Special Commission of Inquiry

into Healthcare Funding

Before: The Commissioner,
Mr Richard Beasley SC

At Level 2, 121 Macquarie Street,
Sydney, New South Wales

Monday, 5 August 2024 at 10am

(Day 044)

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

Also present:

Mr Richard Cheney SC with Mr Hilbert Chiu for NSW Health
Mr Scott Chapman for Ms Dominique Egan

1 THE COMMISSIONER: Good morning.
2
3 MR MUSTON: Our first witness this morning, Commissioner,
4 is Graeme Loy.
5
6 **<GRAEME ANDREW LOY, affirmed: [10.01am]**
7
8 **<EXAMINATION BY MR MUSTON:**
9
10 MR MUSTON: Q. Mr Loy, could you state your full name
11 for the record, please?
12 A. Graeme Andrew Loy.
13
14 Q. Thank you. Your substantive role at the moment is the
15 chief executive of Western Sydney LHD?
16 A. That's correct.
17
18 Q. A role I think you have held since October 2018?
19 A. That's correct.
20
21 Q. But since May of 2024, you've been acting in the
22 position of chief executive of the Sydney LHD?
23 A. That is also correct.
24
25 Q. You have prepared a statement to assist the Inquiry
26 with its work dated 25 July 2024.
27 A. Yes, that's correct.
28
29 Q. Do you have a copy of it with you?
30 A. I do, thank you.
31
32 Q. Have you had a chance to review it before giving your
33 evidence today?
34 A. I read it again last night.
35
36 Q. Are you satisfied that the contents of that statement
37 are true and correct to the best of your knowledge?
38 A. Yes, I am, thank you.
39
40 MR MUSTON: That will be tendered in due course,
41 Commissioner.
42
43 THE COMMISSIONER: Yes.
44
45 MR MUSTON: Q. You tell us in your statement about what
46 you perceive to be some of the significant intersections of
47 an industrial dispute and an accreditation dispute

1 regarding radiologists at Westmead Hospital. I don't want
2 to ask you at the moment about the factual chronology of
3 the events, I'm more interested in the way you see some of
4 those intersections working.
5
6 In paragraph 30 of your statement, if you could go
7 there, you tell us that there was obviously a temporal
8 overlap in the two issues - that is to say, they were both
9 bubbling away at roughly the same time. But then at
10 paragraph 31, you refer to staff specialist radiologists
11 at - I assume the staff specialist radiologists you were
12 referring to in paragraph 31 were at Westmead?
13 A. That's correct.
14
15 Q. And you refer to them having a direct and active role
16 in college matters. What was that role?
17 A. So the relationship between the college and the
18 radiologists, obviously, is a clear relationship - the
19 college is a member organisation, the radiologists are the
20 members - and therefore as a result of that it is not
21 unusual for radiologists to participate in the life of the
22 college.
23
24 In the case of an accreditation process they are
25 active participants in the whole review. So they have
26 a direct implication of it because the process of
27 accreditation revolves around interviews and feedbacks and
28 review of evidence, and that comes from, among others, the
29 radiologists.
30
31 Q. So the radiologists at Westmead were not the direct
32 decision-makers in terms of accreditation at that site?
33 A. That's correct.
34
35 Q. But the role, if I've understood your answer
36 correctly, that they were playing in that process was, as
37 members of the college, providing feedback to the college
38 and those who were the decision-makers, they were providing
39 input which had a capacity to influence the outcome of that
40 process?
41 A. That's correct.
42
43 Q. If we go down to paragraph 32 of your statement, you
44 tell us that it appeared to you, having regard to the
45 issues that you have set out above, that there was - both
46 the withdrawal of the accreditation and the industrial
47 dispute were intertwined. What led you to that conclusion?

1 A. The - and I've pointed it out in my statement there
2 a couple of times - the interrelationship and the roles
3 that the radiologists have in accreditation is very clear.
4 The discussion that we were having around an industrial
5 environment and having to necessitate changes to the
6 employment of the individuals overlapped, as you have
7 pointed out before, both in time and in context. By that
8 what I mean is that there are a number of discussions that
9 we had through the process, and I think I pointed it out on
10 one of the meetings that I had with radiologists in it,
11 where there are references made in meetings with
12 radiologists around impact on accreditation and, you know,
13 a number of these issues played out in discussions and I've
14 talked about the relationship that was challenged as
15 a result of that. It plays out all the way through in the
16 communication style, in comments that are made, in, you
17 know, the challenges that we faced through recruitment and
18 to attract people to the site.
19
20 Q. Is one of the challenges that some of the issues that
21 were being raised in respect of the industrial dispute did
22 have at least a capacity to be relevant to questions around
23 the accreditation of the site as a training location?
24 A. It certainly had the capacity to influence the ability
25 to recruit, which then influenced the ability to meet the
26 recommendations from the college, yes.
27
28 Q. And in terms of the recommendations from the college
29 around just that issue, the recruitment issue, was that
30 predominantly a ratios issue relevant - or in first part,
31 was part of it a ratios issue, trainer to trainee?
32 A. So, yes, the requirement for the additional four FTE
33 came out of a recommendation from the college around
34 supervision time and workload.
35
36 Q. In relation to that, putting to one side the
37 industrial dispute, viewing it from the perspective of the
38 accreditation of the site, was, at least in your view, that
39 an unreasonable request of the accrediting body, that there
40 be the additional four FTE to try and improve the ratios?
41 A. I think there's more than one way to change those
42 ratios around. Adding more staff is one. We also have to
43 be responsible in how we manage our budgets and manage our
44 systems and we have a requirement to meet many different
45 criteria. Increasing FTE is one, changing the profile is
46 another.
47

1 Q. When you say "changing the profile", what do you mean
2 by that?
3 A. Having a mix of staff specialists and visiting medical
4 officers as opposed to all staff specialists; reducing the
5 number of trainees, so you change the ratio from
6 a different lens. So there's more than one way to address
7 an issue, an issue of supervision for training.
8
9 Q. So whilst reducing the number of trainees might
10 improve ratios, from a workload point of view, reducing the
11 number of trainees has the capacity to exacerbate that
12 problem, doesn't it?
13 A. Not as much as removal of accreditation where you have
14 none.
15
16 Q. But viewing it from the perspective of the ability of
17 the supervisors to deliver what the college at least
18 regarded as adequate supervision to the trainees who were
19 there, reducing the number of trainees was not necessarily
20 a solution to that problem insofar as it had the capacity
21 to increase workload?
22 A. I would disagree with that. I think reducing the
23 number of trainees was a valid option. If the concern is
24 the ability to supervise and provide high-quality training.
25 The workload and the demands of the organisation is our
26 responsibility as administrators to make sure that we have
27 a structure where we can meet all the demands of our
28 system, and radiology is only one.
29
30 Q. In terms of that, to the extent that reducing the
31 number of trainees you think might have been a solution,
32 how would you, as an administrator, or you and your
33 administrators, have dealt with that workload issue?
34 A. Well, we would have to have a look at what other
35 workforce we needed and whether there were other
36 opportunities, whether we could increase VMOs or we could
37 put senior RMOs in place that were not through an
38 accredited training program.
39
40 There are a number of levers that you can pull in that
41 space. Remember that the trainees themselves are paid, so
42 from a budget perspective there's available funding to come
43 up with different models. We could have outsourced it,
44 which ultimately is what we had to do in the end. So it's
45 not just a singular issue or a singular solution.
46
47 Q. In terms of the process by which you might engage,

1 ideally constructively, with a college to work through
2 those issues in those various ways of potentially skinning
3 the cat --
4 A. Yes.
5
6 Q. -- did you have a perception that the overlap between
7 the accreditation issue and the industrial issue impacted
8 on that in any way?
9 A. Yes.
10
11 Q. What was that view?
12 A. Well - and I think I pointed it out in my statement -
13 it's quite apparent to me that the industrial issue which
14 affected our ability to recruit, through the second group
15 of criteria that was mentioned by the college, I think in
16 24, actually demonstrates an overreach and the college
17 getting involved in employment contracts, rather than the
18 training and the supervision that was required to actually
19 then try and influence an outcome, and that, from my
20 perception, was an artefact of the construct of the
21 industrial issues that were occurring and the influence
22 that was having on the process.
23
24 Q. You have referred to paragraph 24. You tell us in
25 35 that the items in 1.1.1 directly related to the
26 industrial dispute. In what way, just so we can understand
27 it, do you say that issue alluded to there in 1.1.1, at the
28 top of page 6 --
29 A. So when they've asked for exact credentials and
30 employment contracts, are clear indicators to me that they
31 are start to go look into areas outside of the supervision
32 component. So if the challenge is that we now want to look
33 at every employment contract of every employee who is
34 involved in supervision and that is not universally applied
35 to a training program, then we start to see a bias that's
36 introduced into that process.
37
38 Q. It might be my misunderstanding of it, but 1.1.1
39 refers to a clarification of a discrepancy between
40 previously provided consultant FTE, eg, those previously
41 listed as 0.7 FTE, now listed as 1 FTE. What was that
42 issue?
43 A. So part of the agreement that was in place had some
44 variability around what work needed to be achieved and that
45 they were not required to actively deliver a full FTE of
46 employment. So there was some conditions in that agreement
47 that were - that allowed the radiologists to do other work

1 rather than to do the work that they were - that you would
2 normally typically expect of a radiologist in that site.
3 So that 0.7 to 1 is a reflection of what that construct of
4 that agreement was.
5
6 Q. So the issue that they raised there, the 0.7 to 1 was,
7 in effect, seeking, as you understood at least,
8 a favourable resolution from their perspective of one
9 aspect of the industrial dispute?
10 A. Yes, from my lens it certainly was one of the other -
11 one of the areas where they had a very favourable condition
12 that as a chief executive I didn't support and couldn't
13 support moving forwards, because it was an out-of-award
14 agreement, and so therefore part of that outcome was an
15 impact on the amount of time that the radiologists had to
16 contribute to the organisation, and that was one of the
17 components that was less than popular.
18
19 Q. The next one you tell us about is 1.6.3, a
20 clarification of the supervision arrangements for the
21 SRMOs. You tell us in paragraph 36 that that related to
22 the SRMOs, a role completely outside the remit of the
23 college, those people not being trainees. Could you just
24 explain a little bit what you understood 1.6.3 to be
25 seeking and the way in which you say that tied in to the
26 industrial dispute?
27 A. So when we're talking about supervision and the amount
28 of time and the ratios, the SRMOs were a workforce that
29 were introduced after the construction of the new acute
30 services building at Westmead. We opened that in about
31 '21. To manage the throughput and the increased workload
32 we put on, from memory, I think it was 10 SRMOs that we
33 created a new workforce for to meet the extra demand. They
34 are not accredited training positions and they were part of
35 our general workforce around how to keep up with workload.
36
37 That then became part of the discussion around
38 additional workforce requirements for radiology. We were
39 aware that - it wasn't necessarily a model that was
40 strongly supported in radiology around SRMOs in that
41 building. It was a construct of the capital program
42 rolling out and how we did that and how we grew it. It
43 became a factor in the discussions around the impact of
44 SRMOs on the college training. I dispute that to be
45 a valid argument. The SRMOs are not part of the college
46 training program and it's a parallel workforce, albeit a
47 qualified workforce, to do that.

1
2 So, you know, when you start to reach into other
3 workforce groups to say, you know, how does that impact on
4 college accreditation and you shouldn't be using that type
5 of workforce, that's, in my view, the college stepping
6 outside its remit.
7
8 Q. Just from a layperson's perspective, the SRMOs were
9 not fellows of the college?
10 A. They were not in the accredited training program;
11 that's correct.
12
13 Q. But starting point, they were not radiologists?
14 A. They were radiologist.
15
16 Q. They were radiologists.
17 A. Yes.
18
19 Q. So were they fellows of the college?
20 A. I couldn't tell you the answer specifically about
21 those individuals, but they've certainly been through
22 radiology training and so the senior RMO model is a - is
23 just another workforce. But they're not just general
24 trained JMOs, they've actually been through a training
25 program, but they're not part of the college training
26 program.
27
28 Q. So again just to make sure I understand it, they have
29 received training in radiology but perhaps not an
30 accredited training path, training of the type delivered by
31 the college?
32 A. I'm just trying to think of the right way to
33 articulate it for you. So they've been through training.
34 They are functioning radiologists. They are not engaged as
35 consultants within our organisation because you have to
36 have positions that become available. Just the individuals
37 that were involved, whether they'd been through a previous
38 training program or they were an international graduate,
39 I couldn't tell you off the top of my head exactly what was
40 the make-up of each of those individuals, but there's
41 a couple of different options that could have been there.
42
43 Q. In the industrial dispute was it the college's view
44 that they should not have been employed in that capacity,
45 but staff specialist radiologists should have been filling
46 those roles?
47 A. It was the college's view, in the conversations we

1 had, that there was a risk that they would take away the
2 focus of the consultants and therefore less time available
3 to the training team.
4
5 Q. In what way, at least, was it suggested to you that
6 the SRMOs had the capacity to take away the focus of the
7 consultants?
8 A. If they asked the consultant a question that was
9 taking the time that a training position could have used,
10 then that would be a conflict.
11
12 Q. Now, 2.2.4, "Evidence of adequate, dedicated or onsite
13 secretarial and administrative support for the directors of
14 training" - how did that fit into the industrial dispute?
15 A. Oh, it doesn't. 1.1 are the industrial issues. So
16 that was just another example of what was still outstanding
17 and an example in my statement of how we - whilst I'm not
18 necessarily a believer and it's not standard practice to
19 give additional administrative support to these roles, it
20 was one of the things that we did to try and help negotiate
21 the process and get an outcome with the college.
22
23 Q. When you say it's not something that's usually done,
24 was it your view that it was overreach in terms of the
25 accreditation requests or it was something that might come
26 up in the mix ordinarily as part of those discussions but
27 might not always be given?
28 A. There's many requests that come up through a college
29 accreditation process that are not necessarily related to
30 the ability to supervise or train. It is not entirely
31 uncommon to get requests that we go - that we would
32 question whether that actually is within what would help to
33 assist to deliver a better program.
34
35 That's another example of it. So, you know, if they
36 feel that it would be beneficial to a director of training
37 to have additional admin support, it may make its way into
38 a recommendation. That's - there are opportunities for
39 access to administrative support, many different ways that
40 you could do it. I mean, you know, putting in a
41 recommendation, and in this case holding the accreditation
42 back based on an admin role, I think's unhelpful, doesn't
43 add value to the process, but, you know, in this case we
44 did it anyway because, you know, a lot of this is about
45 negotiation, how you work with the college and how you work
46 with your radiologists to get an outcome that's suitable to
47 everyone that we can all live with. Sometimes an admin

1 position helps that process.
2
3 Q. 2.2.6, "Demonstrate that there are defined
4 arrangements in place to clear current backlog of
5 unreported studies and that these arrangements do not
6 compromise consultant supervision capacity", you tell us in
7 paragraph 38 that that is not - a demand like that is not
8 the remit of a medical college.
9 A. Mmm-hmm.
10
11 Q. Why do you say that?
12 A. It's a straight workload issue. How do we manage to
13 keep up with what's coming through the front door and if
14 there is a backlog that grows - and from time to time you
15 will have, you know, you have leave and all sorts of things
16 that contribute to it - that how we, as an organisation,
17 set up the systems to make sure that we catch up with that
18 backlog to provide the care. That's not a question for
19 a college for accreditation around the daily flow and how
20 you manage your demand, you know. If we were to say "We're
21 not going to have any consultants", that's a different
22 story, but that's not what's happening in this place.
23 What's happening in this situation was that they were
24 starting to get into operational matters that sit outside
25 the college accreditation and sit outside the training.
26
27 Q. But is the workload, at least to the extent that
28 they've referred to it in 2.2.6, not potentially relevant
29 to accreditation and training insofar as the workload has
30 the capacity to compromise consultant supervision capacity?
31 A. Only if you stop everything else and just do backlog.
32 But that's not what was happening and that's not what you
33 would do. When you have a circumstance where you get
34 a demand in load, you have to modify your workforce, you
35 have to come up with alternatives around how you do that,
36 and there are a number of levers to do that. So to be as
37 blunt as to say, "We want to see exactly how you're doing
38 it, we actually want to get into the daily operational
39 management of your organisation", which is what that
40 request really was saying, is not appropriate.
41
42 Q. If they are of the view that because of a backlog and
43 what they're told by people on the ground about workload,
44 there's a possibility that in order to meet that workload
45 the ability to supervise trainees will be compromised, is
46 it not part of the discussion - is it not reasonably part
47 of the discussion that the college might have with you

1 about accreditation?
2 A. Yes, and we could easily - and did in that case - have
3 discussions with them about it and how we would do it, but
4 then to hold back accreditation unless we can put in a plan
5 that demonstrates it is an overreach.
6
7 Q. Why is that? If the college is not satisfied that
8 there's a plan in place which will ensure that the need to
9 meet workload will not compromise supervision, why is that
10 an overreach?
11 A. Because at some point in time, whether we have
12 a conversation about how we're going to do it or they put
13 a documented requirement for a management plan in place,
14 really is a reflection on what the role of the college is.
15 So if what we tell them verbally around what we're going to
16 do with a plan around how we outsource it or how we engage
17 a third party isn't acceptable, how is it that if we put
18 the same thing in writing is acceptable?
19
20 So in reality we've got a college that's saying, "We
21 want to have oversight of the decision-making of
22 management", and my question would be, you know, "Whose
23 responsibility is it to manage the organisation? Is it the
24 college's or is it the administration's responsibility?"
25
26 Q. Accepting that it's the administration's
27 responsibility to manage the facility, if the college's
28 view is that existing workload is such that, without some
29 adjustment to operations, supervision will not be able to
30 be appropriately delivered at the site, why is it
31 unreasonable for them to require - that is, the college to
32 require - in writing that that adjustment will be made
33 before they commit in writing to accrediting the facility?
34 A. Because you have to have flexibility and variability
35 when you manage because circumstances change on an ongoing
36 basis. We might have unforeseen leave, we might have an
37 increase in demand around - through the emergency
38 department, we might have a whole host of other things that
39 impact on it, and so as management, you need the
40 flexibility on a day-to-day or weekly basis to make sure
41 that you can, you know, meet those demands.
42
43 Q. From the college's point of view, though, if leaving
44 that flexibility - let me start again. From the college's
45 point of view, if it genuinely feels that leaving that
46 flexibility there means that the department might drift in
47 and out of a situation where supervision can adequately be

1 provided depending on the circumstances that prevail at the
2 hospital at any given time, why is it unreasonable for the
3 college to question the appropriateness of accrediting
4 a facility in those circumstances?
5 A. Well, the college doesn't set out a day by day, hour
6 by hour, "This is what the supervision requirements are and
7 this is what you have to do and this is time that needs to
8 be done and this is the program that needs to occur"; it's
9 an accredited training program that has variability and
10 flexibility against lots of different colleges around how
11 we go about that.
12
13 It also has to be a partnership with management around
14 the choices that we make on a day-to-day basis around how
15 do we manage demand and workload, and training programs is
16 a critically important piece around the future workforce,
17 so is the work flows and the demand that comes through the
18 front door and so is the safety and quality component of
19 it. So there are more than one criteria and if we lock
20 ourselves in to say, "This is the only criteria that we're
21 going to work on", and we'd have to compromise others as
22 a result of it, then that's not - that's not me fulfilling
23 my duties as a leader to make sure that, you know, we're
24 addressing the range of things that we have to look at.
25
26 Q. In terms of the compromising others, though, is the
27 need to compromise on others, if you were to lock in
28 something in respect of what the college regarded as
29 adequate training, does that compromise come because you
30 live within a budgetary environment and you're not able to
31 make decisions about where to deploy the limited resources
32 that you have at your disposal?
33 A. It's not about budget; it's about looking at demand
34 and looking at what are the priorities and what are the
35 risks on any given day and having the management plan, in
36 this case at Westmead Hospital, working with the head of
37 department in radiology to prioritise what we do on any
38 given time.
39
40 Q. So what would that actually look like in practice,
41 though, that prioritisation? To the extent that it might
42 have been seen by the college as reducing the quality of
43 supervision, what sort of decisions did you want the
44 management to retain flexibility in respect of?
45 A. So they need to plan on any given day and usually
46 that's done within the department, done by the head of
47 department, around how that works. The head of department

1 would meet regularly with the general manager, with the
2 director of medical services and talk through what are the
3 challenges and what needs to happen to support and assist
4 the department to do that. So there's an ongoing dialogue
5 all the way through in any of our departments around how
6 that would be managed. Keeping the flexibility so that we
7 can vary based on any given day, I think is really
8 important.
9
10 Having said that, there is still a roster, there's
11 still a workforce. You know, we know how many people are
12 on site but there's a whole host of things like M&M
13 meetings and all sorts of other meetings that occur that we
14 need to make sure that we can cover.
15
16 Q. If there were more funds deployed to - I'll take it in
17 two steps. If more funds were available to you as the
18 administrator of an LHD, and those funds were deployed
19 toward the radiology department, would that have produced
20 potentially a situation where the need to make those
21 decisions would not have had the capacity to compromise
22 supervision in the way that the college was concerned
23 about?
24 A. In the circumstance, I don't think so, because the
25 funds were available. The approval to recruit was - had
26 progressed. The inability to attract was what was holding
27 back it the challenges in the accreditation and that space,
28 and those four FTE we'd had advertised and were
29 unsuccessful. The risk is that it was a well-known event
30 that was occurring at Westmead and we were then trying to
31 recruit a group of radiologists with a different set of
32 conditions than the ones that were on site and it makes it
33 a really, really difficult environment to attract anyone
34 into.
35
36 So in this circumstance I don't think it was budget, I
37 think it - and the budget was there, the approval was
38 there. In my view very much so it was the known industrial
39 dispute that was making it really difficult to attract
40 anyone.
41
42 Q. You mentioned a little bit earlier that an alternative
43 way of dealing with that might have been through the use of
44 VMOs?
45 A. Mmm-hmm.
46
47 Q. Could you just explain that, how that might have

1 worked, and might potentially have been a way to solve the
2 problem?
3 A. Well, VMOs are another model for engaging consultants.
4 It's just a different employment construct. They could (a)
5 either provide support and assistance during supervision,
6 or they could have freed up time for the staff specialists
7 to do that, so by being able to engage VMOs to increase
8 your workforce, in the absence of ability to attract staff
9 specialists, you still increase your workforce and your
10 skill set that's available to training.
11
12 Q. Could I ask you to go to paragraph 39 of your
13 statement. You see you refer there to your view that the
14 LHD was not able to address matters to the satisfaction of
15 the college as the individuals concerned with the
16 accreditation issues and the industrial dispute were at the
17 centre of both matters. Just to clarify, who were the
18 individuals? I don't need names but positions.
19 A. The staff specialist radiologists.
20
21 Q. So the individuals you're referring to in 39 are the
22 staff specialist radiologists employed at Westmead
23 Hospital?
24 A. Correct.
25
26 Q. Can you track down to paragraph 43. You tell us in
27 the second sentence there that it's not reasonable that the
28 college determine the size and make-up of the surrounding
29 workforce. To the extent that that impacts potentially on
30 supervision, why is it not reasonable?
31 A. So, you know, does it impact on supervision? That's
32 not a question for you. I mean, the question that I have
33 to ask myself, when that comes up, is "Does it impact on
34 supervision?" So the administrative role, for example, you
35 know, I would argue it doesn't, but again, it's a
36 negotiation of how you go through that process.
37
38 To talk about SRMOs and say that impacts on
39 supervision, I don't believe that was reasonable, I don't
40 believe it impacted on training. So that's the surrounding
41 workforce that I'm talking about. And so, you know, my
42 view of it is that the colleges, you know, have a really
43 strong role to play in the training of our future
44 consultants. But it can get, at times, opaque around what
45 does that look like and it becomes about perceptions and
46 individual views rather than a very clear picture of, you
47 know, these are the four positions that you need in the

