, 3049:45, 3049:46, 3050:14, 3050:20, 3050:32, 3050:43, 3051:15, 3051:23, 3051:31, 3051:39, 3051:44, 3051:46, 3052:15, 3062:38, 3062:44, 3070:36, 3070:41, 3071:3, 3071:9, 3071:10, 3071:14, 3071:19, 3076:46, 3077:2, 3090:36, 3091:20, 3091:43
**trajectory** [1] - 3063:11
**tranche** [2] - 3059:46, 3061:38
**tranches** [1] - 3061:17
**transcript** [1] - 3046:37
**transfer** [1] - 3068:11
**transferred** [1] - 3068:16
**transition** [1] - 3069:42
**transparency** [1] - 3067:20
**transparent** [1] - 3060:2
**transplantation** [2] - 3061:29, 3061:33
**travel** [3] - 3020:31, 3020:33, 3020:34
**travelling** [1] - 3070:9
**tread** [1] - 3062:38
**treasury** [1] - 3061:6
**trend** [4] - 3073:16, 3077:33, 3077:35, 3096:16
**trends** [3] - 3073:9, 3073:22, 3073:29
**triage** [4] - 3024:6, 3024:23, 3025:26, 3025:31
**triaged** [1] - 3024:40
**tried** [5] - 3051:45, 3052:32, 3080:24, 3082:4, 3082:6
**truck** [2] - 3036:19, 3037:35
**true** [7] - 3016:30, 3027:24, 3045:9, 3046:16, 3047:34, 3050:23, 3075:37
**truly** [2] - 3030:33, 3042:26
**try** [22] - 3026:31, 3041:17, 3047:39, 3048:33, 3051:36, 3057:33, 3058:42, 3058:43, 3074:26, 3074:29, 3081:40, 3082:8, 3082:10, 3083:23, 3085:19, 3089:22, 3090:26, 3090:39, 3093:43, 3094:20, 3094:45, 3095:11
**trying** [15] - 3021:41, 3033:45, 3044:23, 3044:31, 3044:42, 3045:4, 3056:3, 3059:17, 3064:9, 3074:6, 3074:7, 3080:27, 3081:43, 3084:40, 3084:41
**Ts** [11] - 3028:7, 3029:5, 3029:34, 3031:37, 3033:29, 3036:30, 3040:26, 3041:44, 3099:33, 3099:35, 3100:12
**tsunami** [1] - 3083:21
**Tuesday** [1] - 3100:23
**turn** [3] - 3081:38, 3093:41, 3096:15
**turning** [1] - 3091:28
**two** [35] - 3017:16, 3018:3, 3020:8, 3024:35, 3026:46, 3030:40, 3032:4, 3039:21, 3039:32, 3045:10, 3048:15, 3050:7, 3050:8, 3051:7, 3051:14, 3052:28, 3052:29, 3052:30, 3056:40, 3058:39, 3059:20, 3062:26, 3062:44, 3064:3, 3064:21, 3064:44, 3066:33, 3067:31, 3069:22, 3072:25, 3074:17, 3079:45, 3084:14, 3091:18, 3100:33
**type** [9] - 3022:21, 3030:24, 3034:22, 3039:28, 3040:18, 3040:38, 3049:29, 3082:17, 3094:35
**types** [4] - 3037:14, 3040:11, 3041:3, 3042:1
**typographical** [2] - 3046:26, 3058:12

## U

**UK** [1] - 3088:30
**ultimate** [2] - 3083:26, 3096:31
**ultimately** [7] - 3030:40, 3030:43, 3030:46, 3054:34, 3067:32, 3085:30, 3087:13
**umbrella** [1] - 3072:23
**unable** [1] - 3034:21
**unaccessed** [1] - 3030:36
**unattractive** [1] - 3078:7
**unattractiveness** [1] - 3079:10
**unbroken** [3] - 3058:40, 3059:6, 3059:12
**uncertain** [1] - 3097:33
**uncover** [3] - 3073:19, 3073:42, 3073:43
**uncovered** [1] - 3074:21
**under** [11] - 3018:3, 3018:14, 3027:22, 3034:20, 3041:15, 3050:35, 3062:9, 3066:21, 3067:34,