1 training program, right? So once - the risk is that it
2 blows out into other positions within the departments, or
3 surrounding, that get caught up in an accreditation
4 process, and in this case it did with the SRMOs and the
5 admin position.
6
7 Q. Moving down to paragraph 44, you tell us the only way
8 that the LHD could have had the industrial certainty to
9 realistically recruit the additional 4 FTE would have been
10 for you to reverse the decision to cease the radiology
11 agreement. I think you might have touched on this already,
12 but could you - just for an abundance of certainty, why was
13 that?
14 A. It was very clear to me that our radiologists were
15 very, very opposed to the cessation of that agreement.
16 They had been very clear in conversations with me that they
17 did not support it. There was a high level of challenging
18 communication, which also included comments around, you
19 know, the effect on accreditation and the impact that would
20 have on their organisation. So it played out quite
21 heavily, not just, you know, we have an isolation
22 discussion around accreditation and we have an isolated
23 discussion about industrial. They overlapped quite
24 significantly throughout that process.
25
26 Q. You mentioned a moment ago the possibility that those
27 who were recruited into new positions at the LHD would have
28 been on a different arrangement to those who were already
29 there.
30 A. Yes.
31
32 Q. Just stepping through that, those who were already
33 there were working under the radiology agreement, as you've
34 defined it?
35 A. Correct.
36
37 Q. And whilst that dispute was playing out, there was
38 a freeze, as it were, on withdrawing that agreement?
39 A. Yes. So there was a status quo imposed through the
40 IRC.
41
42 Q. And to the extent that anyone else was going to be
43 employed into the radiology department at Westmead, was it
44 the proposal that they would not be subject to the
45 radiology agreement or that status quo, but, rather, be
46 employed on different terms, namely, pursuant to the award?
47 A. So yes. So any new appointments that I would have put

1 on, I could not have put on under an agreement that was in
2 place that was in dispute, that it would be completely
3 unreasonable, if I was to open it up, then (a) I would have
4 had to go to the ministry to get approval and through
5 a determination to do that, and (b) that would be
6 completely unreasonable to employ someone only to say three
7 months later, "Sorry, I'm turning it off again." You know,
8 how do you - this all adds to the ability to attract people
9 to even apply for jobs.
10
11 Q. Was there any scope, there may not have been, but was
12 there any scope in that attempt to recruit people to
13 recruit them on whatever terms the existing workforce was
14 recruited on, on the basis that, in the event that the
15 dispute was resolved in favour of the ministry and the
16 radiology agreement was set aside, that they, too, would,
17 like all of their colleagues, continue to operate under the
18 award not - in an unmodified way?
19 A. So if I could paraphrase, your question is could
20 I have employed under the existing radiology agreement for
21 a short time and then turned it off again?
22
23 Q. So long as you told them that that was --
24 A. So long as I told them that.
25
26 Q. -- that that was what was on the cards if you won?
27 A. Outside of my delegation I would have to go and get
28 approval to do that through the ministry and, you know,
29 only really the secretary or her delegate could do that.
30 To attract anyone, to even get an applicant in that
31 circumstance, where we say "We're going to employ you on
32 this and then, by the way, we're going to turn off all this
33 sort of stuff and impact your employment", I don't believe
34 that I would get a single applicant in that environment.
35
36 Q. That wasn't quite what you would have been putting to
37 them, though? You might have been putting to them that
38 "I'm going to employ you on this basis and if we're
39 successful in our dispute in the Industrial Relations
40 Commission, I will be turning it off and you will be back
41 on the award", but there was a prospect for them that you
42 would not be successful in the Industrial Relations
43 Commission, in which case they would have continued to
44 operate under the radiology agreement which would have been
45 perhaps superior to conditions they could have got at
46 another public hospital?
47 A. Even if I was unsuccessful in the IRC, I still would

1 not have employed, moving forward, anyone under that
2 agreement because it's - the reason why I was turning it
3 off was because I do not believe it to be an appropriate
4 agreement and it was outside the remit of the normal
5 agreement process for a determination, and, you know, part
6 of my responsibility is making sure that we're spending
7 money appropriately and managing services appropriately.
8 I would not have, in good conscience, continued that
9 agreement. I wouldn't have offered it to any new
10 employees.
11
12 If I was forced through an ICR agreement to
13 grandfather positions, then I would work with the ministry
14 on what the next steps are in that place, but I still would
15 not move forward offering employment based on such
16 a non-award-compliant agreement.
17
18 Q. Because ultimately the way it has panned out is there
19 has been a grandfathering of sorts of the radiology
20 agreement, has there not, or a transition period?
21 A. No. No, I wouldn't characterise it like that. The
22 agreement has ceased. We worked with the ministry and came
23 up with an alternate transition model around how we can get
24 an appropriately approved determination through the
25 ministry around how to assist a transition into a standard
26 award model. I think that's appropriate. To turn it off
27 overnight and do nothing would be (a) really challenging
28 for that workforce and create a lot of uncertainty for us
29 and would make it really difficult - us collectively, being
30 radiologists and management, and make it really difficult
31 over the short term to change the environment in which
32 they're working to make it reasonable. So I think it's
33 appropriate to have a transitional arrangement in place.
34
35 It was entirely appropriate to cease that agreement
36 and the model with which we're doing it is much more -
37 brings it into line with the standard practices and what's
38 approved around how we can do it. So I don't think it's
39 grandfathered, I think it's actually ceased and I think
40 we've come up with a model that all of the radiologists
41 have now signed off and agreed to. They could have chosen
42 not to. They could have gone to a - stayed on a standard
43 award arrangement but from my memory, they've all signed
44 up, and the new ones have also signed up to it. So the new
45 employees now get access to that determination over that
46 sort of five-year window, which is sort of counting down,
47 so we can transition the department collectively.

1
2 Q. So in terms of the general mood of the department and
3 the impact that that dispute has on accreditation, has the
4 determination of the dispute by an independent arbiter been
5 beneficial, do you think? Has it improved relations,
6 albeit the radiologists were not successful?
7 A. I think it's mixed. I think new recruits are clear,
8 because they have a very clear pathway, they know what
9 their employment conditions will be, they know what the
10 circumstance is.
11
12 I think there's a couple of radiologists who have been
13 there for a very long time that I would be surprised if
14 they let go of it, and there will be a group of people
15 there that would not look me in the eye if I walked past
16 them today, and that's unfortunate but that's an artefact
17 of a significant industrial environment that had, you know,
18 lots of challenges through that space.
19
20 But I think from a culture perspective within the
21 department, what we're seeing - what I'm seeing is a real
22 shift. We've now recruited, it's fully staffed, so we're
23 well past that industrial environment. We actually have
24 a head of department who is working really well with us and
25 we're, you know, bringing people in and starting to build
26 it up for the future.
27
28 I think it's in a much, much better space now.
29 I think yes, like any industrial environment, there will
30 always be someone who can't let go of it, but that's okay.
31 As long as you're professional, as long as you can have
32 a good working relationship, as long as everyone's clear
33 around what we do, you know, you will never get a hundred
34 per cent of everyone on board.
35
36 Q. Has the transitional arrangement and the extension of
37 that to apply to any new recruits assisted in terms of
38 recruitment?
39 A. Yes, absolutely. So that's why we're now fully
40 recruited to, because, you know, they have a very clear
41 employment construct now around what's in there, they know
42 what's on offer, they know what the conditions and terms
43 are and they can plan for it, and so that's helped us bring
44 people in.
45
46 Having a strong head of department, you know, and then
47 as people come, others are attracted and, you know, the

1 grapevine gets out that, you know, the issues have now been
2 resolved and there are opportunities to move forward. So
3 I absolutely think that, you know, having that
4 determination in place, having a clear understanding of
5 what's happening, takes off the table that uncertainty.
6 Because uncertainty is the biggest problem.
7
8 Q. Does the transitional arrangement and its
9 availability, at least over four to five years for
10 recruits, make Westmead a more desirable place for
11 a radiologist to accept a position than another hospital
12 within the public system?
13 A. That's a complex question. The desirability to come
14 relates also to the training program, to the complexity of
15 work that's involved, the services that are available on
16 site. So, you know, Westmead is one of the big flagships
17 for NSW Health. As a training site it's quite really
18 attractive generally because you get a very broad
19 experience in one location with lots of complexity and lots
20 of opportunity.
21
22 So, you know, with that as a background for Westmead,
23 if the conditions exist well and the culture is good - and
24 generally at Westmead the culture is really strong, we get
25 on well with the medical staff council, we get on well with
26 the senior consultants, there's good partnerships in
27 general across the system and I think it's actually
28 a really good example of how to have strong relationships
29 with your clinicians. It's just unfortunate in this
30 circumstance that it's then overloaded - you know, a local
31 issue in one department of a bit more than 50 became
32 a problem and then impacted on the college accreditation,
33 and the real issue with that is the impact it had on the
34 trainees who were there at the time.
35
36 Q. In paragraph 45 you tell us that, at least from your
37 perspective, it appears that the college was acting in the
38 interests and on the views of the staff specialist
39 radiologists at Westmead in their approach to
40 accreditation. First thing, do we take it that that means
41 acting on their views in a way that went beyond merely
42 their genuinely expressed views about the needs of the
43 accreditation process?
44 A. Yes.
45
46 Q. What was it that led you to that view?
47 A. Oh, comments around, "If the industrial issue is not

1 resolved, we'll lose accreditation, we will all resign
2 en masse". The passive aggressive communication, sometimes
3 outright aggressive communication. All of this was
4 a component of that industrial space, and in conversations
5 in the industrial space, references to accreditation, you
6 know, occurred as well.
7
8 THE COMMISSIONER: Q. Who were the comments by? "If the
9 industrial issue is not resolved, we will lose
10 accreditation", was that actually said by someone?
11 A. Yes, to me, by radiologists in the department.
12
13 MR MUSTON: Q. Was it ever said to you by the college?
14 A. No.
15
16 Q. Did you have any reason to think - other than what you
17 know about the broad way in which accreditation works and
18 the way it draws upon local staff for information, did you
19 have any reason to think that the college was taking that
20 view?
21 A. No, I don't think the college took that view, but the
22 college has to respond to the feedback from its members.
23
24 Q. Did you think the college was incapable of seeing the
25 potential overlap between the industrial issue and
26 accreditation when it was making its assessment of the
27 views being expressed by staff specialists on site in
28 relation to accreditation matters?
29 A. No, I don't think they were incapable and we actually
30 pointed it out in a couple of different types of
31 correspondence with them, the difficulty that was being had
32 in that space and the impact it was having on
33 accreditation.
34
35 Q. Did you think the college was not sufficiently alive
36 to the nuances of that, such that it was allowing the
37 staff's gripes about industrial issues to influence what
38 should have been an objective exercise undertaken by the
39 college in relation to accreditation?
40 A. I think the college should proactively work with
41 management and come up with an agreement around how we
42 ensure high-quality training occurs and therefore
43 recommendations moving forward around how do we make sure
44 that we maintain that, when there is a parallel issue,
45 there is an opportunity there around, you know, how we work
46 together. That's about putting up alternative models, it's
47 about putting up different solutions and how we work on

1 those, and I think we did that through that process.
2
3 This is quite unique for me. I've been through lots
4 of different college accreditation processes and usually
5 that's exactly what happens - you sit down with them. As
6 a chief executive, I would get invited to an interview, so
7 would management. Usually it's a really collaborative
8 process that works really well. In this circumstance, it
9 wasn't. I'm firmly of the view that the influence of the
10 radiologists in the department was played out through the
11 final decision of the college around whether we lose
12 accreditation or not.
13
14 Q. Having had that experience, unpleasant as it sounds
15 like it was, is there anything you think could be changed
16 about the way the accreditation process works to better
17 facilitate that collaborative dialogue with management that
18 you say is important?
19 A. I think better clarity around the role of college and
20 the remit of accreditation and, you know, having some
21 clearer boundaries in that space I think would be really
22 helpful. A number of the other colleges are really good at
23 it around, you know, if issues get raised, how do we
24 partner and work together to resolve it.
25
26 Q. So just perhaps by reference to what some of those
27 other colleges do, what are the sorts of things, the
28 guardrails that you think could have been in place with the
29 radiologists that weren't there?
30 A. So in other circumstances a college would reach out
31 and say, "We've had this feedback from an individual within
32 the college. We would like you to have a look at it and
33 give us some feedback."
34
35 We need to be careful, obviously, if it's about
36 individuals, that we're not breaching all the privacy
37 issues and employment issues that we need to be mindful of
38 and how we work together in that space.
39
40 I think where it overreaches, where it becomes, "If
41 you don't do that, we're going to take your accreditation
42 off you", that's an unhelpful model. That's where it gets
43 outside the guidelines around how we can partner better.
44
45 Q. Is that a guidelines thing or is it just, at least
46 insofar as it plays out at the moment, very
47 personality-driven?

1 A. I think it's too open. I think it's - the
2 interpretation through the different colleges varies, and
3 we see that, you know, having all of the colleges come to
4 us around what we do in that space. So I think it's -
5 there's not a clear consistent model that's used, and
6 I understand that because there's not a clear consistent
7 requirement for training. You know, training in rural
8 areas and the big flagships, you know, that present
9 different opportunities.
10
11 So, you know, the colleges, like us, need some
12 flexibility around how we do that, but what we need to be
13 clear, I think, in is, you know, where are the boundaries
14 around what is impacting on accreditation and some of these
15 peripheral constructs around what does the workforce around
16 the training program look like - I think that gets them
17 into an area outside of where they need to be.
18
19 Q. Do you think there would be some benefit in
20 introducing into the system an independent arbiter of some
21 sort which is brought in to resolve an accreditation
22 dispute in circumstances where management and a college are
23 unable to do so through the collaborative process that you
24 have identified?
25 A. That may be beneficial. I mean, in the current model,
26 and which we did in here, if you dispute the decision of
27 the college, you actually go back to the college and they
28 review their own decision. Now, how they do that
29 internally, I couldn't answer the question. The college
30 could. But, you know, there is a possibility that there's
31 an opportunity for a different lens in that space rather
32 than just going back to the same group that made the
33 decision in the first place.
34
35 In reality for us, we then had to sit down with the
36 college and map out, you know, where to from here, what
37 does this mean for - particularly, our biggest concern was
38 what did it mean for the trainees that were in the program
39 at the time, and with a very short window of time to turn
40 it off and impact on their training programs the way that
41 they did was a challenge.
42
43 In the end, though, we reached an agreement where they
44 were allowed to continue their training program and it
45 would count for their training time, which was very
46 important. It allowed them, the trainees, then to
47 self-select around when they could move on and make sure

1 that they did their training and it wasn't compromised.
2 That was the most critical part.
3
4 The secondary part was making sure that service
5 delivery is not impacted and what do we do in that space
6 and how do we manage that, and we manage that through third
7 party providers and getting some support and outsourcing
8 some of that work.
9
10 Then the third component of it is around how do you
11 then reaccredit and get back into a college training
12 program and get trainees back on site, which actually for
13 us in that space was less than a year. I think it
14 was October of that same year where we were reaccredited,
15 which is very first in that circumstance around how to get
16 accreditation training back up again, and by the
17 following February we had registrars back.
18
19 Q. In relation to the independent arbiter of some sort or
20 a review body of some description, do you think it might be
21 useful insofar as it would have provided both parties with
22 an opportunity to put their conflicting views in relation
23 to, say, the adequacy of supervision having regard to
24 workload and if the college was right and the independent
25 review body determined that, well, the workload at the
26 hospital, absent some agreement to manage it in a
27 particular way, was going to be such that it would
28 compromise supervision in that circumstance, you would have
29 a clear answer and an ability to do something about it?
30 A. I would say so long as we're clear around what is the
31 remit of the program. So workload is an interesting one.
32 Workload, in and of itself, does not compromise a training
33 program at all; it's how we respond to it. So we would
34 need to be clear, if there is a process such as you
35 describe, that, you know, what is in the remit of a college
36 training program and what is not.
37
38 If I use the example of the admin officer again, you
39 know, should that even be in the remit of a training
40 program, and withhold accreditation because they're of the
41 view that they need more administrative support for
42 a particular role? I would say no. So for that to be
43 effective, we would need to be really clear around what is
44 the remit of that group.
45
46 Q. But if, in that instance, they were able to persuade
47 the independent review body that without that

1 administrative assistance they would not have time in the
2 day to provide the supervision that they needed to provide
3 everyone to do a little bit of training, why would that
4 necessarily fall outside the remit of what a review body in
5 that sort of circumstance might be able to look at?
6 A. Because where does that end? That's the problem,
7 right? So I do not believe it's in the remit of the
8 college to say what is the level of admin support for
9 a training officer.
10
11 Q. Does it possibly - I'm just exploring this with you -
12 end at the point at which the independent review body
13 decides that request or demand actually does not have
14 a sufficient level of connectivity to the quality of the
15 training for me or us to give you that?
16 A. I mean, it's - anything's possible in a scenario like
17 this discussion. The reality is, is it a reasonable
18 discussion to be had in the first place? So what is the
19 role of the training program and therefore what is the
20 reach of the program, and what should it be influencing?
21
22 THE COMMISSIONER: Q. Just so I understand exactly what
23 you meant by part of an answer, you said "workload, in and
24 of itself, does not compromise a training program at all".
25 How should I understand that more fully?
26 A. So if we were to employ more staff, increase the hours
27 of VMOs, go to an outsourcing organisation to cover
28 overnight reads - they're all strategies that you could put
29 in place to address workload issues, but that doesn't take
30 away any of the time that's available for staff specialists
31 to supervise and train trainees.
32
33 MR MUSTON: Q. But was the college's point, as you
34 understood it, that unless one of those things was put in
35 place, the supervisor - the capacity of the staff
36 specialists to supervise would be compromised? Let's take
37 the outsourcing as an example.
38 A. Mmm-hmm.
39
40 Q. Was it the college's position that the current
41 workload, unless - I'll take it back a step. The college's
42 position, "The current workload is such that we're
43 concerned that it impacts on the ability to deliver good
44 supervision to trainees". You said, "We can deal with that
45 in a range of ways, for example, outsourcing some of the
46 reading to keep the workload at a level where that's not
47 a problem"?

1 A. That's an option, yes.
2
3 Q. In circumstances where that's an option, but without
4 it, supervision, without it or some alternate option that
5 equally solves the problem, supervision is going to be
6 compromised, and I'm just trying to understand why that's
7 not potentially an area where the college, as part of its
8 accreditation process, has a role?
9 A. But we had outsourced at that time, so we had started
10 to outsource and we had sat down with the radiologists
11 around what's a safe level of work to achieve and how do we
12 manage not just the throughput and the demand but also the
13 hours of work that they do and the interruptions to sleep
14 overnight and all those sorts of things. So we had already
15 commenced and put in place some offsite readings and that
16 sort of stuff, and it continues to be in place at the
17 moment.
18
19 Q. Was the quarantining of time for training part of that
20 process?
21 A. Yes, and quarantining of time for a director of
22 training. So a number of those recommendations that had
23 been in there and, you know, I think in my statement I was
24 clear that most of the things that the college flagged,
25 we're actually quite supportive of. I think they're really
26 important components that, you know, quarantine training
27 time and support for them is really important.
28
29 The question is, do they then take it to the next
30 level and start to add in components that either are
31 unachievable or unaffordable or that we don't agree with
32 and support as a management team.
33
34 Q. You stepped out of your current role into an acting
35 role where you're facing another slightly challenging
36 workforce environment at Concord hospital?
37 A. I have.
38
39 Q. What's your sense, at least to the extent you've been
40 able to develop one in the time you've been there, of what
41 the particular challenges or concerns of the workforce at
42 Concord are?
43 A. With respect to the commentary on medical staff
44 council? I mean, all that happened long before I got
45 there. So, you know, I'm really not in a position to make
46 commentary around anything that occurred or any of those
47 discussions that happened before --

1
2 Q. I'm definitely not asking you to express a view about
3 why the situation that prevails at Concord is as it is,
4 based on what's happened to date. What I'm interested in
5 is, having arrived, what's your sense of the - first step,
6 do you have a sense that the morale of the medical
7 workforce at Concord is on the low side?
8 A. So my observations of it is that - I'll talk about how
9 I go about working with the senior clinicians, and this is
10 what I generally do. It seems to be, you know, working at
11 the moment and we're building a relationship, because when
12 you're first in a role you have to build trust in a
13 relationship too, before you get honesty and then, you
14 know, an ability to work your way forwards, and it was only
15 the end of May, so it's only a couple of months in, and it
16 takes time to build those relationships.
17
18 I've spent a lot of time just talking. I've spent -
19 I've been to a couple of medical staff council meetings,
20 I've met with a few of the individuals, as I have at
21 Canterbury and at RPA as well, and, you know, I think one
22 of the things I do is invest in time in just trying to
23 understand perspectives and build relationships. So I've
24 been doing that for the last couple of months.
25
26 Certainly the feedback I've got from the consultant
27 group at Concord, and I had a medical staff council last
28 Thursday night, was quite constructive. A lot of good
29 feedback around listening. So I think, you know, you have
30 to establish those relationships first to get, you know,
31 a good picture, but I think for my side of it - and, you
32 know, I just make these assessments when I go into a role
33 on how I do it - some good shoots at the moment around how
34 to build good relationships with the consultants across the
35 system, or across Sydney LHD anyway.
36
37 Q. You mentioned at the medical staff council at Concord
38 the other night there was some good feedback around
39 listening, what was that feedback?
40 A. Well, I have a tendency, particularly in meetings
41 after hours with senior consultants, like, I will stay for
42 as long as they can talk. So that opens up a conversation.
43 I think I was there for probably nearly three hours on
44 Thursday, and so usually one, two, three people will come
45 up to me at the end of it and say, "Thanks for putting time
46 aside. I know it was a big commitment. You know, it's
47 after hours, taking time out, but thanks for spending the

1 time and talking to us and hearing our perspective."
2
3 I had a couple of presentations from each of the
4 different - I think seven now of the different services
5 have given me a presentation on, you know, some of the
6 things that they're trying to address. So, you know, often
7 that feedback is, "Thanks for taking the time to listen."
8
9 Q. Having arrived at Sydney LHD, you've also been
10 confronted with what has been described to us as the
11 clinical stream structure.
12 A. Mmm-hmm.
13
14 Q. Are you able to explain, at least as you have been
15 able to get a handle on it over the last weeks, what that
16 involves?
17 A. I wouldn't say I've completely got a handle across it.
18 It's quite a complex structure and it varies, and I've
19 worked in three - four different districts where they've
20 had stream structures or networks, they're almost inner
21 interchangeable in names.
22
23 Usually, it's a hybrid model of management where your
24 general managers have accountability for budget and
25 performance and KPIs, and they are responsible for the
26 entity, the streams overlay and provide strategic
27 direction, clinical leadership, models of care, safety and
28 quality advice, lots of those sorts of things.
29
30 I'm still learning about Sydney, because there are
31 some operational components in, like, aged care for
32 example, so it will take more than a couple of months to
33 completely understand the relationships and streams across
34 the site and how that works and to see whether they - you
35 know, whether that's the model that I can understand and
36 that everyone appreciates. So I think that's a - there's
37 more time required in that space to have a look at that.
38
39 Q. It's been suggested in some of the evidence that we've
40 received that that structure may have contributed to the
41 communication issues at Concord. Have you - do you have
42 a view on that?
43 A. No, I don't. I mean, it's way too early for me to
44 have seen that and I haven't really spent a lot of time
45 with the streams. I'm more - remember, I came in in May,
46 it's end of budget year, so you've got to get your budget
47 sorted at the end of the year, you've got to get your

1 budget set up for next year. There's a whole host of
2 things that happen in that sort of June/July window of time
3 that demands a lot in these roles.
4
5 So no, I wouldn't say I have any clarity around
6 whether they've contributed to good, bad or indifferent in
7 that space. But it's certainly - you know, I think it's an
8 important part, one of the strengths of the stream
9 structure is that you have senior clinical leaders working
10 very closely with management around how to set strategy
11 moving forward. So, you know, there's a lot of pluses that
12 come out of that model, and I've introduced the network
13 model out in Western Sydney when I was there, and that
14 functions really well, like, the clinical leaders in that
15 space I have a really strong relationship with, but I've
16 been there six years, so they're well established now.
17
18 I think there's a lot of bonuses and benefits that
19 come out of a clinical stream structure that, I mean, as
20 a non-clinician executive, you know, I need to make sure
21 that I have good strong relationships with clinicians, so
22 we both bring the different strengths to the table, and so
23 the streams do that. How effective that is so far in
24 Sydney I'm still working my way through it.
25
26 Q. You have mentioned a few times the medical staff
27 council and meetings that you've attended. What do you see
28 as the role of the medical staff councils in the wider LHD
29 ecosystem?
30 A. Oh, I mean, the role of the medical staff council
31 ultimately is to provide advice to the chief executive of
32 issues that are coming up through the medical workforce -
33 things that they see and things that they would like some
34 support and assistance on or provide feedback and advice
35 on.
36
37 They provide feedback up to the chief executive. So
38 each of the site ones do and then we have a collective one,
39 executive medical staff council, that also, then, is an
40 ex officio attendee of the board meetings, so the board
41 gets visibility through that role as to the discussions
42 that are occurring through medical staff councils as well.
43
44 Q. You mentioned just a moment ago, as part of that
45 process, the medical staff council's seeking feedback and
46 advice on issues - do you perceive them to be a two-way
47 conduit in terms of information?

1 A. I think - because, you know, a conduit of information
2 can be interpreted lots of different ways. I think they're
3 a really strong model around how you build a collaborative
4 relationship between management and the senior medical
5 workforce and can work really well in that space, but they
6 also can be - not everyone's going to agree all the time.
7 It's okay to disagree on issues and have a pathway to
8 resolve those issues.
9
10 Most consultants are quite aware of the fact that
11 there is a senior decision-maker in an organisation and are
12 often looking for transparency of decision-making as much
13 as agreement. I mean, everyone would love you to agree
14 with everything they put up, of course, but that's just not
15 the way that the system works. But so long as there's
16 transparency of that, then I think you've got a good
17 chance.
18
19 Q. How does that transparency work in the context of the
20 medical staff council? What is it about successful
21 engagement with the medical staff council which provides
22 that level of transparency that helps oil the wheels, as it
23 were?
24 A. I think it's - I think you have to adapt your -
25 depending on your relationship with the medical staff
26 council. I mean, I've met a couple of times with Concord,
27 a couple of times with RPA, once with Canterbury. So it's
28 kind of very early in the piece to make a judgment call on
29 that. Certainly at - in Western Sydney, you know, I attend
30 the medical staff council most months. We have a really
31 good dialogue, I meet with the medical staff council chair,
32 and, you know, they know that not everything - not every
33 idea's, you know, achievable or possible, but it's - but
34 the opportunity exists to have that conversation.
35
36 So, you know, I think where you have the medical staff
37 councils and the clinical streams and heads of departments,
38 you know, they just create another opportunity to make sure
39 that we are engaging with our senior consultants in the
40 organisation.
41
42 Q. Is an important part of that conversation or
43 engagement with the medical staff council explaining to
44 them why decisions are being made which are not necessarily
45 the ones that they wanted?
46 A. To the extent you can. You can't always.
47

1 Q. What are the limitations?
2 A. Well, if they're about individual employment or about
3 industrial issues or there are privacy concerns or there
4 are other components that overlay, I mean, we have to make
5 sure that we - it's not just an open and transparent
6 discussion. There may be employment conditions, there may
7 be personal circumstances, there may be a whole host of
8 things that - and I'm talking very generically here,
9 without using examples of anything that come to mind -
10 there could be any reason why or many reasons why detail
11 you can't talk about, and, you know, there are times where
12 you go, "Well, that's my job, guys. You're just going to
13 have to trust that I've made the decision the right way,
14 because that's my responsibility to the organisation to
15 make sure that we do that and I'm sorry there's information
16 that I can't share." You know, sometimes that's tough but,
17 you know, it's not for everything, but there are certainly
18 circumstances where, you know, if you have respect for each
19 other's roles, then you accept feedback.
20
21 Q. What about general concerns about resourcing, for
22 example, where you might have members of the medical staff
23 council from particular departments expressing concerns
24 about the level of resourcing within their departments? Is
25 there a dialogue that you think could be had through the
26 medical staff council to improve the transparency around
27 the decision-making which has led them to think that they
28 are under-resourced?
29 A. I think there's lots of pathways. The medical staff
30 council is one, the heads of department is one, you know,
31 general engagement, communication with the entire
32 workforce - remember, doctors is only one component; nurses
33 and allied health and corporate services, you know, we have
34 to be as equally open with them as much as we can.
35
36 I mean, the reality for Sydney LHD, like anywhere
37 else, you know, we have to manage within our budgets.
38 Every department - not every department, most departments
39 will come to you with a plan on how to expand, where
40 there's new money, you know, if the opportunity comes up.
41 We have to be clear around what are the opportunities in
42 that space and how and when can we do that and how and when
43 can we have those conversations.
44
45 It's not necessarily about transparency around the ins
46 and outs of the clinical decision-making around how we do
47 it; sometimes it's, you know, do we have the opportunity to

1 expand that model of care or introduce that new service or
2 do something different, and, you know, sometimes the answer
3 is, "Well, not this year, maybe next year. We'll need to
4 have a look at it as we go through the process, though".
5
6 I think medical staff council is one. I think there
7 are lots of other structures and I think it's really
8 important that the general managers have really good
9 relationships with their teams to make sure that, you know,
10 there is good communication and good relationships built.
11
12 Q. To the extent that through medical staff council or
13 heads of department, proposals are being put or requests,
14 resourcing requests are being made which are unable to be
15 accommodated within the existing budget, to what extent, if
16 any, are those sorts of requests informing discussions that
17 you might be having with the ministry about the budget
18 which is made available to your LHD, probably more in a
19 Western Sydney case?
20 A. No, I mean, there's a good process with the ministry.
21 You know, it worked really well this year, around, you
22 know, where - if there was opportunities available and
23 funding available, how would we - what would we promote and
24 what would we propose that that be spent on. That worked
25 really well this year I thought, you know, that you have
26 service agreement discussions and, you know, put
27 opportunities up.
28
29 So I actually think that that worked quite well this
30 year, so we could put things up. You know, there's - in
31 this financial year, there is growth, which is really good,
32 and we were quite lucky. I think the ministry has done an
33 outstanding job in creating the environment where we
34 actually had the opportunity to have those discussions this
35 year, which was very helpful.
36
37 Q. Just pausing there, is that new or has that always
38 been the case - that is to say --
39 A. No, no, I mean, there was a couple of years in COVID
40 that were tough, right? You know, COVID influenced a lot
41 of things over a couple of years that changed how we
42 responded. But generally, you know, my experience over the
43 last six years in these roles is that there has - there is
44 always an opportunity, there's a discussion component that
45 comes up, there's meetings that are booked in around
46 negotiations, there are - you know, it's the same as
47 anywhere else, they are transparent with us, you know,

1 where the dynamic is reversed and we're the ones asking for
2 additional funds for whatever, and we have an open dialogue
3 with them around whether there's an opportunity for it,
4 whether they say yes, whether there's another way of doing
5 it, whether - you know, there's a couple of dynamics that
6 you work through.
7
8 I think that that process works quite well at the
9 moment and, you know, certainly I think this year was
10 a really good outcome from what - you know, coming out of
11 the COVID environment where the spend has been different
12 and the management has been driven much more around
13 pandemic response, and to move back into a BAU, that
14 creates a different set of challenges. But I think that's
15 been managed quite well.
16
17 MR MUSTON: I've got no further questions for this
18 witness, thank you, Commissioner.
19
20 THE COMMISSIONER: Thank you.
21
22 Mr Cheney, do you have any questions?
23
24 MR CHENEY: No, Commissioner.
25
26 THE COMMISSIONER: Mr Loy, thank you very much for your
27 time. We're very grateful. You are excused.
28
29 THE WITNESS: Yes, thank you.
30
31 **<THE WITNESS WITHDREW**
32
33 MR MUSTON: The next witness is Dominique Egan. I note
34 the time. By the time Ms Egan is brought in, we might be
35 getting pretty close to 11.30. I am entirely in your
36 hands, but.
37
38 THE COMMISSIONER: All right. We can take the morning tea
39 now. We'll adjourn until 11.35.
40
41 **SHORT ADJOURNMENT**
42
43 THE COMMISSIONER: Yes.
44
45 MR MUSTON: Commissioner, the next witness is Dominique
46 Egan. I think she's represented, by Mr Chapman, who might
47 announce his appearance.

1
2 MR CHAPMAN: May it please the Commission, Scott Chapman,
3 solicitor. I appear on behalf of the Australian Medical
4 Association (NSW) Limited.
5
6 THE COMMISSIONER: Leave is granted for that appearance.
7
8 MR MUSTON: I call Dominique Egan.
9
10 **<DOMINIQUE EGAN, sworn: [11.40am]**
11
12 **<EXAMINATION BY MR MUSTON:**
13
14 MR MUSTON: Q. Could you state your full name for the
15 record, please?
16 A. Dominique Egan.
17
18 Q. You are a director of workplace relations and legal
19 counsel at the Australian Medical Association (NSW)
20 Limited?
21 A. Yes, I am.
22
23 Q. That's a role you've held since January 2020?
24 A. Yes.
25
26 Q. You prepared a statement dated 25 July 2024 to assist
27 the Inquiry with its work?
28 A. Yes.
29
30 Q. Have you got a copy of that statement?
31 A. Yes, I have.
32
33 Q. Have you had an opportunity to review it before giving
34 your evidence today?
35 A. I have.
36
37 Q. Are you satisfied that its contents are, to the best
38 of your knowledge, true and correct?
39 A. Yes.
40
41 MR MUSTON: For the benefit of the record and the
42 operator, it has popped but it's [SCI.0011.0283.0001].
43
44 Q. The AMA New South Wales is, you tell us, the registered
45 industrial body for visiting medical officers in New South
46 Wales?
47 A. Yes.

1
2 Q. Throughout the Inquiry we've heard some evidence,
3 which at least in broad terms divides VMOs into two rough
4 categories - there's specialist GPs delivering care through
5 emergency departments and to admitted patients in small
6 rural facilities?
7 A. Yes.
8
9 Q. And then there are other specialists who deliver care
10 as part of the workforce across the wider system, for
11 example, surgeons, anaesthetists?
12 A. Yes, that's correct.
13
14 Q. Your organisation represents both of those groups?
15 A. We have members from both of those groups. The GP VMO
16 arguments are governed under the RDA settlement package, so
17 RDA New South Wales has a representative role for them as
18 well. We're the chief representative body for sessional
19 and fee for service VMOs in New South Wales.
20
21 Q. So whilst you have some members from both, the
22 principal body that you represent is the second category
23 that you've just referred to?
24 A. Correct.
25
26 Q. You tell us at paragraph 6 that you do, or the AMA has
27 a wider membership that includes staff specialists, CMOs,
28 general practitioners, et cetera?
29 A. Yes.
30
31 Q. In very broad terms, if you know, what proportion of
32 the membership is made up of the staff specialists, for
33 example?
34 A. Unfortunately we don't have that data where we can
35 readily break down our membership into different categories
36 so I can't provide that information, sorry.
37
38 Q. As an industrial organisation, do you have a role in
39 representing staff specialist CMOs?
40 A. We're not the registered body for staff specialists
41 CMOs or doctors in training. That's ASMOF.
42
43 Q. In paragraph 8 of your statement you tell us that an
44 important part of your role is interacting with medical
45 staff councils across the network?
46 A. Yes.
47

1 Q. What do you see as the role of a medical staff council
2 in the wider health ecosystem?
3 A. I think it's probably changed over a number of years
4 but I think it is an important body that brings members of
5 the medical staff together to discuss all range of issues,
6 so the delivery of medical services in a hospital, the
7 interaction with other health professionals in a hospital,
8 a platform to engage with the executive, and also a forum
9 in which people can get together and discuss, you know, the
10 arrangements under which they're working in a hospital
11 system.
12
13 Q. Why do you think the medical staff council as a body
14 is important?
15 A. I think it's important for people to come together to
16 discuss those issues. I think it's important as well for
17 people - it can be difficult in any setting for individuals
18 to come forward and raise issues. I think it provides an
19 important forum for people to raise their individual
20 issues, see whether they're shared across the collective,
21 but also to put matters forward and see whether or not
22 people are going to support certain issues being taken
23 forward.
24
25 Q. In terms of putting issues forward, we've received
26 some evidence which suggests that within the medical
27 fraternity there remains a strong culture not to speak up,
28 not to make waves, for fear of reprisals or being seeing to
29 be difficult or a troublemaker?
30 A. Yes.
31
32 Q. Through your interactions with members, do you have
33 a view as to whether or not that is, in fact, a cultural
34 feature of the medical workforce?
35 A. Yes, I think it is very much so.
36
37 Q. What leads you to that conclusion?
38 A. I think - in my role obviously I speak to a number of
39 different medical practitioners and people will raise
40 issues with us, sometimes just to talk it through but also
41 often we then obviously provide advice about different ways
42 in which to bring an issue to the attention of management
43 or what have you, and a lot of people are "Oh, I just
44 wanted to let you know because you might be able to do
45 something about this. I don't want to speak out and say
46 anything because I'm concerned that that might have
47 implications for my ongoing role at the hospital."

1
2 Q. Are there any particular reasons that you think the
3 medical fraternity, as distinct from others, have that
4 concern about the ramifications, potential ramifications,
5 of speaking out?
6 A. I don't know as opposed to other members of staff in
7 the health profession how they would feel about that,
8 because I don't have direct evidence of that. I think in
9 recent years people have just felt that they then feel that
10 once they raise an issue, an issue is raised in relation to
11 them - this is speaking obviously very generally - and
12 that's their experience, or that if they speak out, they're
13 told not to do so.
14
15 Q. That sort of cultural practice, for want of a better
16 phrase --
17 A. Yes.
18
19 Q. -- is it confined to the making of disciplinary
20 complaints or addressing workforce grievances about
21 colleagues or does it extend more widely to, say, speaking
22 out about concerns around resourcing and decision-making by
23 the executive, do you think, based on your experience, at
24 least, or your conversations?
25 A. I don't think it's confined to workforce issues.
26
27 Q. Coming back to the medical staff councils, obviously
28 it would vary from facility to facility, but do you think.
29 At least as a conceptual body within the health system,
30 they are working at the moment?
31 A. I think it probably varies across the system, having
32 been out and speaking to different medical staff councils,
33 I think - but even - sorry, I will say that even in
34 communities where we've gone to speak and they have a very
35 strong medical community, I think even there, they probably
36 don't feel that the medical staff council mechanism
37 necessarily serves them very well either.
38
39 Q. Why is that?
40 A. Whereas some will report that it provides a good
41 mechanism for interacting with the executive and provide -
42 obviously providing feedback through the chair to the
43 executive, other medical staff councils tell us that
44 that isn't the case and that they don't have - they don't
45 feel that they can bring issues forward and when they
46 do, they feel that they're just being told that they're
47 raising issues that are creating too many problems, and

1 they don't - and the executive doesn't meaningfully respond
2 to them.
3
4 Q. Do you have any sense of what, if anything, might be
5 changed about the structure or the scope of the medical
6 staff councils to overcome some of those concerns that have
7 been raised?
8 A. I think perhaps giving it perhaps a - revisiting the
9 way in which it's defined, but also perhaps empowering the
10 chair to have more of a role and be seen to be that voice
11 to take issues forward and be able to speak out on behalf
12 of the medical staff council. You know, once motions are
13 passed through the council that have the support of the
14 majority of members, that that person is then able to speak
15 out about those issues without fear of reprisal. Again
16 I think - and it might just be apprehension on the part of
17 the chairs but there's a variety of views about whether
18 they can actually speak out about things or whether, you
19 know, they can't do that either in their role as chair.
20
21 THE COMMISSIONER: Q. Can I just ask you how I should
22 understand part of the answer you gave when Mr Muston had
23 asked you about whether medical staff councils were working
24 and in part of your answer you said:
25
26 *[Some, yes] ... they don't feel that they*
27 *can bring issues forward and when they*
28 *do, they feel that they're just being told*
29 *that they're raising issues that are*
30 *creating too many problems ...*
31
32 Should I understand that to mean that what's being reported
33 to you is that by raising something that's a concern or
34 a problem, the mere raising of that is a problem in itself;
35 is that how I should understand it?
36 A. Yes, yes, yes.
37
38 MR MUSTON: Q. Our understanding or our researches might
39 be imperfect but it would appear that at an earlier point
40 in time the regulations contemplated the chair of the
41 medical staff council attending meetings of an LHD board?
42 A. Yes.
43
44 Q. That's no longer the case, as we understand it;
45 regulations, I think, have changed?
46 A. I'm not certain about that.
47

1 Q. Do you think some more formal sense of connectivity
2 between the medical staff councils and the boards of the
3 LHD might be useful?
4 A. Yes, I do.
5
6 Q. Why would that be?
7 A. I think anybody feels once you've got a seat at the
8 table and you have that forum where you can raise issues,
9 but perhaps also be privy to obviously not all of the
10 workings of the local health district but to some of the
11 decision-making processes, and that you can then share that
12 back in an appropriate way with the medical staff council,
13 would address some of those issues, where I think what
14 we're hearing from people is they feel marginalised from
15 decision-making processes at their hospitals and districts.
16
17 Q. When you say "marginalised", what did you have in mind
18 there - that they're not being brought into those
19 decision-making processes or that the reasoning behind them
20 is not being shared or what?
21 A. Possibly a bit of both, but I think largely they feel
22 that they're not part of those discussions and decisions.
23
24 THE COMMISSIONER: I suppose I could ask you this,
25 Mr Muston, outside, but I'm not aware of the researches
26 that you've just mentioned. The fact that a representative
27 from the medical staff councils is not on the boards, was
28 that decided upon because it's thought to be operational
29 and the boards aren't operational or we just don't know?
30
31 MR MUSTON: We don't know.
32
33 THE COMMISSIONER: Thank you. Sorry to interrupt.
34
35 MR MUSTON: Researches, such as they are at the moment,
36 suggest that at an earlier point of time the regulations
37 contemplated the chair attending the meetings, whereas in
38 2018, that changed. I'm not sure why.
39
40 THE COMMISSIONER: Thanks.
41
42 MR MUSTON: Q. You tell us in paragraph 9 of your
43 statement that in your role, you also meet with key
44 stakeholder groups, including colleges and societies.
45 Colleges and societies, I think we've been told, play an
46 important role in the training of the medical workforce?
47 A. Yes.

1
2 Q. We have received evidence that suggests that the
3 withdrawal of accreditation for facilities by colleges and
4 societies can have a fairly significant impact on trainees?
5 A. Yes.
6
7 Q. And on the delivery of care by a particular
8 facility --
9 A. Yes.
10
11 Q. -- that's had its accreditation withdrawn.
12 Acknowledging the importance of high-quality training, do
13 you have a view about whether the balance that's currently
14 struck in relation to training as between the facilities
15 and the colleges is appropriate, or do you think it might
16 be adjusted in some way?
17 A. It's probably not something that I have direct
18 knowledge of. I'll make an observation based on some of
19 the feedback we get from our members, which is that, you
20 know, quite often a loss of accreditation, there is quite
21 a process often for that, and so I think there is often
22 a dialogue between the colleges and the hospitals or
23 districts around that, so I don't think it's that there
24 isn't communication, but again that may vary from college
25 to college, but I couldn't comment any further on that.
26
27 Q. We've heard some evidence this morning to the effect
28 that there might sometimes be a bit of a muddying of the
29 water in terms of accreditation where it overlaps with,
30 say, industrial issues, or industrial disputation at
31 a particular facility, and that the current process
32 potentially allows those industrial disputes to influence
33 accreditation decisions. Through the AMA's involvement in
34 industrial disputes, do you have any view about whether
35 that is right or wrong or you're not in a position to
36 comment?
37 A. Not through any industrial involvement from the AMA.
38 We don't have any direct knowledge of that, but I think I'm
39 aware of some of the instances that are being referred to,
40 but I think that involved ASMOF.
41
42 Q. Could I ask you to go to paragraph 10 of your
43 statement where you tell us that the current workforce is
44 exhausted due to chronic understaffing. What's the basis
45 that you have for holding that view?
46 A. So surveys undertaken by AMA New South Wales; a survey
47 of the senior medical workforce in 2021. I can see that

1 that coincided with COVID, and so that was a particular
2 time where people were feeling obviously very tired and
3 exhausted due to the furloughing of staff and all of those
4 pressures that were on the health system; also a survey
5 that was undertaken by Deloitte at AMA NSW's request in
6 2022, in the lead-up to the state election; and also my
7 speaking to speaking to members is that they feel that, you
8 know, they're constantly being asked to do more with
9 less and fewer - sorry, less recruitment going on in the
10 system to bring in more people in to help them with that.
11
12 THE COMMISSIONER: Q. Should I understand the opinion
13 you've expressed in 10 about exhaustion; in 9 you have
14 talked about regular meetings with stakeholders, et cetera;
15 in 11 you've talked about the AMA regularly doing surveys
16 with doctors in training; and in 12 you've talked about the
17 Deloitte white paper you've just mentioned --
18 A. Yes.
19
20 Q. -- I take it that opinion in 10 about exhaustion is
21 a distillation of all of those bits of information you've
22 received in your role to be able to express that opinion?
23 A. Yes, that's correct, correct.
24
25 Q. Can I just ask you this about exhaustion. For those
26 interested, this is transcript page 4539 from Friday.
27 Could the witness just be handed this extract from the
28 transcript on Friday. I just want to see if you could help
29 me with your experience about the topic of exhaustion.
30 What I've just had handed to you is an extract from some of
31 the evidence given by Dr Bethan Richards, who's the chief
32 wellness officer of Sydney LHD. You may know her. I don't
33 know.
34 A. Yes, yes.
35
36 Q. And at the top of 4539, you'll see we were talking
37 about - her word was "burnout", I think probably related to
38 exhaustion, sounds like it is?
39 A. Yes.
40
41 Q. And she talks about, on this page, the three domains
42 of burnout, emotional exhaustion, depersonalisation or
43 cynicism, and impacts on professional efficiency. Is that
44 the sort of thing you're talking about in relation to
45 exhaustion as well?
46 A. Yes.
47

1 Q. Dr Richards was also asked - if you turn the page to
2 4540, I'm wondering if you could help me with this.
3 I asked her, at about line 4 or 5, "How should I understand
4 the size of this problem?" She described it in a nutshell
5 as "huge". You'll see that in line 5?
6 A. Yes.
7
8 Q. And went on to give some statistics about that. Is
9 that also your impression about the size of this exhaustion
10 problem, that it's - her word was "huge". Should
11 I understand it from your opinion to be a large problem?
12 How would you describe it?
13 A. Yes, I'd describe it as a large problem, yes.
14
15 Q. About midway down that page she talked about junior
16 doctors being particularly vulnerable. Do you see that at
17 about line 22 and onwards?
18 A. Yes.
19
20 Q. And "being particularly vulnerable", I asked what she
21 meant by that. She said, "Well, they have the least power
22 in the system" - you will see that at line 27 - "the lack
23 of control and flexibility is a key driver, lack of job
24 security." Is that consistent with your opinion as well?
25 A. Yes.
26
27 Q. Then she went on to describe the problem as extending
28 beyond junior doctors and also impacting non-medical staff.
29 I won't ask you about that, but at 4541, commencing at
30 about line 25, I put to her something that she agreed with,
31 that the role of being a doctor and a nurse in a public
32 hospital is a fairly stressful job at the best of times.
33 I assume that's the feedback you get from the people you
34 represent?
35 A. Yes.
36
37 Q. And so any additional pressures on that beyond what
38 they normally would be just can be the straws that break
39 the camel's back, for want of a better expression?
40 A. Very much so.
41
42 Q. And at page 4542 - I'm just wondering if you get this
43 sort of feedback from your members too - she talked about
44 frustration and disempowerment, but also at line 15 of 4542
45 she talked about a lack of social connectedness at work
46 which is part of the problem. Is that also consistent with
47 the sorts of feedback you get from your members?