3072:21, 3076:19
**undergoing** [1] - 3099:45
**undergraduate** [1] - 3091:15
**underspend** [2] - 3093:32, 3093:37
**undertake** [4] - 3049:15, 3059:43, 3066:25, 3073:17
**undertaken** [2] - 3066:6, 3088:18
**undistinguished** [1] - 3063:6
**unfilled** [1] - 3052:35
**unfortunate** [3] - 3051:30, 3051:43, 3052:34
**unfortunately** [2] - 3051:24, 3096:6
**unified** [2] - 3058:5, 3087:13
**unique** [1] - 3045:19
**unit** [3] - 3050:1, 3063:42, 3070:15
**unitary** [6] - 3084:44, 3096:19, 3096:22, 3097:7, 3097:26, 3098:1
**United** [1] - 3075:24
**units** [2] - 3018:4, 3022:24
**University** [2] - 3090:21
**university** [2] - 3065:16, 3092:20
**unless** [4] - 3060:3, 3060:6, 3061:45, 3073:5
**unmeasurable** [1] - 3065:25
**unofficial** [1] - 3052:13
**unplanned** [1] - 3064:30
**unravel** [1] - 3082:14
**unsustainable** [1] - 3077:17
**unused** [1] - 3021:40
**up** [57] - 3016:23, 3016:39, 3017:11, 3018:15, 3022:22, 3025:9, 3025:21, 3030:6, 3033:35, 3035:46, 3036:26, 3036:34, 3036:40, 3038:15, 3039:35, 3040:33, 3044:47, 3045:13, 3046:36, 3049:4, 3051:8, 3053:39, 3054:33, 3057:43, 3059:39, 3061:35, 3062:37, 3063:2, 3063:8, 3063:39, 3064:39, 3065:19, 3066:15, 3067:20, 3067:34, 3069:3, 3069:9, 3072:42, 3077:10, 3077:22, 3077:30, 3079:24, 3081:38, 3087:19, 3088:23, 3090:44, 3091:25, 3092:4, 3092:6, 3092:14, 3093:41, 3093:43, 3094:23, 3094:40, 3095:9, 3095:28, 3098:43
**up-front** [1] - 3054:33
**UPA** [1] - 3086:25
**updates** [1] - 3073:12
**upskilling** [1] - 3070:10
**usage** [1] - 3071:38
**useful** [1] - 3085:26
**usual** [1] - 3099:14
**USYD** [1] - 3090:23
**utilise** [2] - 3021:37, 3021:41

## V

**vacant** [1] - 3062:45
**valuable** [3] - 3053:17, 3064:12, 3087:22
**value** [6] - 3052:32, 3053:14, 3054:7, 3055:14, 3055:31, 3073:15
**Value** [2] - 3061:17, 3061:38
**value-add** [1] - 3054:7
**variable** [2] - 3027:28, 3027:33
**variance** [2] - 3034:3, 3044:13
**variations** [1] - 3059:15
**various** [3] - 3017:42, 3065:1, 3090:19
**vascular** [19] - 3060:31, 3063:30, 3063:34, 3063:35, 3063:42, 3063:44, 3064:3, 3064:13, 3064:21, 3064:24, 3064:25, 3064:26, 3064:27, 3064:30, 3064:31, 3064:38, 3064:43, 3064:44, 3065:16
**vast** [2] - 3037:6, 3077:13
**versus** [2] - 3045:9, 3066:21
**very-oft-mentioned** [1] - 3050:32
**vested** [1] - 3092:33
**via** [1] - 3059:40
**viable** [4] - 3032:14, 3032:26, 3096:17, 3096:18
**video** [2] - 3069:18, 3084:5
**view** [14] - 3020:47, 3025:21, 3027:37, 3032:37, 3034:32, 3038:4, 3054:44, 3069:29, 3079:2, 3079:6, 3082:39, 3083:31, 3087:45, 3089:41
**viewpoint** [1] - 3051:43
**views** [1] - 3028:2
**virtual** [13] - 3029:34, 3033:5, 3033:6, 3034:21, 3038:41, 3044:28, 3059:38, 3059:40, 3060:36, 3068:41, 3069:10, 3070:16, 3070:22
**Virtual** [2] - 3033:7, 3072:21
**virtually** [1] - 3033:23
**visiting** [3] - 3018:35, 3032:31, 3064:44
**visits** [1] - 3100:23
**vital** [4] - 3052:40, 3060:16, 3060:22, 3060:24
**VMO** [14] - 3030:1, 3034:10, 3034:16, 3042:11, 3066:9, 3066:20, 3069:22, 3072:22, 3077:1, 3095:20, 3095:22, 3095:24, 3096:7, 3096:16
**VMOs** [2] - 3096:11, 3096:20
**voice** [2] - 3053:7, 3055:26
**voices** [1] - 3055:26
**vRGS** [5] - 3033:6, 3033:33, 3033:35, 3033:43, 3033:46