1 A. Yes, I think it is consistent, yes.
2
3 Q. I did ask her at 4543 - and it's a very big question -
4 about what she thought, if money wasn't a problem, could be
5 done to alleviate what seems to be a pretty insidious
6 problem in a public health system about the burnout or
7 exhaustion of the people who are providing care to
8 patients.
9 A. Yes.
10
11 Q. If I asked you that question - you can take it on
12 notice, but you may have thought about this: what would be
13 the sorts of things that you think might improve the
14 exhaustion you've talked about in your statement?
15 A. Well, I think more workforce, first and foremost.
16 I think better interaction with the executive as well and
17 around service planning, and again taking on board your
18 comment of assume that there are no resourcing constraints.
19
20 Q. Yes, yes.
21 A. I think, yes, more involvement in service planning,
22 both immediate but also into the future, because again --
23
24 Q. So part of that suggests to me (a) being listened to?
25 A. Yes.
26
27 Q. But (b) perhaps being what I would call actively
28 listened to - that is, a genuine engagement --
29 A. Correct.
30
31 Q. -- rather than just a tick-a-box, "Well, we heard
32 you, thanks." Is that right?
33 A. Yes, yes.
34
35 Q. Sorry, I interrupted you.
36 A. No, no, you got to where I was going anyway, so that's
37 fine.
38
39 Q. As I said, feel free to take the question on notice,
40 because it's not a - I appreciate it's not --
41 A. Look, I might take it on notice and see if there's
42 other things I want to add, but they would be the two
43 things I would say, is more involvement and more workforce.
44
45 Q. All right. I won't ask you - I don't need you to
46 answer, but at 4545, at lines 17 and 26, Dr Richards said:
47

1 *Staffing and workload is a massive issue.*
2
3 And then at 26:
4
5 *Leadership --*
6
7 which I take to mean an aspect of listening actively --
8 A. Yes.
9
10 Q. -- but she's covered much of that as well?
11 A. Yes.
12
13 Q. And you certainly embrace that?
14 A. Yes.
15
16 MR MUSTON: Q. If I can pick up that workforce - the
17 more workforce as a potential solution to burnout, you tell
18 us in paragraph 16 of your statement that there's a finite
19 number of medical practitioners to serve both the public
20 and private system.
21 A. Yes.
22
23 Q. Is it your view there should be more?
24 A. Sorry?
25
26 Q. Is it your view that the system would be better if
27 there was more?
28 A. I suppose - I suppose the answer to that is yes.
29
30 Q. So that I suppose another way of phrasing that might
31 have been to say: do you think that the challenges
32 presented by a finite workforce are attributable, at least
33 in part, to us not training enough doctors to enter that
34 finite pool?
35 A. Yes. I think as well, though, in any system, there's
36 probably always going to be that finite number of people
37 who have to work across both systems, so I guess in part
38 what I was saying was there needs to be that recognition
39 that you're probably not going to be able to secure a whole
40 workforce that is just going to work in the public system
41 or just work in the private system; in fact, probably both
42 are complemented by having people crossing over.
43
44 Q. But to the extent that more workforce might be
45 a solution to some of the burnout problems --
46 A. Yes.
47

1 Q. -- assuming for present purposes that it's able to be
2 funded, a larger pool of doctors would mean that that
3 finite workforce is spread less thinly across those two
4 systems?
5 A. Yes.
6
7 Q. Does the AMA have any role in discussions that happen
8 or take place around the number of funded university places
9 for medical students in New South Wales or Australia, that
10 you're aware of?
11 A. Not that I'm aware of.
12
13 Q. Do you think there would be some utility in the AMA
14 having some role or being a part of those discussions?
15 A. Yes.
16
17 Q. You may not have a view on this, but it has been
18 suggested that increasing the number of graduates would not
19 necessarily assist with the challenges because it would
20 just increase problems of maldistribution without solving
21 problems in areas where the medical workforce is spread
22 most thinly. Do you have a view on whether or not that
23 would be right?
24 A. I think - well, I think we see strain in the system
25 more acutely in, obviously, rural and regional health, and
26 so, yes, simply increasing numbers won't necessarily solve
27 the problem because if everybody still wants to just work
28 in Sydney, there just won't be enough places for everybody
29 in Sydney. And so I think it probably needs to be a bit
30 more strategic around it than simply increasing numbers.
31
32 Q. If there's not enough places for people to work in
33 Sydney, though, it makes working in a rural and regional
34 area perhaps a more realistic alternative to having no job.
35 A. Yes, but I think we also - and this is a bit of
36 anecdote - see people saying, "I'll stay in Sydney and
37 work fewer hours to be in Sydney where my children go to
38 school" - or a whole host of other social things happen -
39 "rather than going somewhere else where I'm going to get
40 more hours." At the moment I think that's part of what we
41 are seeing.
42
43 Q. So back at paragraph 10, when you were telling us
44 about the current workforce being exhausted due to
45 understaffing, you go on to make the observation that award
46 and contract conditions must be updated to attract and
47 retain the best and brightest in the New South Wales public

1 hospital system?
2 A. Yes.
3
4 Q. I gather from that that it is your view that the
5 current awards, insofar as they deal with members of the
6 medical workforce, are in need of updating?
7 A. Yes.
8
9 Q. Is there a process on foot at the moment about or
10 aimed at reforming those awards?
11 A. So AMA New South Wales at the moment is in the process
12 of preparing to run an arbitration under the Health
13 Services Act to review remuneration, but really based on
14 a lot of our feedback from our members is looking at terms
15 and conditions and the way in which people work to make
16 sure that they're appropriately rewarded for that.
17
18 Q. So in terms of the AMA's involvement, is that an
19 involvement in award reform, adjustment to the VMO
20 determination or both?
21 A. So that's adjustment to the VMO determination because
22 that's our role under the legislation. We are, though,
23 also very supportive of the efforts of ASMOF and the
24 processes that they will follow to reform their awards for
25 staff specialists and junior medical officers.
26
27 Q. I gather from an answer you gave a moment ago that
28 it's not just about the dollars that are being paid but
29 about the conditions as well?
30 A. Yes.
31
32 Q. What are some of the key challenges as you see it
33 presented by the existing conditions?
34 A. I think the last time the VMO determinations were
35 meaningfully reviewed was in 2007, and obviously the health
36 system and technology has made considerable advances since
37 then, but also the original bones of it really date back to
38 the early 1990s as well. So again I think things have
39 changed, but I think the current arrangements don't
40 recognise the extent to which people can provide services
41 without being physically in the hospital, but the
42 arrangements are all based on the idea that you're in the
43 hospital delivering services, and so people feel that
44 they're not being fairly remunerated for the actual service
45 delivery that they're providing. So that's one example.
46
47 Another is it's really based around that idea that

1 most services are provided between the hours of 8am and
2 6pm, which would be ideal for everybody, but the health
3 system, in fact, means that regular operating was going
4 well beyond 6pm. Sometimes the schedules take place on the
5 weekend, so there's obviously emergency lists but regular
6 lists can be scheduled in as well. There's no loading
7 payable to practitioners who staff those lists, so they are
8 the sorts of things we're looking at.
9
10 Q. In terms of the arbitration process, is it a debate
11 about particular clauses of the existing determination or
12 does the process contemplate, as it were, picking up
13 a blank sheet of paper and writing a determination which
14 is fit for purpose in 2024 and, say, for the next five to
15 10 years?
16 A. That's a good question. It could be one or either.
17 I think we're trying to look at - I think the bones of how
18 VMOs work is still there, and they're still appropriate,
19 but I think it's adding in - the additional ways in which
20 services are delivered is probably the main way in which
21 we're looking at going about it.
22
23 Q. Do you think that a fixed time frame within which that
24 reform process needs to be concluded would be potentially
25 beneficial - that is to say, a sunset date by which the
26 reform of the VMO determination and various other awards
27 which operate within the health space need to be resolved
28 would be useful?
29 A. Yes.
30
31 Q. Why do you think that might be useful, having regard
32 to your understanding of that process - that is, the
33 arbitration and review process?
34 A. I - well, I think deadlines are good for everybody,
35 they always keep everybody focused, but I think as well,
36 particularly at the moment - I mean, at the moment we're
37 trying to get back into the industrial court to follow this
38 process through and I think if there's a time frame for the
39 examination arrangement, it also allows a review of VMO
40 arrangements, but alongside staff specialist arrangements.
41 A lot of the issues sort of arise in relation to the
42 industrial instruments not reflecting how people currently
43 work, the same for the staff specialist award.
44
45 If those processes could be run in tandem, I think
46 that could be beneficial to the system and to all medical
47 practitioners working in it.

1
2 Q. Could I take you to paragraph 13 of your statement
3 where you tell us about the Deloitte white paper that AMA
4 New South Wales commissioned. You set out there under
5 paragraph 13, a number of bullet points which identify the
6 particular challenges settled upon by Deloittes. Is there
7 anything you wanted to add in relation to them or expand
8 upon them in any way, particularly the first one? Perhaps
9 if you could explain exactly what, as you understand it,
10 the concern is with the growth in demand for services and
11 the role that primary care plays in that process?
12 A. I think with an ageing population in particular, but
13 also with more complex medical conditions that the
14 population is currently dealing with, to try and make sure
15 that people can access appropriate levels of care outside
16 the hospital system is equally as important as making sure
17 that we're increasing service provision in the hospital
18 system.
19
20 THE COMMISSIONER: Q. In other words, investing in
21 primary care?
22 A. Sorry?
23
24 Q. Investing in primary care?
25 A. Yes.
26
27 MR MUSTON: Q. In relation to the second point, the
28 changes in patient expectations, what impact is that having
29 on the system as you see it or understand it?
30 A. I think it's more challenging for people delivering
31 medical services and health services more generally.
32 I think patients have greater expectations about the
33 services that they're going to receive and the quality of
34 those services. I'm not saying that - that's not
35 inappropriate, but I think that adds to the pressures that
36 people delivering those services feel, and again, if there
37 was more staff, then perhaps those services - the pressures
38 could be alleviated somewhat.
39
40 Q. Is that also a significant challenge for health
41 administrators, though, the changing expectations in
42 relation to services which are delivered?
43 A. Correct. I think it's a challenge for the whole
44 system, yes.
45
46 Q. So an example that has been given to us during some of
47 our regional hearings, that small rural facility where

1 a local person might once have gone to have their appendix
2 removed, changing expectations are such that it's just not
3 deemed appropriate anymore for someone to have their
4 appendix removed by, say, a VMO who might do one every few
5 years --
6 A. Yes.
7
8 Q. -- as distinct from going to a larger facility where
9 there's a regular removal of appendices in the workforce.
10 That's not a problem that can be solved by staffing
11 increases. What, at least in your view, having regard to
12 the interests of your members, do you think needs to be
13 done to try and address that challenge?
14 A. In rural and regional areas?
15
16 Q. In rural and regional in particular?
17 A. I think having strong regional hospitals that have
18 those specialists able to deliver services. I think then
19 that - based on the feedback from our members, if people
20 who are in the smaller multi-purpose type facilities,
21 general practitioners feel well supported by a good
22 specialist base in the regional centres, that would
23 actually mean that people can access care in a more timely
24 manner, so they might be identified for transfer into
25 a larger centre at an earlier point in time, or if services
26 do have to be delivered on the ground, that they know that
27 they've got that specialist support to help them to do
28 that.
29
30 Q. Is an important part of that a constructive dialogue
31 between health administrators, medical practitioners and
32 local communities around potential contraction of services
33 at some of the smaller sites?
34 A. Yes.
35
36 Q. Do you see the AMA as having a role in assisting
37 health administrators with that dialogue to start setting
38 expectations, making sure that community expectations
39 around what can be delivered at smaller sites align with
40 community expectations about what safely should be
41 delivered at those smaller sites?
42 A. Yes. Yes, I do, and I think it's bringing the medical
43 profession forward to be a part of those conversations, but
44 where we can help to facilitate and be a part of that,
45 that's very important.
46
47 Q. In paragraph 15 of your statement, in the second

1 sentence, you tell us about the New South Wales Government
2 having dedicated significant funding to the building of new
3 infrastructure, but there not having been the same
4 resourcing dedicated to increasing workforce numbers. What
5 did you have in mind, or did you have anything particular
6 in mind when you were making that observation, or is it
7 more just a general observation that there's not enough
8 staff?
9 A. A general observation, but I think often we see new
10 facilities open, and it's probably not just a reflection of
11 the availability of medical staff but staff generally, that
12 there aren't then sufficient staff to open the beds and
13 open the wards that have been built to provide services to
14 patients.
15
16 Q. Do you have a view about whether the investment in
17 infrastructure that has been made has been necessary and
18 appropriate?
19 A. I don't have a view about that. I wouldn't say it was
20 inappropriate. I think it's matched growing population.
21
22 Q. In paragraph 18 of your statement, you tell us about
23 a request that the AMA has made for the number of VMOs
24 working in the New South Wales system?
25 A. Yes.
26
27 Q. You haven't received a response to that request?
28 A. That's correct.
29
30 Q. That is to say, you have not been told how many VMOs
31 there are currently working in the New South Wales health
32 system?
33 A. Correct.
34
35 Q. Has any reason been given to you for refusing to
36 provide that information or failing to provide --
37 A. No, we just haven't received a response.
38
39 THE COMMISSIONER: Q. In 2023, when in 2023?
40 A. We reapplied for authorisation in about October 2023,
41 so it would have been about that time.
42
43 MR MUSTON: Q. Is there any particular part of the
44 ministry that you sought that information from?
45 A. From the workforce branch, from Phil Minns.
46
47 THE COMMISSIONER: Q. Have you followed up?

1 A. Yes, we made a further request this year in February
2 2024.
3
4 Q. And there's no explanation for --
5 A. No, we just haven't received a response.
6
7 MR MUSTON: Q. Why is that information - that is to say,
8 information about the number of VMOs working in the
9 New South Wales system - important or useful for AMA?
10 A. I think it's important for us to know how many VMOs
11 there are in the system. It helps us also to understand
12 how many are providing services on a sessional basis, how
13 many are providing services on a fee for service basis, but
14 also it would help us to then ask some further questions,
15 I suspect, once we got that information, around where those
16 people are being engaged and so forth.
17
18 Q. And from the purpose of the AMA's operations, what
19 would it be doing with that information once it obtained it
20 and responses to any further questions that came up of the
21 type you've just alluded to?
22 A. So in relation to the request that was made in 2023,
23 we have authorisation from the ACCC to collectively
24 negotiate with local health districts on behalf of VMOs.
25 Obviously, as a part of that process, they want to know how
26 many VMOs there are and what's the extent to which we might
27 be engaging with local health districts around those
28 negotiations. So it's important for us, in that sense, to
29 provide feedback to other bodies, but it's also important
30 for us to sort of really have that sense of what does the
31 medical workforce look like in New South Wales, because
32 while we are the industrial body for VMOs, we're obviously
33 advocating for all medical practitioners in the system and
34 I think it's important to have that understanding about how
35 people are engaged.
36
37 Q. In the context of an environment where there is a VMO
38 determination which governs the conditions on which VMOs
39 are retained within the system, what sort of negotiations
40 are you having with LHDs on behalf of the VMO section of
41 the workforce?
42 A. So a lot of our negotiations obviously happen with the
43 Ministry of Health, but we can have negotiations at a local
44 level around particular service issues they're having for
45 a particular specialty or perhaps even at a hospital more
46 generally. We can go and try and negotiate non-standard
47 arrangements if that might be appropriate at a local level

1 to address an immediate workforce need or a service
2 delivery need. So that's - yes.
3
4 Q. In paragraph 22, you tell us that the AMA does not
5 support the practice of other health organisations
6 providing some VMOs with rolling three- or six-month
7 contracts rather than a quinquennial contract. What's the
8 particular challenge that you are referring to in that
9 paragraph, from the perspective of the VMOs?
10 A. So from time to time we see certain hospitals or local
11 health districts engaging in a practice, and sometimes it's
12 just specialty specific, where they will engage VMOs
13 perhaps during a whole five-year quinquennium on rolling
14 contracts of three- to six-months duration rather than
15 appointing them under a five-year contract or part thereof.
16 I think that's - I'm not engaged in service delivery
17 planning, it would seem to me that that would create a bit
18 of a difficulty in that regard, but particularly for VMOs I
19 think it creates a lot of uncertainty where you're hoping
20 that VMOs will make a commitment to a local community but
21 also for VMOs - so, for example, in some regional areas
22 we've just recently had it raised with us, VMOs who are
23 there on rolling contracts, they can't get finance to buy
24 a house, they can't get finance to establish rooms, they
25 don't want to relocate their entire family because they
26 don't know from three months to a six-month period whether
27 or not they'll have a contract to provide services.
28
29 THE COMMISSIONER: Q. How should I understand the
30 expression "some VMOs"? How widespread is this? Do you
31 have any data on that?
32 A. I could provide examples of hospitals where I know it
33 has occurred. From my experience, I would say it varies,
34 and from time to time you see it come up at different
35 locations as opposed to others. So I would say I've seen
36 it in metropolitan areas and I've seen it in regional
37 areas.
38
39 MR MUSTON: Q. Would the availability of a fractional
40 appointment as a staff specialist overcome some of those
41 uncertainties for the VMOs, if it were available?
42 A. For short-term placements?
43
44 Q. Short-term placements, I understand from your answer,
45 is part of the challenge; the short-term nature of the
46 three- to six-month rolling contract gives them a lack of
47 certainty?

1 A. Yes.
2
3 Q. Could that certainty be introduced through accepting
4 or being offered and accepting a fractional appointment as
5 a staff specialist in a particular facility?
6 A. As a permanent staff member?
7
8 Q. Yes.
9 A. It may. For some people as well, though, they like
10 the VMO contract model, so again I think offering people
11 the contract for the balance of the term as opposed to
12 short-term rolling contracts would also provide people with
13 a sense of certainty.
14
15 THE COMMISSIONER: Q. I understand the problem you've
16 told us about in relation to VMOs who are on these
17 short-term contracts in terms of lack of security and
18 trouble getting finance, those sorts of things, and you
19 mentioned you've seen it in metro LHDs and also regional
20 LHDs. Is there any common theme as to who gets
21 a short-term appointment and who gets the five years?
22 A. No.
23
24 Q. Or it appears quite random; there's no --
25 A. Yes.
26
27 THE COMMISSIONER: Okay, thanks.
28
29 MR MUSTON: Q. You suggest in paragraph 23 that
30 a potential solution to this problem is some legislative
31 reform, and in particular, an extension of appointment
32 terms beyond five years. Why do you think that might be
33 useful?
34 A. I suppose that's something that we've been looking at
35 in the context of concerns raised by other stakeholders
36 about the fact that VMOs are a transient workforce.
37 I personally don't agree with that, I think people make
38 a commitment to an area and are looking for the next
39 five-year contract. But if there is concern that that does
40 create uncertainty or difficulty in planning in the system,
41 then under the legislation they could look at a longer
42 length of a VMO appointment as a way of perhaps addressing
43 some of that uncertainty that some might think exists in
44 the system.
45
46 Q. You said a moment ago that some people might find the
47 VMO arrangement more desirable than, say, a fractional

1 appointment as a staff specialist. Based on the feedback
2 from your members, what is it about the VMO arrangement
3 that at least some people might consider to be more
4 desirable than a salaried position?
5 A. For some of our members it provides them with greater
6 flexibility when they're providing services across - so
7 some may provide services across a number of local health
8 districts, for example, in the metro area, or even in metro
9 areas and regionally. A number of them are also working in
10 the private hospital system and they find that that
11 arrangement works best for them in that regard.
12
13 Q. Just dealing with that last aspect of it, working
14 across both the private and the public system, why is it
15 that the VMO arrangement works better than a fractional
16 staff specialist appointment that might - say if they're
17 a 0.5 within the public system, they would still have 0.5
18 that they could devote to the private system, what is it
19 about the VMO arrangement that is more desirable?
20 A. I think one of the advantages is it allows people to
21 flex up and flex down. So again depending on service
22 demands, but also, too, you know, they can accommodate
23 changes in shifts and schedules with that VMO contract
24 arrangement in place.
25
26 Q. To the extent that you allude in paragraph 22 to the
27 need to provide some greater certainty to the VMOs --
28 A. Yes.
29
30 Q. -- do you accept that the system also needs a level of
31 certainty to enable it to engage in forward planning of its
32 workforce, service delivery and the like?
33 A. Yes.
34
35 Q. That ability on the part of a VMO to flex up and flex
36 down that you allude to, to best accommodate the mix
37 between public and private that works for them --
38 A. Yes.
39
40 Q. -- how is that to be reconciled with the need of the
41 system, of the hospital administrators, to have their own
42 level of certainty about the workforce which is available
43 to them?
44 A. Sorry, I should also have said it works for both,
45 because often when VMOs flex up and flex down, it's to
46 address service delivery needs in the public hospital
47 system. So if there's a need to ramp it up to get through

1 wait list reduction work, then VMOs can accommodate that.
2
3 Equally at times when perhaps there isn't that same
4 urgent need, then VMOs would say, "Well, then, that's fine,
5 I'll pick up some work somewhere else." So I think that's
6 the flexibility. So I think it works to the advantage of
7 both.
8
9 Q. Works to the advantage of both in that you've got an
10 ability for the - the system, that is, has an ability to
11 flex down where the need is not quite as great as the
12 workforce including the VMO workforce could provide, but to
13 the extent that the system needs to flex up, it depends on
14 a willingness of the VMO workforce to flex with it, doesn't
15 it?
16 A. Yes, it does.
17
18 Q. They're not compelled to do that?
19 A. Yes. But the VMO determination also provides
20 a mechanism within it for the annual review of service
21 provision and that allows you to obviously look at busier
22 periods within the year and quieter times within the year
23 and plan on that basis, I think probably one of the things
24 that I think could probably be used more often by local
25 health districts. They regularly engage in a performance
26 review process, but we often don't find our members telling
27 us they're engaging about looking at service delivery from
28 year to year and looking at what did we need this year,
29 what might we need next year, to give both parties that
30 ability to plan and change as service deliveries might
31 require it.
32
33 Q. You mentioned that in the statement. Is it your view
34 that there are provisions of the determination which could
35 lock VMOs into the provision of care in a way that gave
36 some certainty as to the delivery of service by the health
37 district?
38 A. Yes, so under the determinations, it contemplates that
39 under the contracts each year there will be - so for
40 sessional VMOs who are paid on an hourly rate, a commitment
41 to a number of hours; for fee for service, then there's
42 a service plan, because they're remunerated by reference to
43 the services that are delivered.
44
45 I think what we often see at the quinquennial
46 reappointment process is districts trying to contemplate
47 what they're going to need for five years and saying that

1 that's very difficult, whereas under the determination, it
2 actually provides for that to be reviewed every year and
3 a review of the services provided in the previous 12 months
4 and what might be needed in the coming 12 months and then
5 for the VMO and the local health district to reach
6 agreement about what the plan would be for the coming
7 12 months?
8
9 Q. Is that 12-month monthly process, routinely happening
10 in the case of VMOs?
11 A. I don't believe so, no.
12
13 Q. You tell us in paragraph 26 of your statement that one
14 of the strengths of the New South Wales public hospital
15 system lies in the mix of VMOs and staff specialists. What
16 is it about that mix that you think is a strength of our
17 system as compared with, say, other jurisdictions?
18 A. I think providing people with that choice about the
19 arrangements under which they wish to work. I think
20 historically - and it's probably not so much the case now -
21 medical practitioners were very much of the view they
22 didn't want to be employees, they wanted to be contractors,
23 they were self-employed, they were running their practice
24 in the way in which they wished to do so. But I think, you
25 know, we're now seeing what our members tell us,
26 particularly when they've got young families or what have
27 you, actually the staff specialist model works really well
28 for them, they have access to paid leave and so on and so
29 forth and a bit more certainty around arrangements.
30
31 Then as they progress in their career, they might want
32 to look at a VMO model, and I think similarly when they get
33 towards the end of the career and they're a bit more, "I
34 want to do a bit more research and other things", then
35 again the staff specialist model might work for them. But
36 I think providing people with choice about how they're
37 engaged and making that choice actually available to people
38 is a really positive thing.
39
40 Q. As you've alluded to in the statement, it's suggested
41 by some that VMOs carry less of the administrative and
42 teaching burdens of hospitals than their staff specialist
43 colleagues. First question about that: do you agree that
44 the medical workforce, assisting in meeting the burden of
45 administration and teaching, is an important part of the
46 health system?
47 A. Yes.

1
2 Q. And, secondly, do you have a view about whether the
3 VMOs are, at least as a general proposition, less involved
4 in administration and teaching than staff specialists, and
5 break it up if you want to?
6 A. In terms of teaching, I think VMOs teach a lot more
7 than they're recognised for. I think, based on what our
8 members tell us, they do it, they don't really claim
9 remuneration for it. They see it as part of their role as
10 a part of the medical profession in bringing on the next
11 generation. Some will claim some of their hours because
12 they make a choice to do so; some won't claim because they
13 make the claim and it's not paid.
14
15 I don't think an allowance is often made for it in the
16 VMOs' budget. The allowance is really focused around
17 clinical service delivery and not really breaking that
18 down, and again that's where I think the annual review
19 provisions could be good to say, "Well, how much time are
20 you spending teaching and not?" But my experience very
21 much is, I think speaking to any VMO really engaged in the
22 public hospital system, that's the reason why a lot of them
23 actually stay in the public hospital system because they
24 value that opportunity to interact with the next generation
25 and teach and train them.
26
27 So I think it's difficult to do that analysis,
28 because, as I said, a lot of them don't claim or are told
29 not to claim because there's not money in the budget for
30 that, so it's difficult to know how much time they're
31 doing, but I think a lot of them are doing quite a lot.
32
33 In terms of administrative roles, a number of our
34 members have been or are heads of department, so again,
35 they do fill those roles. I mean, there are other roles
36 other than heads of department, but again, they all
37 participate in those roles and committees. Again, they -
38 I think anecdotally people are telling us as a head of
39 department they get about six hours a week to spend on
40 that.
41
42 As a staff specialist you probably, because they have
43 that allowance for non-clinical time, might get more
44 financial recognition for that, but I don't think that VMOs
45 don't want to do it or - and are not doing it in the
46 system.
47

1 Q. Could I ask you to go forward to paragraph 40 of your
2 statement, where you tell us about some of - at least the
3 changing arrangements as of 1 July 2024, with the
4 reintroduction of the industrial court. At the end of that
5 paragraph you tell us about what you understand to be the
6 role of the industrial court in relation to the VMO
7 determination. What is the source of that belief?
8 A. The belief - sorry, could you just ask the question
9 again?
10
11 Q. So you were informed by ministry that it was an
12 oversight --
13 A. Yes.
14
15 Q. -- that the provisions regarding the qualifications of
16 the arbitrator were not amended.
17 A. Yes.
18
19 Q. Where did that information come from - that is, the
20 fact that it was said to be an oversight?
21 A. So in discussions with the ministry, when we first
22 realised that it wasn't contemplated that jurisdiction
23 would be brought back within the industrial court, the
24 ministry's obviously made inquiries with the industrial
25 relations department and others about the drafting of the
26 legislation and came back to say it was a genuine
27 oversight, because there were other amendments made to the
28 Health Services Act to bring other certain matters
29 concerning VMOs back into that jurisdiction, but this
30 hadn't been covered.
31
32 Q. Who was it who informed you that it was an oversight,
33 to the best you can recall?
34 A. I believe it was Melissa Collins.
35
36 Q. And at least as matters stand, have you been given any
37 indication of whether or when that oversight is going to be
38 addressed?
39 A. I understand it's possible it may be addressed in the
40 coming months. They are reviewing the Health Services
41 Regulation later this year. We would like to see it done
42 before that process is completed, but yes - hopefully, it's
43 imminent.
44
45 Q. You have set out in your statement helpfully a range
46 of the issues that you think need to be refreshed in the
47 VMO determination. I don't propose to take you through all

1 of them, but could I just ask you this in relation to the
2 rising costs of medical indemnity that you address at
3 paragraph 75. You tell us in that paragraph about the
4 distinction between what you understand to be the medical
5 indemnity cover available through the TMF for rural and
6 regional doctors as contrasted with metropolitan doctors?
7 A. Yes.
8
9 Q. Could you just expand a little bit on what you
10 understand, based on discussions with your members, the
11 problem within the metropolitan area to be?
12 A. So in the last two or three years a number of our
13 members have come to us expressing concern about the extent
14 to which their medical indemnity and premiums have
15 increased. Now, obviously we've seen that across the
16 entire insurance industry, and for some specialists it's
17 probably - they probably increased more because, for
18 example, bariatric surgeons have been the subject of
19 a number of claims in recent years, and so probably as
20 a craft group they have seen their premiums increase more,
21 and some others have as well.
22
23 But what our members are saying to us is when
24 a patient comes through the public hospital system and
25 makes the choice to be treated as a private patient, that
26 often is a choice made without any consultation with the
27 VMO. The VMO doesn't have the opportunity to provide them
28 informed financial consent but also to make their own
29 choice about whether they will accept to treat a patient in
30 that setting and some VMOs will tell us that in the public
31 hospital system, they don't have a lot of control over what
32 happens, they might have more control in a private hospital
33 setting where it's smaller, and a lot of the patients that
34 present obviously have a number of comorbidities, they're
35 often quite unwell because they come through the emergency
36 department, and so the risks of an adverse incident
37 occurring are significantly greater, and if there is an
38 adverse incident, they bear that under their own medical
39 indemnity insurance, and once they've a claim, then that
40 can have an adverse impact on their medical indemnity
41 premiums.
42
43 So VMOs are saying if they don't get the option to
44 decide whether or not they're going to accept a patient as
45 a private patient under their care, that it would make
46 a difference to them if TMF provided the indemnity cover
47 for those patients because then they don't bear the risk

1 under their own medical indemnity insurance and the flow-on
2 financial consequences.
3
4 Q. Has the AMA, to the best of your knowledge, engaged
5 with ministry around this problem?
6 A. We have raised the issue in meetings this year and
7 we're seeking to have further discussions with them about
8 this issue.
9
10 Q. As matters stand, what do you understand to be the
11 ministry's position in relation to that issue, namely,
12 the --
13 A. Extended TMF cover?
14
15 Q. Yes.
16 A. We haven't formally made that request yet. We're just
17 having a discussion around the impact and the position of
18 VMOs at the moment, but we haven't formally made the
19 request at this point in time.
20
21 Q. In respect of the particular practitioner, whether the
22 patient is - whether they're indemnified by the TMF or not,
23 a claim is always potentially going to be made against
24 them?
25 A. Yes.
26
27 Q. They would, in the ordinary course, notify not only
28 the TMF, if covered by the TMF, but also their professional
29 indemnity insurer?
30 A. Yes.
31
32 Q. So to the extent that the making of a claim has the
33 capacity to impact on premiums going forward, that's
34 something which an adjustment to the TMF arrangements in
35 the metropolitan areas might not make a big difference to;
36 would that be right?
37 A. To their personal medical indemnity premiums?
38
39 Q. Yes.
40 A. It would if they - if their medical defence
41 organisation is not funding the defence of that claim, then
42 that would make a difference to them. The mere
43 notification - well, there's probably a debate about that.
44 The mere notification of a claim probably doesn't have an
45 effect on somebody's premium. It will be a question of who
46 then is responsible for the management and defence of that
47 claim.

1
2 Q. To the extent there is a claim which is ultimately
3 substantiated has the capacity to impact on premiums, the
4 point I'm trying to make is that there will be some impact,
5 potentially, through a substantiated claim on the private
6 professional indemnity insurance?
7 A. Yes.
8
9 Q. Whether or not it's the private professional indemnity
10 insurer or the TMF who is paying?
11 A. Yes, potentially, yes.
12
13 Q. But is it your point that at least in respect of those
14 claims where there might be some impact, the impact would
15 be reduced if it was the TMF rather than the private
16 indemnity insurer --
17 A. Correct.
18
19 Q. -- professional indemnity insurer, who's paying it.
20 At paragraph 28 [sic] you tell us it's difficult to get
21 a clear understanding of the number of locums engaged in
22 the public hospital system. I assume that the survey that
23 you've alluded to there is not intended to suggest that the
24 107 respondents to the survey reflected necessarily
25 anything like the number of locums who are working in the
26 public system?
27 A. Absolutely not, no.
28
29 Q. Has the AMA sought information from ministry about the
30 number of locums working within the system and the way in
31 which they're being deployed?
32 A. Yes, often sort of directed to the district itself,
33 and I think in my statement I refer to an example where we
34 made a request under the GIPAA legislation to identify the
35 number of locums that had been engaged at a particular
36 hospital, and we were told that it couldn't be done because
37 they were engaged under VMO contracts and they couldn't
38 identify which were the locum contracts and which were the
39 permanent VMO contracts.
40
41 Q. Again, going back to a question I asked earlier, from
42 the AMA's perspective, why would that information - that
43 is, the break down between locums and VMOs - have been
44 useful information?
45 A. In that instance, members had come to us because they
46 had a department that had an ageing workforce and they were
47 trying to attract and retain new consultants to come and

1 join them, and in the interim, the local health district
2 was obviously engaging locums to meet those shortfalls.
3 And part of what we wanted to demonstrate, well, what's the
4 cost of engaging those locums and having them come, because
5 we were told there couldn't be any additional incentives
6 paid to VMOs to attract them to come and relocate in the
7 area, and we want to do that analysis between what's the
8 true cost of a locum, what's the cost of a VMO and could
9 the money that's being spent here perhaps be spent here.
10
11 THE COMMISSIONER: Sorry to interrupt. You drew the
12 witness's attention to paragraph 28.
13
14 MR MUSTON: If I did, I think I meant 78.
15
16 THE COMMISSIONER: 78, thanks. Sorry, you keep going.
17 I'm there now.
18
19 MR MUSTON: I probably did say 28.
20
21 THE COMMISSIONER: The transcript records 28, so there is
22 a reasonable chance you did.
23
24 MR MUSTON: It's always right.
25
26 Q. Did you get the sense that the particular local health
27 district that you were engaging with on that occasion had
28 not itself undertaken that economic analysis, that is --
29 A. I couldn't answer that. If they had, they weren't
30 sharing with us, but I don't know whether they had or not.
31
32 Q. Could we just continue with the locums. You talk
33 about some of the challenges that communities in rural and
34 regional areas face and the way that locums, in effect,
35 become part of the business as usual provision, which you
36 tribute to the industrial instruments being updated. Is it
37 really just the industrial instruments and the remuneration
38 which are the reason that some of those rural and regional
39 areas have been forced to rely on locums to deliver
40 business as usual service, or is there more to it?
41 A. There could be any number of reasons, I suppose, for
42 it, over and above the industrial arrangements. I think,
43 though, when people are being offered more money to come
44 and do it on a short-term basis, and fly in and fly out,
45 although some permanent VMOs also have a fly-in/fly-out
46 arrangement, I think that makes it hard to recruit and
47 retain under the existing industrial instruments if there's

1 no additional remuneration paid for people to go into those
2 areas.
3
4 Q. To the extent that the remuneration which is available
5 to locums is, we're told, much greater than would be
6 available to make someone a permanent member or for someone
7 who chose to become a permanent member of the workforce,
8 and the permanent workforce has declined to the extent that
9 it has by, in part, people shifting off into locum
10 positions, how does the system deal with that, do you
11 think?
12 A. I'm not sure if this is answering your question, but
13 I think they need to provide greater incentives to people,
14 particularly in rural and regional areas, to go and work
15 there. For example, a lot of fee for service VMOs - sorry,
16 a lot of the VMOs in those locations are remunerated on
17 a fee for service basis, they don't get paid an on-call
18 allowance. If they're on call and they come in to treat
19 a patient but they don't end up providing - for example,
20 the operation doesn't take place for any number of reasons,
21 they don't get any remuneration at all for coming in.
22
23 A locum is engaged on a block payment for 24 or
24 48 hours for the provision of those services. I think
25 unless you address the way in which locums are
26 remunerated - it might not even just be the quantum but the
27 way in which they are remunerated - and the way in which
28 permanent workforce is remunerated, you're always going to
29 have a bit of a challenge in that regard.
30
31 Q. So is the suggestion a closer alignment between the
32 conditions and form of remuneration available to both
33 permanent VMO based workforce, at least, and locums,
34 wouldn't necessarily mean a shift to what locums are
35 currently being paid?
36 A. No, not necessarily.
37
38 Q. But equally, some move, you think, from what VMOs are
39 currently being paid and the arrangements which they are on
40 to try and bridge a gap?
41 A. Yes, I think a recognition of the services that are
42 being provided in those communities and some form of
43 remuneration for those would be very important.
44
45 Q. In paragraph 82 you tell us that the AMA is aware that
46 there are hospitals where locums have been engaged to
47 provide services when consultants at those hospitals could

1 have undertaken the work but weren't offered that work.
2 Could you expand on that? What is the particular situation
3 that you're alluding to there?
4 A. So one example is a VMO who contacted me and said she
5 had been contacted by a locum agency about the availability
6 of work at her hospital - I think not appreciating she
7 worked at that hospital - under locum arrangements, and the
8 comment of the VMO to me was, across the department, they
9 could have actually picked up that additional - I think it
10 was wait list reduction work, at the time. Within the
11 department they could have actually undertaken that work
12 and met that requirement within the department, but it
13 hadn't been offered to them.
14
15 Q. Where did the breakdown occur there, do you think?
16 A. Well, again, I would say it's a lack of probably good
17 communication between administration and medical
18 practitioners around issues of capacity and service
19 planning.
20
21 Q. Is it possible that that communication breakdown was
22 bi-directional - that is to say, both sides could have
23 communicated a bit better?
24 A. It could have been, yes.
25
26 Q. Is there anything that you think could be changed
27 about the system to reduce the risk that communication
28 breakdowns of that type have, the sort of impact that at
29 least in that instance it had?
30 A. Well again, I think it's involving medical
31 practitioners more in - again, perhaps in more regular
32 discussions around service planning, again, utilising that
33 annual review provision under the determinations, but also
34 just engaging with departments around issues of capacity
35 and proposed, you know, upticks in activity and whether
36 they can be met by people within the existing department or
37 whether there is a need to get additional staff in to
38 address that.
39
40 Q. You tell us in paragraph 84 that the professional
41 support payment for locum expenses, insofar as it's
42 accessible, has drifted from what was contemplated in 2007
43 when it was introduced. What do you understand to have
44 been contemplated by the professional support payment for
45 locum expenses?
46 A. So in 2007, one of the issues at that time, as it is
47 now, was recruitment and retention of regional workforce,

1 and so the professional support payment was introduced to
2 help - in recognition of the fact that people in regional
3 and rural areas have to travel further to get to
4 conferences, so there was meant to be some contribution
5 towards that, but also the availability of a payment to
6 meet the engagement of locums who, when they come in to -
7 they can be engaged to work just in the public hospital
8 system, but often VMOs, particularly in regional areas, are
9 providing outpatient services through their rooms because
10 there aren't outpatient clinics at the hospital, but also
11 they're providing services to the local community so they
12 get a locum in to cover their rooms as well as working in
13 the public hospital system, and there was recognition that
14 that can be quite a significant expense. Often you have to
15 meet the accommodation and travel expenses for those people
16 to get them to come, and so it was - the professional
17 support payment was designed to be a payment that VMOs
18 could use to contribute to the costs of travel to
19 a conference, conference registration fees, getting a locum
20 in - to allow them to do all of those things, but also in
21 recognition of the fact that sometimes people just find it
22 really hard to take a break in regional and rural areas,
23 which is another reason why people don't want to go there,
24 and that that would help people to take a break, even if it
25 wasn't for conference leave, but to get a locum in so that
26 they could actually get away and have a break.
27
28 Q. So the situation as it stands is, if you as a VMO want
29 to go to a conference, for example, you can access the
30 payment to cover the conference fees and cover a locum for
31 the duration of the conference?
32 A. Part of those fees, yes. It's an all-up payment of
33 $15,000 a year. It hasn't been indexed since 2007 but yes,
34 it's to help to meet some of those costs.
35
36 Q. And at least insofar as those costs are concerned, the
37 payment, to the extent VMOs are making an application for
38 it, it is being provided - that is the payment?
39 A. They make - they are at the moment.
40
41 Q. So they are receiving it at the moment. To the extent
42 that it relates to going away for a conference, for the
43 duration of that conference, the cost of the locum is
44 contributed to by that payment?
45 A. I think it's very difficult for people to get approval
46 for locum costs at the moment. Through various ministry
47 policies, they've increasingly tightened that up, so that

1 now VMOs have to demonstrate the net cost of the locum and
2 what did the locum bring in at the private rooms and so on
3 and so forth. It's become much more difficult, and again,
4 that's something else the VMO needs to do, and so a lot of
5 people just don't do it at all now. And it was meant to be
6 something that was easily accessible to make it easy for
7 VMOs. I think it's become really hard for people to access
8 it. Some districts as well just say, "We're not paying it
9 for locum costs."
10
11 Q. So the difficulty is instead of a process whereby
12 someone says, "I want to go to a conference, I want to get
13 a locum to cover me for the week that that conference is
14 running in" - in any old country in the world?
15 A. Yes.
16
17 Q. Now, they have to, in some places, at least,
18 demonstrate what the locum has cost them, demonstrate what
19 the locum has brought in by way of Medicare billings and
20 the like, show the differential between the two, and they
21 are, as it were, capped at a contribution towards that
22 differential rather than the overall locum cost?
23 A. Yes.
24
25 Q. Which you say is an administrative burden that, in
26 many cases, VMOs are not willing to take on?
27 A. Yes.
28
29 Q. That's conferences. What about a situation where
30 a VMO working in a rural or regional centre says, "I don't
31 want to go to a conference, I just want to go on a holiday
32 with my family for a break", do I gather from the evidence
33 that you've given that the payment is not being made to
34 them to cover the locum in those circumstances?
35 A. Yes.
36
37 Q. And at least as you understand it, that's a departure
38 from what was contemplated in 2007 when the payment was
39 introduced?
40 A. Yes.
41
42 Q. Could I ask you to go to paragraph 92 of your
43 statement, where you tell us a little bit about the VMoney
44 system and some of the challenges which you see VMOs facing
45 with respect to that system --
46 A. Yes.
47

1 Q. -- and in particular, the auditing process. First of
2 all, do you accept that some balance needs to be struck
3 which involves or enables an auditing of claims to ensure
4 that what's being claimed for reflects the work that's
5 actually been done?
6 A. Yes.
7
8 Q. And hopefully not common, but there will be cases of
9 inflated claims within the system?
10 A. Yes, from time to time.
11
12 Q. How do you think the system should be adjusted to deal
13 with the challenges that you point to in paragraphs 89 to
14 92, whilst at the same time making sure that over-claiming,
15 unintentional or, worst case, intentional, is able to be
16 picked up and adequately addressed?
17 A. I think - and I was just talking to some doctors about
18 this on the weekend at AMA national conference - the way
19 that it's done at the moment is that VMOs feel that the
20 starting point is you must question everything that's been
21 submitted because it might not be correct; that their
22 claims are checked by administrative staff, in the first
23 instance, that may be appropriate, but they're looking at
24 an operation report or something that might not reflect
25 what the VMO's claimed, they then jump immediately to
26 rejecting that claim. There is no attempt to speak to the
27 VMO to say, "Operation report doesn't marry up with what
28 you've put in. Can you explain why that might be the
29 case?"
30
31 Even if you didn't want to go to the VMO, worst case
32 scenario, you thought that maybe they'd done the wrong
33 thing, then discussing it with the head of department or
34 the director of medical services - there's no engagement
35 with the medical fraternity around those claims, whereas
36 I think people's experience in the past was they would be
37 asked more directly about, "We've got a problem with your
38 claim, so before it's rejected could you provide us with
39 some more information or some context", whereas that
40 doesn't happen now, or, equally, they would raise it with
41 the head of department around, "We've got these claims.
42 Could you maybe have a chat with the VMO because it doesn't
43 seem to marry up." None of that happens, from what I've
44 heard, on the ground anymore. It's purely an
45 administrative process and it's reject first and ask
46 questions, if they're ever asked, at a later point in time.
47

1 Q. Is there a practical difference between reject first,
2 as you've put it, on the one hand, and not approve until
3 further information is provided?
4 A. I think it makes VMOs feel disenfranchised. I think
5 it makes them feel like they've done - they know they
6 haven't done the wrong thing but they think, "I'm not going
7 to engage with this. This is becoming, you know, a war of
8 admin versus VMOs."
9
10 It's also, often when claims are rejected, they don't
11 become aware of that fact until about a month or more after
12 they've put the claim in, so then they have to go back and
13 go through everything to then find the evidence, or they're
14 told to go in and amend the medical record, so that it then
15 reflects that they were there or what have you. VMOs most
16 often don't have time to do that, particularly in regional
17 areas, and so they simply just don't pursue the claim at
18 all and are not paid.
19
20 Q. But in relation to those cases where the query relates
21 to a failure of the medical record or the operation report
22 to marry up with the claim, would we be right to assume
23 that it's the VMO that's responsible for preparing the
24 operation report or completing the medical record or those
25 parts of the medical record relating to the care that they
26 have delivered?
27 A. So sometimes it's a discrepancy between what the VMO
28 has put on the operation report and what somebody else
29 might have recorded on the operation report - so, for
30 example, starting times and finishing times. And again,
31 there's no question around that, it's just accepted that
32 the other - the entry that's odd with what the VMO has put
33 in must be the correct entry, for example. I think that's
34 problematic.
35
36 I think as well with the medical record, the public
37 hospital system operates on the basis of a team delivering
38 care, so often entries in the medical record are made by
39 a member of junior medical staff, and that's been the
40 practice for as long as I can remember it. So again, it
41 may not be that - the VMO didn't appreciate that they
42 hadn't made the note that the VMO had been there or for the
43 length of time that the VMO might have been in attendance
44 for that, the provision of that service.
45
46 Under the determination, a VMO has to keep a record of
47 the services they provide and be able to provide that, but

1 they wouldn't necessarily go back to the medical record
2 when they're putting in their VMoney claim to check all of
3 those things as they do it.
4
5 Q. It might be an education piece, but as the party who's
6 seeking to claim the payment, does at least some
7 responsibility rest with the VMO to ensure that the medical
8 record, whether completed by the VMO or by some more junior
9 member of staff, actually marries up with what they
10 understand to have been the service that they've delivered
11 in a particular instance?
12 A. Yes, I think - I think the underlying expectation is
13 that it does, and I think probably for the most part it
14 does, but there are those cases where it doesn't happen or
15 a service has been provided in the middle of the night and
16 somebody hasn't, you know, put down all the information at
17 the time, is where those things happen. I don't think it
18 happens routinely for a VMO that that's never documented
19 for them.
20
21 Q. Can I ask you some questions about non-standard
22 arrangements. There's scope in the legislation for those
23 non-standard arrangements to be approved by the secretary?
24 A. Yes.
25
26 Q. And those non-standard arrangements do, from time to
27 time, get implemented within the system --
28 A. Yes.
29
30 Q. -- so far as you are aware? At 96 you give us an
31 example of a situation in Dubbo.
32 A. Yes.
33
34 Q. Just in relation to that, I infer from what you've
35 told us in paragraph 96 that an adjustment to remuneration
36 through a non-standard arrangement is something that you
37 think might have been used in that instance?
38 A. What we're saying is it's something that should be
39 looked at. I don't know whether it would have addressed
40 the problem at that hospital at that time but I think it's
41 something that should be put on the table for discussion
42 and a review of why doctors in training don't want to go to
43 rural and regional areas, and if it is because they have to
44 give up accommodation in the city or do other things, then
45 I think it's worth looking at what incentives actually help
46 to get people to those areas. They might love it and they
47 might decide to go back there in due course.