## W

**wages** [1] - 3039:40
**wait** [5] - 3040:23, 3083:18, 3083:23, 3088:31, 3088:33
**waiting** [3] - 3064:35, 3081:37, 3094:23
**Wales** [26] - 3015:20, 3025:13, 3048:23, 3051:11, 3056:25, 3056:43, 3057:35, 3061:12, 3071:11, 3075:26, 3075:27, 3076:11, 3076:16, 3076:44, 3076:46, 3077:2, 3077:4, 3088:32, 3089:2, 3090:15, 3091:15, 3091:22, 3091:23, 3091:25, 3091:40
**Walgett** [1] - 3064:9
**wants** [1] - 3092:9
**ward** [1] - 3095:28
**water** [1] - 3062:39
**WATERHOUSE** [8] - 3045:43, 3046:3, 3046:5, 3046:35, 3053:21, 3053:31, 3065:31, 3074:33
**Waterhouse** [3] - 3015:29, 3058:9, 3065:5
**ways** [4] - 3030:45, 3054:6, 3062:39, 3078:6
**wearing** [1] - 3071:19
**WEDNESDAY** [1] - 3101:6
**Wednesday** [7] - 3051:2, 3057:31, 3098:41, 3100:22, 3100:27, 3100:37, 3100:46
**week** [14] - 3017:24, 3026:11, 3034:27, 3057:29, 3069:22, 3084:2, 3084:7, 3084:8, 3084:14, 3084:15, 3086:27, 3090:45, 3095:3, 3099:5
**weekend** [1] - 3072:40
**weekly** [1] - 3070:22
**weeks** [4] - 3033:41, 3046:28, 3052:36, 3073:41
**weighted** [1] - 3026:42
**weighting** [1] - 3040:40
**West** [2] - 3076:13, 3084:40
**west** [9] - 3029:17, 3031:33, 3046:31, 3056:41, 3064:32, 3076:38, 3088:37, 3089:36, 3090:17
**Western** [9] - 3016:16, 3057:35, 3061:30, 3070:38, 3076:2, 3076:6, 3076:11, 3076:43, 3089:1
**western** [2] - 3085:18
**Westernised** [2] - 3058:32, 3058:35
**Westmead** [1] - 3050:9
**Westmead's** [1] - 3070:21
**whereas** [1] - 3090:2
**whilst** [1] - 3041:19
**whole** [15] - 3028:19, 3032:15, 3033:18, 3078:25, 3082:7, 3082:14, 3083:19, 3086:2, 3087:9, 3087:37, 3091:36, 3092:18, 3092:31, 3092:32, 3092:39
**wide** [3] - 3016:47, 3018:32, 3027:13
**widely** [1] - 3058:4
**wider** [1] - 3044:17
**wife** [4] - 3060:42, 3064:4, 3077:2, 3091:21
**Williams** [9] - 3075:3, 3075:9, 3075:11, 3087:35, 3093:45, 3095:15, 3096:27, 3097:6, 3098:6
**WILLIAMS** [1] - 3075:5
**willing** [1] - 3097:32
**Wingewarra** [1] - 3015:19
**winning** [2] - 3058:44, 3062:20
**wins** [1] - 3042:19
**Wiradjuri** [1] - 3046:22
**wish** [3] - 3016:26, 3049:13, 3067:7
**withdraw** [2] - 3049:12, 3095:40
**withdrawal** [2] - 3051:8, 3051:22
**withdrawn** [1] - 3051:3
**withdrawn,the** [1] -