1
2 Q. But in relation to that particular example where two
3 interns put their hands up to fill 10 intern positions,
4 would you accept that there might be a constellation of
5 other factors which --
6 A. There could be a number of factors as to why.
7
8 Q. -- play into that? For example, the desirability as
9 starting as an intern in a hospital where you might want to
10 one day try and secure a vocational training position?
11 A. Yes. There could be any number of reasons but I think
12 that's one issue that's worth having a look at.
13
14 Q. Finally, could I ask you to turn over to paragraph 105
15 of your statement where you tell us that if public health
16 organisations do not wish to engage in alternative dispute
17 resolution, then consideration must be given to providing
18 VMOs other avenues to raise and resolve disputes, which is
19 something you tell us about in the context of processes and
20 procedures for lodging complaints and dispute. I just
21 wonder, could you tell us what you have in mind when you
22 allude there to alternative or other avenues?
23 A. So, for example, staff specialists under their
24 arrangements have the right to notify dispute to the
25 Industrial Relations Commission, and so once you get into
26 that jurisdiction, then often, you know, your first port of
27 call is a conciliation process to try and resolve
28 a dispute. I guess that that would be an example of,
29 should VMOs have rights to come within the industrial
30 relations system to engage with public health organisations
31 if they don't want to engage under the mechanisms that are
32 in place under the VMO determinations. But I think it's
33 important that people have a mechanism to have their
34 disputes dealt with.
35
36 Q. What are the limitations of the current mechanisms, as
37 you see them, which mean, say, an ability to have recourse
38 to the Industrial Relations Commission might be
39 advantageous?
40 A. I think the degree to which public health
41 organisations engage in the disputes process is very
42 variable. We do have experiences where we notify a dispute
43 and we have often a number of meetings, we don't even get
44 to mediation and we can come to an agreement about how to
45 move forward. But equally, in other cases, it can take
46 months and 10 letters just to get the district to
47 acknowledge that the VMO's raised an issue, and then get

1 a meeting. And in others, people just refuse to engage at
2 all in the process or engage up to a certain point and then
3 say, "Actually, we're not engaging in this anymore", and so
4 I think that's part of the frustration, but I think it's
5 also another way in which VMOs feel that they're not being
6 listened to, and it's an important mechanism.
7
8 I mean, the issues we get asked to lodge disputes
9 about vary considerably, as you might imagine, but some of
10 them are very straightforward, but VMOs just feel there's
11 no other way to bring it to the attention of their
12 hospital. But again, it's meant to be an alternative
13 dispute resolution. I don't know if it's because there's
14 a misapprehension that because it's called a dispute
15 process, that it's more formal than it perhaps otherwise
16 is, but I just think it's really important to have some
17 mechanism that works that VMOs can engage in.
18
19 Q. Is it possible that that mechanism is something that
20 could be built in to the determination?
21 A. It is in the determination.
22
23 Q. But improved in a way as part of the determination
24 review process that's currently on foot?
25 A. Yes, I - well, yes, I think, and maybe - you know,
26 nobody wants to have, you know, penalties or what have you
27 for people who don't engage, but maybe then there's an
28 escalation pathway elsewhere if local health districts
29 aren't engaging, that might be a way of dealing with it,
30 perhaps.
31
32 MR MUSTON: Thank you, Commissioner, I've got no further
33 questions for this witness.
34
35 THE COMMISSIONER: I might ask you, Mr Chapman, do you
36 have any questions of the witness?
37
38 MR CHAPMAN: No, thank you.
39
40 THE COMMISSIONER: Mr Cheney, do you have any questions?
41
42 MR CHENEY: No, Commissioner.
43
44 THE COMMISSIONER: Thank you very much, Ms Egan, for your
45 time. We're very grateful. You're excused.
46
47 THE WITNESS: Thank you.

1
2 **<THE WITNESS WITHDREW**
3
4 THE COMMISSIONER: All right. We'll adjourn until 5 past
5 2.
6
7 **LUNCHEON ADJOURNMENT**
8
9 THE COMMISSIONER: Good afternoon.
10
11 MR GLOVER: The next witness, Commissioner, is Melissa
12 Collins, who is in the witness box.
13
14 **<MELISSA ANNE COLLINS, affirmed: [2.07pm]**
15
16 **<EXAMINATION BY MR GLOVER:**
17
18 MR GLOVER: Q. Could you state your full name, please?
19 A. Melissa Anne Collins.
20
21 Q. You are the acting executive director of workplace
22 relations in the ministry?
23 A. Yes.
24
25 Q. You have been in that role since about February of
26 this year; correct?
27 A. That's right.
28
29 Q. Your substantive positions is director industrial
30 (medical) relations and policy?
31 A. Yes.
32
33 Q. And you've been in that role since about January 2019;
34 is that right?
35 A. That's right.
36
37 Q. To assist the Commission in its work you've made two
38 statements?
39 A. Yes.
40
41 Q. The first dated 17 July 2024?
42 A. Yes.
43
44 Q. Do you have a copy of it there with you?
45 A. I do.
46
47 MR GLOVER: Just for the purposes of the transcript, it's

1 [MOH.0011.0025.0001].
2
3 Q. Have you had a chance to read it again before giving
4 your evidence today?
5 A. Yes.
6
7 Q. And are you satisfied that it is true and correct?
8 A. Yes.
9
10 Q. You made a second statement on 3 August?
11 A. Yes.
12
13 Q. That is [MOH.0011.0038.0001]. Do you also have a copy
14 of that statement with you?
15 A. Yes.
16
17 Q. Have you read it again before giving your evidence
18 this morning?
19 A. Yes.
20
21 Q. And are you satisfied it's true and correct to the
22 best of your knowledge and belief?
23 A. Yes.
24
25 Q. Thank you. Can we go to your 17 July statement and
26 we'll start at paragraph 2, where you tell us about your
27 acting role. Can you just describe in general terms what
28 your function is in that acting position?
29 A. Yes. So our workplace relations is a branch of the
30 Ministry of Health. It's divided into three main roles.
31 Probably the one that focuses most of the statement is on
32 workplace relations, so looking after all the industrial
33 instruments and, I guess, leading the relationship and
34 negotiation around awards and industrial instruments with
35 the unions.
36
37 I also am responsible for the people and culture unit
38 within the Ministry of Health, so just the Ministry of
39 Health, and the safety and security team.
40
41 Q. And in paragraph 6, you refer to a copy of the
42 position description for that role.
43
44 I might just have it brought up on the screen. It's
45 [MOH.0010.0145.0001]. Commissioner, it's H1.19.
46
47 If we turn to the second page, thank you, operator, do

1 you see there the heading - there's a screen to your right
2 there, or there's one across --
3 A. My eyesight's not that good.
4
5 Q. Yes, whichever one suits you. Do you see a heading
6 "Key challenges"? Just read those three dot points to
7 yourself and let me know when you've finished.
8 A. Sure.
9
10 Q. Do you see the first dot point there:
11
12 *Developing modern employment mechanisms and*
13 *systems that enable workforce reform to*
14 *build the health workforce of the future.*
15
16 A. Yes.
17
18 Q. What do you understand that challenge to be?
19 A. Oh, I might have a long answer for that.
20
21 Q. Take as long as you need.
22 A. So, look, I think as I say in my statement, we have
23 a lot of awards, we've got 43 awards, numerous industrial
24 instruments. Many of those awards I think are difficult to
25 use, and what I mean by that is they are outdated and when
26 I say that, it is different for all the different
27 instruments. Some are overly prescriptive in parts, some
28 are ambiguous in others.
29
30 Look, please, if I am talking too much, please just
31 feel free to interrupt and ask the next question.
32
33 Q. I won't hesitate.
34
35 THE COMMISSIONER: Q. Feel free to give a full answer.
36
37 MR GLOVER: Q. Just take your time so the lady sitting
38 immediately in front of you gets it all down.
39 A. I have prior apologised and committed to trying to
40 talk slowly. Look, I think to answer this question about
41 how - why it's such a challenge to develop modern
42 employment mechanisms is, in my view, many, many of our
43 awards did not go through what I'll call the structural
44 efficiency principles or structural efficiency reforms of
45 the late '80s, early '90s. So in that, by that I mean we
46 still have so many instruments, we still have so many
47 classifications, we still have so many allowances.

1
2 I see that there needs to be structural reform, so
3 a consolidation of the awards, in my view, consolidation of
4 some of the conditions and some of the many classifications
5 we have. I think that would bring some modernisation.
6
7 I think many of the health awards also didn't go
8 through the federal modernisation principles, where again,
9 I think federally, about 2,000 agreements were consolidated
10 into about 100 modern awards, so in my view, NSW Health
11 missed both those significant reforms. As a consequence,
12 we've got awards that, in my view, would benefit from
13 modernisation. So --
14
15 Q. So --
16 A. Please --
17
18 Q. You go. No, I didn't mean to cut you off.
19 A. That's, I guess, a premise. But to do that
20 modernisation is, of course, very difficult, has been very
21 difficult in the context of limitations around successive
22 governments' wages policies and regulations in the
23 Industrial Relations Act.
24
25 Q. Just to be clear when you, in that last passage,
26 referred to "successive governments' wages policies", what
27 did you have in mind?
28 A. Sorry, that probably wasn't clear. The previous New
29 South Wales Government had a wages policy which capped the
30 amount of award-based increases that would be offered, and
31 I think importantly, the Industrial Relations Act, which
32 was - I think the regulation, apologies, at 146C meant that
33 if an increase was wanted by a union, the Industrial
34 Relations Commission were also bound by that. So they
35 couldn't award increases that would result in costs that
36 didn't have employee-related offsets.
37
38 Q. We'll come back to some of those features in a moment.
39 In the initial phase of your answer you spoke of issues of
40 structural efficiency in a number of awards. What other
41 aspects of the awards lead you to the conclusion that they
42 are, firstly, outdated?
43 A. Look, I think a lot of them are not written in plain
44 English, so quite hard for our managers and indeed our
45 employees to understand. They're long, and I think in the
46 way that they're not modern in that, as I alluded to,
47 overly prescriptive. So we have clauses in there that

1 refer to how change rooms are structured and the number
2 of - and water bottles that need to be provided. Those
3 things are more a feature of awards pre-1990s. There are
4 numerous allowances. They're also outdated, I think, in
5 the fact that we have - in two ways, that, firstly, the
6 awards often have provisions that we don't use anymore or
7 allowances that we don't use anymore; but also in some of
8 our awards, don't necessarily reflect the way in which
9 those classifications work or indeed that we would need
10 them to work. I was going to say, I could give an example,
11 if that would be helpful.
12
13 Q. Please do.
14 A. I think I go to some of this in my statement, but the
15 staff specialists award is the obvious one. We, in many
16 what we call critical care specialties, are increasingly
17 needing a service outside business hours and moving towards
18 a 24/7 environment, and the staff specialists award, as was
19 arbitrated recently, and we've since submitted a variation,
20 does, outside emergency physicians, restrict rostering
21 outside of those business hours.
22
23 Q. You do deal with some of this in your statement, but
24 we may as well explain that now. So the staff specialists
25 award has something about normal or usual working hours in
26 it, does it?
27 A. Yes.
28
29 Q. What are they?
30 A. It's probably in my statement. Off the top of my head
31 I think is it 8 till 6.
32
33 Q. And when you refer to emergency physicians in that
34 answer, are they subject to a slightly different
35 arrangement?
36 A. That's right. They can be rostered until midnight.
37
38 Q. Sorry, say again?
39 A. They can be rostered till midnight.
40
41 Q. Are they the only category of physicians that have
42 that flexibility?
43 A. That's right.
44
45 Q. And is the issue you're pointing to, in the modern
46 environment, that there are physicians across the board who
47 may need to work something other than normal or usual

1 working hours as provided for in the award?
2 A. That's right and, look, I probably can't talk to
3 whether that needs to be all physicians, but certainly the
4 advice I get from my executive director of medical services
5 colleagues is that, at least in the critical care areas, we
6 are increasingly needing 24-hour coverage, 24/7 coverage.
7
8 Q. The information you have is that it's at least more
9 than emergency physicians who need to be rostered beyond
10 normal usual working hours; correct?
11 A. That's right.
12
13 Q. Just back to the "Key challenges" in the first dot
14 point. What do you understand "modern employment
15 mechanisms and systems" to be that would enable workforce
16 reform to build a health workforce of the future? What
17 does it mean, to you?
18 A. Look, I think modern employment mechanisms and
19 systems, I think is probably a broader proposition than
20 just NSW Health. However, I guess we work in the system of
21 which the New South Wales Government exists, which is the
22 Industrial Relations Commission, and whilst I do note that
23 there's a challenge, I think generally a system that allows
24 both parties to conciliate and if the dispute can't be
25 resolved to have the matter arbitrated - I think that
26 remains appropriate. I don't necessarily think in terms of
27 that is a challenge.
28
29 I think it's - I think the modern employment
30 mechanisms really, the challenge being is to modernise our
31 awards. I think all that's really within NSW Health's
32 power, although I would say it is slightly more complicated
33 than that: the awards are not made unilaterally by
34 NSW Health or the government, the unions are a party to
35 those awards, so there's obviously a negotiation and
36 a funding envelope and I guess if those negotiations fall
37 down, I believe the Industrial Relations Commission is the
38 appropriate avenue for resolution of those matters.
39
40 Q. I'll take you back to your 17 July statement and to
41 paragraph 20, please. In this section you highlight the
42 distinction in the roles of the ministry on the one hand
43 and health agencies on the other. I just want to take you
44 down to paragraph 24. There you tell us that compared to
45 previous structures, including under the then Department of
46 Health, the ministry's responsibility is reduced in size
47 consistent with its core functions. What was the previous

1 structure that you're referring to, firstly?
2 A. So, and again going from my memory, so the ministry
3 used to be the Department of Health, and there were area
4 health services. As I understand it, the ministry had
5 a much more centralised role, and post 2011 or '12, the
6 model changed to a much more devolved structure. At the
7 time it was very much the introduction of local
8 decision-making. Whilst I think there was always local
9 decision-making, it was much, much broader, so decisions,
10 I guess, were devolved to local health district executives
11 and hospitals.
12
13 Q. In the context of employee relations, what is the core
14 function or the core function of the ministry that you
15 describe in paragraph 24?
16 A. Look, the ministry do make - the ministry of workplace
17 relations branch do still maintain centralised awards.
18 That hasn't changed. The employment functions are devolved
19 to the local health districts, such as recruitment of
20 staff, termination of staff, operational management of
21 staff. The ministry doesn't play a role in that. We play
22 that central role in setting the awards and providing
23 advice on the awards to the system and, I guess, then
24 dealing with statewide disputes about those awards.
25
26 Q. What about workforce strategy?
27 A. The ministry certainly has a strong role in workforce
28 strategy. I think workplace relations role is something -
29 in terms of our branch is probably a little bit to the side
30 of that. We're very lucky that we work very closely with
31 the nursing - NAMO, the nursing and midwifery office and
32 workforce planning and talent development branch. So the
33 three executive - whilst I'm an acting, the three executive
34 directors meet regularly around strategy - things that in
35 each of our portfolios influence the other, and I guess to
36 the extent that the industrial instruments either play
37 a role in that strategy or perhaps are a key challenge to
38 achieving those strategies, so that's certainly, I guess,
39 more our role.
40
41 Q. Can I take you to paragraph 31, please.
42 A. Yes.
43
44 Q. In this section of your statement you're describing
45 some of the functions of health agencies. Can I just ask
46 you about a few of the subparagraphs here. In 31(a) you
47 tell us health agencies use the strategic and operational

1 guidance provided by the ministry to inform their workforce
2 plans and strategies, et cetera. What's the strategic and
3 operational guidance that you are referring to there?
4 A. Look, I think it takes many forms, from broad things
5 around the health - the future health workforce plan, the
6 health workforce plan. Right now we're looking at - well,
7 my branch isn't leading it, workforce planning and talent
8 development is - updating the cultural framework. I think
9 that's around providing that broad strategy.
10
11 Then all three branches provide operational guidance,
12 so it may well be that a district has a dispute with
13 a union, whilst it might not be a statewide dispute,
14 certainly they might seek our guidance around managing
15 that, if it's a statewide dispute generally our branch
16 would manage it, so we also provide, I guess, operational
17 guidance on how the awards work, yes.
18
19 Q. In paragraph 31(c) you tell us that health agencies
20 contribute to broader system-level workforce approaches?
21 A. Yes.
22
23 Q. How do they do that?
24 A. Look, again, sorry, various ways. So we have various
25 forums, directors of people and culture, of which all the
26 district and other - pillars and other agencies come
27 together, and certainly we have operational meetings and
28 strategic meetings to work through, I guess, different
29 issues and challenges.
30
31 We also meet with the executive directors of medical
32 services separately, and again that focuses on all the
33 different workforce approaches. We talk about what's
34 working well, what's not, to try and get consistency of
35 approach across agencies. That's a lot of the function of
36 those meetings. And I guess more broadly there is the
37 senior executive forum, and in terms of workforce, there is
38 a - I think it's Thursday night, it could be more, but I've
39 only been to the Thursday night sessions, which focus
40 particularly on workforce issues, again sharing things that
41 are working well, sharing challenges. It's an opportunity
42 for the ministry to consult with the system, to input into
43 broader strategies. I think that's how some of those
44 things work.
45
46 Q. Thank you. Commencing in paragraph 35 you tell us a
47 little about the industrial framework. If I can take you

1 down to paragraph 40, you tell us about requests from
2 health agencies for determinations for a variation of award
3 conditions. Do you see this?
4 A. Yes.
5
6 Q. Is this the process that applies to what is sometimes
7 described as "non-standard arrangements"?
8 A. Yes, and I might answer as well, as this is in my
9 second statement of 3 August, I just describe it as
10 "approved non-standard arrangements" and that's what
11 paragraph 40 is referring to.
12
13 Q. All right. And you tell us there that there's about
14 500 that have been approved since 2005, and in your
15 3 August statement, I think you tell us there are about 20
16 to 30 applications a year on acknowledge; is that right?
17 A. Yes. Yes, thereabouts, yes. And certainly with
18 COVID, it was higher, the COVID years, so - but if you kind
19 of look at an average, that tends to be about right.
20
21 Q. Are you involved in the process of reviewing and
22 considering those applications?
23 A. Yes.
24
25 Q. Both in your substantive role and your current acting
26 role?
27 A. Yes, in my substantive role I would normally only look
28 at the ones that involve medical officers.
29
30 Q. We might have the policy you refer to in paragraph 40
31 brought up on the screen, it's [MOH.0010.0144.0001]. If we
32 can scroll down, please, operator, to the next page, and
33 keep going, please. Over the page. Further down, please,
34 operator, I'm sorry, keep going. Keep going. Here, under
35 the heading "3", are the factors that are taken into
36 account in considering whether to approve such a request.
37 In paragraph 41 of your statement, you tell us that, in
38 your experience, the primary consideration of the delegate
39 in considering such an application is the third of those
40 dot points. Do you see that?
41 A. Yes.
42
43 Q. Why do you say that's the primary consideration in
44 considering these types of applications?
45 A. I mean, primary, but all three are important, and why
46 I think I draw that out is because the ministry still
47 operates in the broader framework of the fair pay and

1 bargaining policy, that's the policy now. Under the
2 previous government, I'll just call it the wages policy.
3 So NSW Health I guess, in looking at when you approve
4 a non-standard, is when you need to look with flow-ones.
5 So if we were to approve a non-standard that would,
6 I guess, flow on to the entire system, I think we would
7 really need to consider, well, how does that align with the
8 fair pay and bargaining policy? We do need to be careful
9 that we're not being inconsistent. So I think - I don't
10 think this policy is intended to be a back door to be
11 inconsistent with the broader government's policy. So
12 I think that's why it - I say it's primary.
13
14 Q. In that answer you referred to the "fair pay and
15 bargaining policy". Is there a tension between approval of
16 an arrangement under - of a non-standard arrangement and
17 that particular policy?
18 A. I think in terms of a tension, yes. I think these -
19 when it's broader. I think these - and I think, as I say,
20 it tends to be often one or a small group of specialists,
21 in the medical field, and often it's to respond to an acute
22 problem that hopefully is short-term and cured in time,
23 whether it's through recruitment and retention or different
24 solutions.
25
26 I think this, if we were to use this policy to provide
27 far-reaching wage increases for certain groups of staff,
28 I think that would be problematic in terms of the tension
29 with the fair pay and bargaining policy, because when we
30 have - when we seek to get bargaining parameters, for
31 example, that needs to go to ERC - sorry, excuse me,
32 expenditure review committee of cabinet, so central
33 government do play a role in setting wages in NSW Health.
34 I think that's a long way of saying yes, I think there
35 probably can be a tension.
36
37 Q. In your second statement you set out some of the types
38 of non-standard arrangements of which the ministry is
39 aware. I might take you to that statement, please. This
40 passage starts from paragraph 10, but I would like to just
41 ask you about a few of these examples and have you expand
42 on them. If we go to paragraph 15, please, this is under
43 the heading, "Non-standard issuing of contracts or
44 application of policy", and the first one is:
45
46 *Offering Sessional, Fee-For-Service, or*
47 *Rural Doctor Settlement Package contracts*

1 *to VMOs at a facility that is not*
2 *applicable ...*
3
4 That is, those arrangements are offered to doctors who
5 would not otherwise be entitled to them, having regard to
6 where they work?
7 A. Yes, that's right.
8
9 Q. Is there any more to it than that simplified
10 statement?
11 A. No, I don't think so. The reasons are varied but,
12 yes, it's effectively - for example, sessional is intended
13 for teaching hospitals, largely used at the big tertiary
14 hospitals, and we say our policy is that sessional is
15 what's to be offered there. So in offering a fee for
16 service, you would be offering something more lucrative
17 than would otherwise be available.
18
19 Q. Why do you say it's more lucrative?
20 A. Fee for service tends to be a more generous
21 remuneration package. They're structured differently so
22 it's not as simple as apples and apples, but generally it's
23 seen to be more lucrative.
24
25 Q. And in 15(b) you refer to:
26
27 *Offering a doctor dual staff specialist and*
28 *VMO appointments within a given department*
29 *at a given facility.*
30
31 A. Yes.
32
33 Q. Is it the fact that they're offered within a given
34 department at that facility that is the vice?
35 A. That's right. I think there's, I guess, an inherent
36 conflict of interest, when it's in one facility or one
37 department. When are you a staff specialist? When are you
38 a VMO? And I guess, for example, you might be a full-time
39 staff specialist and may have a VMO appointment to do
40 additional work on the weekend. I guess when does your
41 staff specialist appointment stop and, when does your VMO
42 appointment start? And I guess it's seen as they are two
43 distinct arrangements and, I guess, cherry-picking the best
44 of both.
45
46 Q. What about if there was a VMO appointment at one
47 facility and a staff specialist appointment at a different

1 facility? Is that still a problem in your view?
2 A. Certainly much less of a problem.
3
4 Q. Why?
5 A. Well, I guess we would see it more as a multiple
6 assignment. So picking two, I don't know, Sydney
7 hospitals, Hornsby and Bankstown, I guess there's not the
8 conflict in that you're a staff specialist appointment at
9 Hornsby and staff specialist is a salaried model, so we say
10 that encompasses reasonable overtime. So, for example, if
11 you've got to come in and do a ward round on the weekend,
12 we would say that's reasonable overtime.
13
14 And I guess if you are at Hornsby and you're getting
15 paid a VMO appointment to do that reasonable overtime, we
16 say, "Well, actually, your staff specialist appointment is
17 a salaried appointment and therefore already compensates
18 you for those hours." Where I guess if you're doing
19 a shift at Bankstown, you say, "Look, different districts,
20 different hospitals, it's not so much a conflict." It's
21 what we would call a multiple assignment.
22
23 Q. Does it not still have the same feature, though, if
24 a doctor has been appointed as a staff specialist in the
25 one facility, that encompasses fair time doing reasonable
26 overtime which they are then taking up at a different
27 district?
28 A. Look, I think that's arguable. I guess we tend to
29 look at appointments in the form of a hospital or district,
30 and we do cover, yes, these things for multiple
31 assignments. I guess because we're such a big system we
32 say, "You can have two contracts", as an example, Hornsby
33 and Bankstown, and we say "That's not problematic" and we
34 have multiple assignments across all - many - nursing is
35 very common, you might do two part-time assignments, for
36 example.
37
38 So I think, look, as an industrial relations
39 practitioner, it's odd, I guess, to have a multiple
40 assignment - sorry, I'm just going to slow down, I'm
41 starting to speed up. So, yes, look, I think it is
42 certainly odd, but I think the conflict is much better
43 managed outside, I guess, your district or your hospital.
44
45 Q. And no doubt considerations of approving dual
46 appointments for different districts take into account
47 workforce need, the ability to fill those positions,

1 et cetera?
2 A. Yes, that's right. And I guess in some specialties,
3 there can be a concern as well: are you moving work or
4 leaving work to be doing that work as a VMO, which, you
5 know, paid an hourly rate, it could be higher. I think
6 that's - I'm not suggesting that necessarily that's what
7 doctors are doing, but I guess that's the perception or it
8 could be a perception, and I think we have to be really
9 careful around, I guess, those what could be called
10 corruption risks.
11
12 Q. The next category in the heading immediately above
13 paragraph 16 is "Payment inconsistent with template
14 contract and/or industrial instrument", I'd just like to
15 ask you about the type of arrangement you described in
16 subparagraph (c):
17
18 *Permitting Level 5 Staff Specialists not to*
19 *attend work for 25% of time ...*
20
21 et cetera. Just have a read of that subparagraph and tell
22 me when you're ready.
23 A. Yes.
24
25 Q. Can you just describe in practical terms the
26 arrangement that you're drawing attention to in that
27 subparagraph?
28 A. I will do my best. These are all a bit complicated.
29 So staff specialists level 5, the arrangement is that the
30 25 per cent is for private patients. I guess there are
31 still private patients in our hospitals. So if they're
32 offsite 25 per cent of the time, how are they treating
33 those private patients? I don't think - I guess do you
34 want me to go into private patients in public hospitals?
35
36 Q. Yes, please.
37 A. Okay. Hopefully I do a good job of this, and I'm
38 happy to provide further detail at a later time if you
39 think.
40
41 Q. Thank you.
42 A. So for both VMOs and - and cut me off if I'm providing
43 too much detail, please.
44
45 Q. I don't think it's possible to provide too much detail
46 in this context.
47 A. Yes, indeed. So staff specialists and VMOs have

1 what's called rights of private practice. That is to allow
2 them to treat private patients, so patients who may have
3 private health insurance, may not, it might just be
4 Medicare. For VMOs generally, they direct-bill those
5 patients, so we say that their operating their private
6 business, and that's a benefit of the appointment.
7
8 The same effectively exists for staff specialists, in
9 that they have the opportunity to treat private patients,
10 the same patients, patients who elect to be private, may
11 have private health insurance, may not, otherwise use their
12 Medicare benefits. As staff specialists, it's different to
13 VMOs in that the LHD or public health organisation bills
14 the private patients on their behalf.
15
16 That money goes into what we call the number 1 account
17 and then part of that money can be paid to the staff
18 specialist as what we call drawing rights. So that's
19 additional income to compensate for their private work, and
20 any money remaining after that, after infrastructure
21 charges and indemnity charges, goes into what's called the
22 number 2 account. The number 2 account is used for a range
23 of things. There's a policy that outlines how it can be
24 disbursed, which we can provide separately.
25
26 And just, sorry, to be clear, for staff specialists,
27 that's for level 2 to 5 staff specialists.
28
29 Q. Those levels are set under the award?
30 A. That's right. The staff specialist makes the
31 election.
32
33 Q. Yes. And those features feed in to the next category
34 of arrangements that you describe in paragraph 17, building
35 on that answer that you've just given, I want to ask you
36 about the first three of them.
37 A. Sure.
38
39 Q. First of the arrangements under the heading "Payments
40 involving inappropriate use of VMoney, payroll or trust
41 accounts", is:
42
43 *Paying from a health agency's General Fund*
44 *into a Staff Specialist's No 1 Account.*
45
46 What is the arrangement that you're describing there?
47 A. I don't think it's much more detailed than what we've

1 said for - sorry, what I have said in my statement in terms
2 of this category, is, for whatever reason, and there could
3 be various reasons between the doctor or groups of doctors
4 and likely LHDs, where a negotiation has been made and
5 payments are being made directly to the doctor. It would
6 depend on the individual arrangement. It could be for
7 a certain service, it could be for additional hours, it
8 could be for a range of things, it could be a personal
9 payment. So I can't necessarily talk to what the various
10 reasons for it would be.
11
12 Q. In what way is it guaranteeing --
13 A. Sorry, excuse me, I was going to (b). Did you mean
14 (a)?
15
16 Q. Yes, (a).
17 A. Sorry if I've misheard you. Apologies.
18
19 Q. That's okay.
20 A. Okay, so in terms of how (a) works, this is when
21 a staff specialist may have elected to be a level 2 or
22 level 3 or 4 and has not met the amount of private income.
23 So this is they haven't treated enough patients to have
24 enough income that goes into the number 1 account to draw
25 as their income drawings for the private practice. So that
26 has - so normally at (a) that is what has not occurred, and
27 so often an arrangement takes place between the doctor and
28 the district where the district guarantees that. So they
29 don't have to treat the private patients - excuse me,
30 I misspoke. They still have to, I guess, treat the private
31 patients, but they --
32
33 Q. The level of billings from that activity has not
34 reached a certain level and the health agency takes the
35 view it will pay from its own other resources that amount
36 into the trust account; is that a fair summary?
37 A. That's an excellent summary.
38
39 Q. I'm learning. I think you've in your earlier answer
40 covered what I wanted to ask you about (b). Could we just
41 explain, at least for my purposes, the arrangement in (c) -
42 that is, paying from the staff specialist number 2 account
43 to the number 1 account, which is generally not permitted?
44 A. Look, I guess it's probably I guess a variation on (a)
45 generally, as I understand, in that the staff specialist
46 won't have earned the sufficient amount of money to allow
47 them to take those drawing rights. So instead of that

1 top-up coming from the general fund, money is moved from
2 the number 2 account into the number 1 account for the
3 staff specialist to be able to draw that money as their
4 drawing right.
5
6 Q. Just remind me, what is the usual deployment of funds
7 in the number 2 account?
8 A. The number 2 - apologies, I don't know it off the top
9 of my head. It could be in the statement. It's a bit
10 nerve racking up here, so --
11
12 Q. No need to be nervous.
13 A. Number 2 account is we have a policy on disbursements,
14 so how the money can be spent. I would make the
15 observation that it tends to be quite wide-ranging.
16 I think the predominant use of it is for training and
17 education purposes, registration payments, but also at
18 times equipment bought for the hospital, employment of
19 research staff. So it's quite wide-ranging but it is not
20 for the purposes of income.
21
22 Q. Can I take you ahead to paragraphs 26 and 27, please,
23 of your statement. Just have a read or a scan of 26 and 27
24 and just let me know when you've refreshed your memory
25 about what's in them.
26 A. Yes.
27
28 Q. It's still pretty fresh, considering you signed it on
29 Saturday?
30 A. Indeed, yes.
31
32 Q. So in these two paragraphs you set out what you
33 consider to be the circumstances that have given rise to
34 some of the unauthorised non-standard arrangements that the
35 ministry has become aware of; correct?
36 A. Yes.
37
38 Q. And is it also the case that these sorts of factors
39 influence the utilisation of non-standard arrangements
40 which the ministry might authorise if the application
41 process is followed?
42 A. Yes.
43
44 Q. And is it a fair summary of the matters you set out in
45 paragraphs 26 and 27 that really what you're describing are
46 market forces within the medical workforce at the moment?
47 A. That's right. I can expand on that if you'd like.

1
2 Q. Please do.
3 A. I think these factors, as I've kind of set out in
4 26, there's so many influences and reasons for it, but
5 I think - and I think it has been canvassed with other
6 witnesses. I think supply is a huge part of it. Obviously
7 that starts from universities to training places and then,
8 I guess, a maldistribution with more in Sydney, but I guess
9 because of that supply and NSW Health is, and any health
10 agencies' appropriate reliance on medical workforce,
11 I think these arrangements, it's, I guess, a breeding
12 ground for these types of arrangements, because we so need
13 them for service provision, there's not enough of them, so
14 it's, I guess, a perfect storm for some of these
15 arrangements to take place.
16
17 Q. Health agencies are taking steps they consider to be
18 appropriate to secure the workforce they need?
19 A. That's right.
20
21 Q. One of the factors you refer to in paragraph 27 is the
22 unfavourable comparable remuneration arrangements as
23 between NSW Health and other jurisdictions. Do you see
24 that?
25 A. Yes, I do.
26
27 Q. That's something that is raised across a number of
28 specialties and roles within NSW Health, is it?
29 A. Yes, it is.
30
31 Q. Has NSW Health done any, to your knowledge,
32 benchmarking or work to ascertain whether those concerns
33 are validly held?
34 A. Yes - yes, I might explain and then perhaps you might
35 need to ask me more questions.
36
37 Q. Please do, yes.
38 A. So certainly we undertake benchmarking compared to
39 other states for various classifications. It's not -
40 certainly for staff specialists, it can be trickier because
41 of the interplay of rights of private practice and how
42 different states have rights of private practice. They
43 might do a donation model so it looks very different. But
44 generally that's one of the functions of our branch is to
45 be on top of, I guess, the market environment. So
46 certainly that's certainly something we do.
47

1 I think - and this might not be the question you have
2 asked, so please interrupt if it's not. I think there is
3 a difference between benchmarking and working out what the
4 ideal rate is. I think it's not as simple as saying,
5 "Well, if we solved the interstate jurisdictional issue or
6 the unfavourable remuneration, that would fix supply."
7 I think it's much more multifaceted than that.
8
9 Q. What are the other aspects of that multifaceted
10 dynamic that you're referring to?
11 A. Look, I think a good example that I might give is
12 Queensland. Queensland - you will have no doubt heard from
13 other witnesses, and I hear pretty much daily in my role,
14 that Queensland pays its nurses and certainly medical
15 professionals significantly more than New South Wales.
16
17 Now, from what I understand from interstate colleagues
18 is, whilst that is true and perhaps they - the south-east
19 corner, being kind of Brisbane and Gold Coast - don't have
20 necessarily the same recruitment and retention problems as
21 regionally, but they report to me that rurally, once you
22 get outside that south-eastern corner, they suffer that
23 same recruitment retention supply issues as New South
24 Wales. So I think it's not as simple to say that, yes, if
25 you paid more, you would fix the problem.
26
27 Q. If you paid more, you would fix the problem rurally
28 and regionally do you mean or more generally?
29 A. Or just more generally. I think more remuneration -
30 sorry, more - I can never pronounce it, which is highly
31 embarrassing.
32
33 Q. I get it wrong all the time.
34 A. Look, who doesn't want a wage increase, and I think
35 there comes a point around competitiveness. NSW Health
36 still has good figures around turnover, around attrition,
37 around our retention rate. So I think to - I don't know
38 that we're necessarily in dire circumstances, but I guess
39 12 years as a wages policy where others - kind of
40 restricting both wages but also conditions, where the other
41 states haven't had that handbrake, I guess, is certainly
42 problematic.
43
44 I guess the other thing is, you know, in my role
45 I deal with the unions and industrial associations, so we
46 hear from them that - I guess if you can look over the
47 border and someone's paying a lot more, it doesn't help

1 with them feeling valued and engaged.
2
3 Q. Do I take it from that answer that to the extent that
4 the medical workforce - take the medical workforce first of
5 all - is expressing a view that the remuneration available
6 in New South Wales is uncompetitive with other
7 jurisdictions, you accept that?
8 A. Broadly, yes. I think it's - with staff specialists
9 around rights of private practice, it can be more
10 difficult, but as a - I think it's broadly factual, yes.
11
12 Q. What about the nursing workforce? Does the same
13 apply?
14 A. It's different because it will depend whether you're
15 looking at base salary, whether you're looking at top of
16 band. I think on base salary, largely New South Wales and
17 Victoria traditionally have been lower than the other
18 states.
19
20 Q. What about the allied health and other workforces?
21 Has similar benchmarking been done in those areas?
22 A. Yes. Again it's a little bit difficult because
23 they're not necessarily comparing the same structure, but
24 yes, New South Wales is certainly at the lower end, on base
25 salary.
26
27 Q. It we go back to the 17 July statement and to
28 paragraph 42. In a couple of your answers so far you've
29 referred to the wages policy. I might just have that
30 brought up on screen, please. It's [MOH.0010.0143.0001].
31 This is the policy that you've been referring to as the
32 wages policy, is it?
33 A. Yes.
34
35 Q. Is it still current?
36 A. Yes, this is the - so the new government, the Labor
37 Government's policy, and before that there was other
38 versions of wages policy, so I probably do use them
39 interchangeably, I guess.
40
41 Q. Is there a material difference between this policy
42 that's on screen and the one that was in force prior?
43 A. Yes, and the one that was in force prior, also with it
44 went the regulation, which was then 146C of the Industrial
45 Relations Act, which I guess bound the Commission to not
46 providing increases above what was in the then policy,
47 where this policy does not do that.

1
2 Q. In general terms, though, what boundaries does this
3 policy place on the ministry in engaging with unions and in
4 general workplace reform?
5 A. Sure. So this policy provides that, broadly, the
6 government have made a wages offer. At the moment
7 government have made that wages offer to the unions, which
8 is an increase of 10.5 per cent over three years. So
9 outside that offer, agencies are permitted to bargain with
10 unions, but anything above 10.5 has to be funded by
11 productivity or other savings, for example, efficiency
12 savings. So it's, I guess, a bit more broadly defined, but
13 that is challenging for an agency such as NSW Health.
14
15 Q. When you say it "has to be funded by productivity or
16 other savings", how is that examined in practice?
17 A. Look, I could bring up the exact clause, but it --
18
19 Q. Is it 6.3?
20 A. It could be.
21
22 Q. Can we go to 6.3. I might have it completely wrong.
23 Is that the one you had in mind?
24 A. Yes, so it's 6.3:
25
26 *... commensurate reforms to work practices,*
27 *work systems, and provide demonstrable*
28 *enhancements to the delivery of services to*
29 *the public and/or cost savings.*
30
31 THE COMMISSIONER: Q. Is that what you had in mind when
32 you said a little bit - only two answers back - you were
33 talking about the 10.5 per cent and you said:
34
35 *So outside that offer, agencies are*
36 *permitted to bargain with unions, but*
37 *anything above 10.5 has to be funded by*
38 *productivity or other savings, for example,*
39 *efficiency savings.*
40
41 That's what you had in mind?
42 A. That's exactly right.
43
44 Q. You then added:
45
46 *So it's, I guess, a bit more broadly*
47 *defined but that is challenging for an*

1 *agency such as NSW Health.*
2
3 Can you just help me by telling me why that --
4 A. Sure.
5
6 Q. I mean, I can guess, but I'd rather hear it from you,
7 why it is challenging for NSW Health?
8 A. Yes. So, look, I guess for many reasons. Now, this
9 is, I would say, at 6.3, much broader in terms of scope
10 than the previous government's wages policy. So I think
11 there is more flexibility for agencies to have constructive
12 and collaborative discussions with the unions. But it's
13 still challenging in that, in NSW Health, almost
14 60 per cent of - 57 per cent of our budget is wages. After
15 that, operating expenses, of which we've got goods and
16 services, procured services. So it's not leaving a lot in
17 the budget to find savings, and I guess --
18
19 Q. I see. So productivity gains or efficiency gains are
20 pretty difficult in a system that's, over the years,
21 presumably - and it seems to be being made relatively
22 efficient? Is that what you mean by --
23 A. That is exactly what I mean. And, like, the other
24 thing I would say is, because we've had a policy, in the
25 sense of always having to have found savings, it's been
26 leaner and leaner, and if there were to be productivity
27 savings that were easy to achieve, we would have
28 hopefully --
29
30 Q. If there was a lot of low-hanging fruit left, it would
31 have been - yes, I know what you mean.
32 A. Exactly. And I think another challenge is that
33 I think - can I give an example?
34
35 Q. Yes, please do.
36 A. In the medical officers awards, so the award that
37 covers JMOs, we have to roster for two weeks. The
38 system's - it would be hugely improved if we could roster
39 over four weeks, which is a much more normal industrial
40 arrangement that you would do, four weeks or a longer
41 period, depending on the work. JMO managers say, "What
42 would be amazing, if we could roster over a rotation, for
43 example, three months."
44
45 My gut, my industrial relations gut, tells me that
46 there would be efficiencies in that and potential cost
47 savings, but it's very hard to, without doing it, be able

1 to prove it. So I think that can be a challenge that when
2 you - for example, if we were to make that --
3
4 Q. What's the impediment to doing that?
5 A. To?
6
7 Q. To doing that longer term rostering; what's the
8 impediment?
9 A. It's in the award that it's two weeks. And I guess --
10
11 Q. That's a fairly strong impediment, I suppose, at the
12 moment.
13 A. Indeed. And I'll maybe go into this, and a lot of the
14 things I've kind of touched on around ambiguities,
15 prescription, structure, we have to bargain our way out of
16 that. The unions have a job to do and as a lifelong union
17 member I want them doing that job, and just because I say
18 it would be really great if we could roster over four
19 weeks, they wouldn't ordinarily give that up for nothing.
20 So whilst in my gut it tells me there probably is a saving,
21 you have to prove it, and to do that, you almost need --
22
23 Q. Help me with what makes you think there would be
24 a saving.
25 A. Now, I'm not a rostering manager so hopefully I can do
26 this justice.
27
28 Q. Well, to the extent you have a view for some reason,
29 tell me what it is and why.
30 A. So when you are trying to fit in roster patterns over
31 basically 24 hours within two weeks, you're trying to do
32 all 80 hours in two weeks, as opposed to double that over
33 four, which gives you more flexibility to meet demand. So
34 often we do something called "rostering not required". So
35 we might pay you for a shift that we don't even need you
36 there for and you don't work it, but because we must
37 roster, we have contractual obligation to roster those
38 80 hours, but if we were doing it over four weeks, we could
39 spread the shifts. So I would hope that it would see an
40 end to rostering not required, and hopefully a reduction
41 in - a potential reduction in overtime. But you almost
42 need to roster it and do it to see if you can get those
43 gains.
44
45 Q. That might be the kind of demonstrable enhancement
46 that went with a pay increase; right?
47 A. That's right. But I guess we've got to prove it. So

1 you almost have to kind of do a trial, perhaps.
2
3 Q. Yes, sure.
4 A. And then that might --
5
6 Q. That's an example of where something like 6.3 might
7 work?
8 A. Yes, if we could prove the savings. We'd obviously
9 need to still go to the expenditure review committee of
10 cabinet. Now, the problem is, even though I think it would
11 be a saving, I think the inefficiency is: how much is it?
12 I think many of those things, you know, changing the
13 incinerator allowance --
14
15 Q. You did say this was only a gut feel, so I'm not
16 taking that as being too precise, but --
17 A. Yes. But changing a range of things in the award will
18 make the system, in my view, more efficient, easier to
19 administer, easier for staff and managers, but what it
20 doesn't necessarily do is give you big dollars. So you're
21 talking, I guess, things around the edges, and then, okay,
22 I could go - I could probably talk all day about award
23 reform, but I think, yes, some of the challenges are
24 twofold, that you would have to almost do it to prove it;
25 the savings might not get you there, you know, it might end
26 up only being 0.5 of what might be for an increase, which,
27 you know, isn't nothing but it's still challenging, and
28 largely you've got to buy out those things. So the union
29 would say, "Well, we might give you that, but what else
30 will you give us?" So it just all becomes very
31 challenging. Does that help?
32
33 THE COMMISSIONER: Yes, thank you.
34
35 MR GLOVER: Q. Can I take you to paragraph 44 of
36 your July statement, please. This is in the section of
37 your statement where you deal with the advantages and
38 limitations of current industrial arrangements. In the
39 first sentence of 44 you tell us:
40
41 *Ongoing work is required to assess the*
42 *suitability of the current conditions in*
43 *enabling the relevant objectives of the*
44 *[NSW Health] Workforce Plan ...*
45
46 Firstly, what are the current conditions that you're
47 referring to?