3052:6
**WITHDREW** [3] - 3045:39, 3075:1, 3098:20
**witness** [11] - 3016:3, 3016:4, 3045:41, 3074:34, 3075:3, 3076:4, 3088:25, 3093:25, 3097:24, 3098:22, 3098:31
**WITNESS** [6] - 3045:37, 3045:39, 3074:44, 3075:1, 3098:16, 3098:20
**wonder** [1] - 3091:24
**wondering** [1] - 3072:38
**word** [2] - 3048:29, 3064:17
**words** [2] - 3055:30, 3067:41
**work-placed** [1] - 3051:47
**worker** [1] - 3095:1
**workers** [1] - 3055:31
**workforce** [43] - 3021:15, 3022:42, 3022:44, 3023:3, 3023:4, 3023:5, 3023:15, 3025:10, 3034:43, 3043:40, 3055:29, 3056:4, 3059:1, 3059:36, 3060:5, 3062:3, 3066:7, 3066:41, 3067:1, 3067:2, 3067:8, 3067:11, 3067:15, 3070:36, 3070:40, 3071:15, 3071:23, 3073:43, 3073:44, 3074:17, 3074:22, 3074:27, 3074:28, 3074:31, 3077:15, 3077:19, 3077:20, 3088:42, 3089:5, 3089:16, 3090:9, 3092:42
**workhorses** [1] - 3051:42
**workplace** [1] - 3047:35
**works** [6] - 3041:19, 3080:8, 3086:31, 3087:26, 3088:2, 3094:37
**workshop** [1] - 3057:31
**world** [1] - 3090:3
**worry** [3] - 3055:11, 3078:13, 3092:6
**worse** [1] - 3096:44
**worsening** [2] - 3081:41, 3082:11
**worst** [1] - 3056:42
**wrangling** [1] - 3071:12
**wrap** [1] - 3098:43
**wriggle** [1] - 3045:5
**write** [2] - 3066:34, 3087:34
**writing** [1] - 3031:43
**wrote** [1] - 3056:11

## Y

**year** [38] - 3017:9, 3023:47, 3024:4, 3024:10, 3024:15, 3024:20, 3024:27, 3025:25, 3027:10, 3027:16, 3030:18, 3033:41, 3040:8, 3040:25, 3047:1, 3048:47, 3049:1, 3049:7, 3049:35, 3054:3, 3055:18, 3055:19, 3055:24, 3057:28, 3057:38, 3060:46, 3061:15, 3061:44, 3064:43, 3066:32, 3067:10, 3077:3, 3088:31, 3090:25, 3090:31, 3091:16, 3091:41
**year's** [1] - 3077:40
**years** [32] - 3019:9, 3022:16, 3022:17, 3037:31, 3039:34, 3044:40, 3046:40, 3049:36, 3057:8, 3058:39, 3059:13, 3059:14, 3059:20, 3067:31, 3072:35, 3075:21, 3077:5, 3077:6, 3077:34, 3077:38, 3079:25, 3080:15, 3080:18, 3083:38, 3090:14, 3091:20, 3091:24, 3091:42, 3096:43, 3097:8
**Yeoval** [3] - 3084:7, 3086:24, 3086:25
**yesterday** [8] - 3023:46, 3030:35, 3037:26, 3055:16, 3056:20, 3058:4, 3081:7, 3086:36
**young** [5] - 3078:7, 3078:17, 3079:22, 3079:47, 3090:34

## Z

**Zambo** [1] - 3080:15
**zero** [7] - 3044:31, 3044:39, 3044:43, 3045:4, 3045:5, 3045:14, 3045:18