1 A. Oh, I really just mean the awards.
2
3 Q. Employment conditions?
4 A. Yes, and I think there's probably - yes, that's what
5 my branch's focus is on. Other branches will be a little
6 bit more broad than that.
7
8 Q. Can I just take you briefly to the workforce plans,
9 [SCI.0001.0043.0001]. Can we go ahead to page 16 in that
10 document. Firstly, I should have asked you, are you
11 familiar with this document?
12 A. I am, yes.
13
14 Q. Just have a read of 6.1 and the various dot points
15 there. That's something that sits within your branch, 6.1?
16 A. Yes. And whilst I note that we are the lead, we are
17 working with our WPTD, which is workforce planning and
18 talent development colleagues on some of these things, so
19 it might be that - so "tests and pilot workforce models to
20 reflect emergent health care needs", or dot point one,
21 we're working together on a - hoping to work together on
22 a trial of paramedics working in hospital facilities.
23
24 THE COMMISSIONER: Can you tell me where that document is?
25
26 MR GLOVER: It is exhibit A48. It was tendered
27 in November.
28
29 THE COMMISSIONER: Okay. It's not going to be here.
30 That's all right.
31
32 MR GLOVER: No.
33
34 Q. Can you just describe in general termination the work
35 that is being done to advance the initiative in 6.1? To
36 the extent it calls on the work of others, please let us
37 know as well.
38 A. Sure. So I guess this is ongoing work in our branch,
39 is looking at awards more broadly, how we would design them
40 if we - I guess if the opportunity and funding arose. So
41 in terms of contemporary employment arrangements, one of
42 the things we do is very closely monitor what's happening
43 in the federal sphere and the fair work cases. So I guess
44 that's somewhat, I guess, background and preparatory work
45 if there was an opportunity to change and modernise some of
46 the awards.
47

1 Q. What about the approach of other state jurisdictions?
2 Is that something that's looked at in that research phase
3 as well?
4 A. Yes, yes. So we monitor what goes on in the other
5 states in terms of, I guess, innovative work, in terms of,
6 it might be that they're trialling a new type of position,
7 but largely it's, as I describe, we kind of monitor
8 salaries and interstate comparisons and award negotiations.
9 So Victoria, nursing have just been through theirs. We're
10 trying to keep an eye to what happens there.
11
12 Q. We touched on salary comparisons earlier, and in
13 your July statement you caution that it's not always
14 comparing apples with apples, or something to that effect.
15 Through the work that you've described earlier and the work
16 in relation to 6.1, though, is the ministry taking some
17 steps to try and, at least as best it can, normalise those
18 comparisons?
19 A. Certainly for some workforces, yes.
20
21 Q. What workforces do you have in mind?
22 A. Nursing, some of the allied health, paramedics,
23 noting, I guess, the government made an offer which was
24 accepted and those awards have been varied, but that was
25 one of our key groups.
26
27 Q. What about the medical workforce?
28 A. Yes, medical as well. It's just - it's a little bit
29 more challenging.
30
31 Q. And the ministry gets itself to a position where it
32 feels as though it can make a meaningful comparison of what
33 the medical workforce is being paid in other jurisdictions?
34 A. Yes. Yes, although that is challenging with rights of
35 private practice. We probably don't have visibility on
36 that.
37
38 Q. Other than the workforce and preparatory work that
39 you've described, is there any other work that you've been
40 involved in in advancing the outcome described in 6.1 of
41 the workforce plan?
42 A. Yes. I think there's other things that we do, and
43 it's working across the system, working with unions about
44 sometimes introducing new classifications. A good example
45 is the assistant in medicine, which is done via
46 a determination with, I guess, the consent and support of
47 ASMOF. ASMOF is the Australian Salaried --

1
2 THE COMMISSIONER: We know.
3
4 MR GLOVER: Q. -- Officers Federation.
5 A. So I mean that's, I think, a really good example of
6 looking at contemporary employment arrangements and what's
7 best practice, so introducing that, working with the
8 unions, working out salary and what the, I guess,
9 employment arrangements are there, and evaluating, which -
10 whilst we play a part in. Care assistants was something
11 introduced in COVID.. I guess, post evaluation, that
12 wasn't something that continued.
13
14 We're currently doing, what's now being now led by
15 WPTD, doing a trial of integrating paramedics into
16 hospitals. But it is in its very early stages, and
17 perhaps, yes, we'll see where that goes. The nurses
18 association have indicated a status quo dispute, so we'll
19 work that through in the usual industrial way.
20
21 Q. I take it from that answer you liaise with the
22 industry bodies quite frequently in exploring those
23 innovations and initiatives; correct?
24 A. Yes.
25
26 Q. Is there a share of data or information between the
27 ministry on the one hand and those bodies, to your
28 observation?
29 A. Yes, depending on what the - what you're doing at the
30 time, so using the paramedics example, there's certain data
31 that, you know, will be collected and presumably provided.
32 Assistants in medicine, look at, you know, where they are,
33 where they're working, how they're working and sharing
34 those things with ASMOF.
35
36 Q. To the extent that a union may make a request for data
37 from the ministry about the workforce, is that something
38 you would be involved in or would that go to someone else?
39 A. It depends on the request. It'll either come to me -
40 it might come to me and then be circulated elsewhere. Our
41 branch - we don't deal with data generally. That's
42 probably outside our expertise.
43
44 Q. Tell me if you don't know the answer to the questions
45 I'm about to ask you.
46 A. Sure.
47

1 Q. So we heard some evidence this morning about a request
2 from the AMA about VMO numbers in the system.
3 A. Yes.
4
5 Q. Are you aware of that request?
6 A. Yes, I have become aware.
7
8 Q. Today?
9 A. Look, I suspect - we have --
10
11 Q. Firstly, did you know about it before that evidence
12 was given today?
13 A. I was aware of a second request. I don't recall being
14 the first. And if I may, we have a very good working
15 relationship with the AMA, myself, I speak and have regular
16 meetings, as does Phil Minns, the deputy secretary, as does
17 Susan Pearce, the secretary. I would suggest that there is
18 no reason, perhaps other than oversight, that that request
19 hasn't been met, and I guess if they ask for that request,
20 we would provide those numbers to the extent possible.
21
22 Q. So from that do we understand there's no reason that
23 you're aware of as to why the number of VMOs within the
24 system is not something that could be readily shared with
25 the AMA and perhaps more widely?
26 A. That's right, with one caveat, I guess.
27
28 Q. Yes?
29 A. It depends exactly what they're after in terms of
30 whether it's numbers, because we have a number of - with
31 the VMO contracts, many VMOs have more than one contract.
32 So it can be tricky as to is it head count, is it FTE, is
33 it number of contracts, but generally I think --
34
35 THE COMMISSIONER: The statement said "seeking the current
36 numbers of VMOs". That's what the statement said.
37
38 MR GLOVER: Q. But whether it's the number of VMO
39 contracts or the number of head count, that data could be
40 presented with whatever qualifier needed to be applied to
41 it?
42 A. Yes, that's right. And one of the things that we've -
43 our branch has set up, with a range of stakeholders, is
44 a working party on rural medical employment arrangements.
45 The AMA, are there, the Rural Doctors' Association are
46 there and looking at a range of things - so different
47 models. We're looking at a model called the fixed daily

1 rate. We're now looking at a model around is there
2 another - is there a better salaried model that might work,
3 and through the course of those discussions and workshops,
4 we've provided a range of data. So I don't think there's
5 a suggestion that the number of VMOs is secret and through
6 those meetings and discussions we frequently provide
7 a range of employment-related data.
8
9 Q. I take it you would accept that the flow of
10 information and data between both the ministry to the
11 industry associations and back the other way is important
12 in designing this modern health workforce that is aspired
13 to in clause 6.1, and indeed one of the challenges for your
14 current role?
15 A. I think broadly, yes. I mean, the unions will always
16 want more data than we may or may not want to provide, and
17 I think there are various reasons for that. I guess I'm
18 acting in the executive director role, often unions -
19 I make no criticism of this - may want certain data for
20 dispute purposes, but generally I think the provision of
21 data to the extent we have it, to the extent that it's not
22 misused - I think data can be - the provision - Richard
23 Griffiths will speak to this no doubt better than me, but
24 I think you've got to be careful in how you provide data,
25 how it's described and so forth.
26
27 Q. When you say "misused", what did you have in mind?
28 A. I think as - just going back to that VMO example, are
29 you talking about head count, are you talking about number
30 of contracts? So you can describe things in different ways
31 that might have different meanings, depending on how you
32 cut the data.
33
34 Q. Can I take you back to your statement. There are just
35 a few more paragraphs I would like to ask you about. In
36 paragraph 53 --
37 A. Is it, sorry --
38
39 Q. I'm sorry, your July statement. I'm sorry,
40 Ms Collins.
41 A. No, that's fine. Yes.
42
43 Q. You tell us that tracking of time worked is a present
44 and ongoing challenge across all levels and the
45 introduction of a statewide time recording system is seen
46 as a way to track, et cetera. Firstly, what is the
47 challenge in tracking time worked that you are describing?

1 A. Depending on which classification of staff you're
2 talking about, it can be challenging. I think looking at -
3 in JMOs, we recently - there was a class action and then
4 a contravention action brought ASMOF around the working
5 hours of JMOs. I guess had we had a better system of
6 recording time in the hospital, perhaps those wouldn't have
7 arisen. The ministry has happily - as have districts - put
8 a range of processes in place over many years to improve
9 that, but I think that's, I guess, an example of where that
10 could be improved.
11
12 It is, I guess, my view, and it has been observed by
13 other agencies - audit office, ICAC - that NSW Health does
14 not necessarily have good oversight of where and when staff
15 specialists are working in our facilities.
16
17 Q. And in terms of introducing a time-recording system,
18 is that something that the ministry is pursuing to deal
19 with those challenges?
20 A. Not actively. It's something we have discussed with
21 ASMOF in relation to - high level, in kind of roundabout
22 ways with ASMOF. In terms of internally pursuing it, we've
23 had conversations with eHealth and HealthShare and our
24 HealthRoster colleagues about what could be done in terms
25 of from a system point of view. Traditionally, ASMOF have
26 certainly opposed any move around tracking and recording of
27 hours, but in more recent discussions they've indicated
28 a willingness in the JMO space. But it's --
29
30 Q. Go ahead to paragraph 56 please. Consistent with all
31 the answers you've given today, you've described an
32 opportunity to modernise industrial instruments. Although
33 in the last sentence you describe the new framework within
34 the Industrial Relations Act as being one not without its
35 own challenges. What are the challenges that you're
36 drawing attention to there?
37 A. Oh - well, principally funding, I guess, as I alluded
38 to earlier. Government have made the 10.5 - said earlier -
39 the 10.5 per cent offer. 6.3 of the fair pay and
40 bargaining policy sets the framework about anything on top
41 of that. So without a funding envelope to bargain our way
42 out of what I would say to be outdated awards is incredibly
43 challenging.
44
45 THE COMMISSIONER: To say the least.
46
47 THE WITNESS: Yes.

1
2 MR GLOVER: Q. Would you go ahead to paragraph 63,
3 please.
4 A. So 63?
5
6 Q. Yes, 63. There you draw attention to the fact that
7 workforce shortages are not limited to New South Wales, and
8 then in the second sentence you say:
9
10 *As a result, NSW Health remains mindful*
11 *that any significant changes to*
12 *remuneration and employment arrangements*
13 *will likely impact other public health*
14 *systems (and potentially the private*
15 *sector) as they have structured their terms*
16 *and conditions of employment to compete*
17 *with NSW Health.*
18
19 What is the caution that you are issuing us all with by
20 that sentence?
21 A. Look, obviously a very New South Wales-centric answer.
22 Traditionally, as I understand it, in the medical
23 profession New South Wales and Queensland [sic] have been
24 seen as the most attractive places to work, for the reason
25 that we have more tertiary referral hospitals, so therefore
26 more complexity of patients, interesting work, connections
27 with colleagues and so forth. So traditionally, other
28 states have had to compete with New South Wales and
29 Queensland [sic] so - oh, sorry, excuse me, have had to
30 compete with New South Wales and Victoria as being,
31 I guess, more desirable to work.
32
33 So if NSW Health was to suddenly --
34
35 THE COMMISSIONER: Q. Sorry, when you said "Queensland"
36 earlier in your answer, did you mean Victoria?
37 A. I did, yes. Yes, I apologies. So, yes, traditionally
38 Queensland [sic] and New South Wales, most attractive
39 places to work --
40
41 Q. You just said "Queensland" again. Do you mean
42 Victoria?
43 A. Oh, God, I've done it again. I'm sorry.
44
45 Q. There is really no rational way of confusing
46 Victorians and Queenslanders, so let's stick with Victoria
47 and New South Wales.

1 A. Thank you. Thank you, Commissioner. So should we
2 increase - if we became the highest - if we paid the most
3 in Australia, I suggest it would be very difficult for the
4 other states to maintain their specialists. I suspect that
5 they would seek to work in New South Wales because of the
6 attractiveness of New South Wales, and I guess --
7
8 Q. It couldn't be every specialist, though, from
9 Queensland, for example, wanting to come. There's a limit
10 to how much of a problem this would create or is it really
11 something that would be a huge problem for states other
12 than Victoria and New South Wales?
13 A. Look, I think I agree. I don't think we're talking
14 about an acute problem. I don't know that states
15 leapfrogging over each other is in the public interest. In
16 the end, there's only a finite amount of money. Many --
17
18 Q. Staff specialists, whoever they may be, might be at an
19 age where they may have put roots down in their home states
20 or wherever they are?
21 A. I agree. I would also say the same applies in
22 New South Wales, actually.
23
24 Q. Yes, sure.
25 A. I think we hear anecdotally - and, of course, I hear
26 from the unions - "Everyone's jumping over to Queensland".
27 I don't think our recruitment statistics support that.
28
29 Q. So you think "everyone" might be an exaggeration?
30 A. I think it's a very --
31
32 Q. Some. Some, no doubt.
33 A. No doubt. I think it's a very small number for all
34 the reasons you've just described, in that you've set down
35 roots, your family are here, your partner works here. It's
36 not as simple as --
37
38 Q. But I guess for - maybe for any specialty, some leak
39 still creates - it doesn't have to be huge numbers to
40 create a problem in a tight workforce?
41 A. That's right. In a workforce where there's not enough
42 supply, in Australia, or indeed the world, any staff
43 specialist who leaves or any specialist, whether it be VMO
44 or staff specialist who leaves, creates a problem. But
45 I do worry, I guess, about that leapfrogging, if we're
46 always trying to outdo each other rather than have a rate
47 that - there's always going to be someone who is the

1 highest and someone who is the lowest, but is not as
2 varied, I think, is ultimately in the public interest for
3 Australia about having a decent spread of specialists.
4
5 THE COMMISSIONER: I wanted to ask a question about this
6 workforce issue generally but am I - would I be
7 interrupting you?
8
9 MR GLOVER: No, Commissioner.
10
11 THE COMMISSIONER: Q. Can I just ask, could we go back
12 for a moment to - sorry - the document with your role
13 description that Mr Glover took you to immediately, sorry,
14 at the start of your evidence. [MOH.0010.0145.0001].
15 That's it, yes. Just sticking on that page, Mr Glover
16 asked you about the first bullet point. The second bullet
17 point, I take it if we reduced it to conducting industrial
18 relations negotiations, the world wouldn't end if that's
19 all it said.
20 A. Correct.
21
22 Q. But the second bullet point:
23
24 *Delivering a high-quality integrated*
25 *workplace relations function that operates*
26 *statewide, incorporates changing business*
27 *models and operations and balances limited*
28 *staffing and budget resources.*
29
30 What should I understand by "balances limited staffing and
31 budget resources", what does that really mean directly?
32 A. It means it's a really hard job. Look, I think --
33
34 Q. But does that mean - budget resources, I take means
35 balancing limited money; right?
36 A. That's right.
37
38 Q. If I'm being plain - yes?
39 A. Correct.
40
41 Q. Who's the limited staffing, though? Is that the
42 health workforce or is that this office?
43 A. I think it's intended to be both. So certainly as
44 we've explored, in terms of limited staffing, across the
45 system in, I guess, my industrial relations function for
46 the system, there are, in medical and certainly in allied
47 health, shortages that are becoming, in terms of pipeline

1 and supply and maldistribution, more acute, and I think the
2 industrial relations system does have a part to play in
3 trying to address that, although, as I've said before, very
4 challenging for a range of reasons. But I think part of my
5 role is to, if not influence, but certainly to be aware and
6 try and work with the districts, work with workforce
7 planning, talent development colleagues, system
8 performance, around some of those limitations and
9 challenges that those limitations present in an industrial
10 environment.
11
12 Q. If we could go back to the page before that, so
13 I guess it's page 1, yes, "Key accountabilities", the
14 second bullet point:
15
16 *Manage the relationship with the health*
17 *unions and peak medical organisations on*
18 *all major industrial issues within*
19 *NSW Health ...*
20
21 et cetera. And then the next bullet point over the page:
22
23 *. Lead the envisioning, design and*
24 *implementation through successful*
25 *negotiation of workplace arrangements that*
26 *are consistent with the environments of*
27 *"Future Health" to unlock the ingenuity of*
28 *NSW Health staff ...*
29 *. Develop, implement and evaluate human*
30 *resource and [work health and safety]*
31 *policy.*
32
33 Can I just ask you, tell me if this is not in your remit of
34 your current position, but the last two witnesses we've
35 had, Ms Egan from the AMA and Dr Richards from the Sydney
36 Local Health District, who at least part of her role,
37 whilst she is a specialist doctor, she's also the chief
38 wellness officer, both of them told me - and assume I've
39 been told this before, either in hearings or out of
40 hearings - that there's burnout and exhaustion in the
41 health workforce at levels that they respectively described
42 as either "huge" or "large", which I take to mean the same
43 thing. Is it any aspect of your role to develop policies
44 or strategies that address the problem that they and others
45 have identified concerning burnout or exhaustion in our
46 health care workers? And please, they've also - I think
47 the evidence is clear, this is not a New South Wales-only

1 problem; it may be an international problem, in fact. But
2 is that any part of your role or is it is someone else in
3 the ministry or is it meant to be dealt with in the LHDs?
4 How should I understand it?
5 A. Look, I would say both. So the ministry certainly has
6 that centralised role in terms of policy development. And
7 I think burnout is managed in various ways. So part of my
8 role, a big part of managing burnout is appropriate leave.
9 So the leave management policy comes under our branch.
10 Also fatigue management policy comes under our branch, and
11 the new NSW Health mental health and wellbeing framework
12 comes under our branch.
13
14 I guess there's various other things, they're probably
15 three of the main ones. So I think managed, to the extent
16 the centre can, those issues, so they come under our role,
17 and then districts and health agencies operationalise
18 those. So whilst we can provide tools, such as working
19 hours dashboards, that's not my branch but I guess the
20 ministry provide - with HealthShare and eHealth provide
21 those tools to help the districts manage those things. So
22 yes, parts - the policy response comes under our remit.
23
24 Q. All workers get leave. I'm not sure whether they all
25 get fatigue management. What does "fatigue management"
26 mean?
27 A. Look, I guess it probably means different things to
28 different people. I think in terms of --
29
30 Q. For the health workforce it means?
31 A. Well, appropriate rostering, appropriate leave
32 management, appropriate management of on-call - yes,
33 appropriate rostering, so rostering in a best practice
34 way that the --
35
36 Q. Not having people work 24 hours a day three days in a
37 row, that sort of thing?
38 A. Yes. Hopefully that doesn't happen, but more --
39
40 Q. That might have been an extreme example but - yes.
41 A. Yes, yes. I mean, looking at how we roster, that
42 we're not rostering someone on a night shift and then an
43 annual leave day afterwards, so putting those best practice
44 processes in policies. I think that's what we mean by
45 that.
46
47 It also means, in a broader sense, fatigue management

1 is at a local level, managers having awareness of those
2 working hours and monitoring those working hours, putting
3 processes in place when they're concerned about burnout.
4 I think this is something we see junior medical officer
5 managers do really well, because that is a workforce
6 I think more than any of ours that probably are certainly
7 doing the highest amounts of overtime, I would say.
8
9 Q. Do you have a sense that, despite all the things
10 you've just told me are done to try and manage there or
11 alleviate it or reduce it - leave, rostering, mental health
12 and wellbeing framework you've told me about - do you have
13 a sense that, even putting all those things in place and
14 doing all that you can, and maybe all that others can, that
15 there's still a considerable exhaustion/burnout problem,
16 that without more, can't be reduced to a lesser level than
17 something that's described as "large" or "huge"?
18 A. Well, is it "large" or "huge"? I'm probably not the
19 best person to answer that. I think when you look at the
20 PMES survey - and there's also surveys, AMA surveys, the
21 Australian Medical Council survey, that look at it - I'm
22 not necessarily convinced that those numbers indicate it's
23 massive or huge.
24
25 Q. Right.
26 A. But could we - we could always improve, I think, in
27 those things, and where there are, I guess, workforce
28 supply issues, those matters are always going to be more
29 acute. I think it's really challenging for human services
30 agencies - health, education, justice and so forth -
31 because we can't close our front door. We are very - you
32 know, other than some ambulance bypass, we are very
33 limited. We have, I guess, a federal government national
34 health reform process in place that governs that we can't
35 close our doors, and ethical and moral obligation around
36 public health care.
37
38 I think that can be really challenging and probably
39 some of the answer is looking at structures - award
40 structures I think will help with that, but broadly, it's
41 how we deliver the work in an environment where supply is
42 challenging, acuity and activity are increasing. Can we
43 continue - if that keeps going, we can't keep doing what
44 we're doing, otherwise, well, there just won't be the - but
45 for many reasons, but I think those things will contribute
46 to that fatigue and burnout. So there's always more that
47 can be done, but I think it's a huge challenge for

1 NSW Health.
2
3 Q. Outside of award reform, which you've already spoken
4 about, I get the impression that you think that the supply
5 problem is at the core of exacerbating the extent of
6 exhaustion and burnout that might exist, however it's
7 described in terms of scale?
8 A. Yes, I think so. I mean, look, I've obviously got
9 a lot of opinions on the awards, and in many cases,
10 I actually think my opinion's not misaligned with the
11 unions'. We've had really, really constructive
12 conversations with the HSU and ASMOF. I leave the nurses
13 association out because its award is not as problematic,
14 I would say. But, of course, those things need a very
15 large funding envelope. But I think they are contributors
16 but not the - you could have perfect awards and it's not
17 going to fix those issues.
18
19 Q. When we're talking about the challenges of the funding
20 envelope, if we can call it, in the end, what we're talking
21 about is the challenges of the budgetary process?
22 A. Simple as that.
23
24 Q. If we're just direct about it - yes?
25 A. Yep.
26
27 MR GLOVER: Q. Picking up on that last passage, if I can
28 take you to paragraph 54 of your July statement, please,
29 you've told us in your answers and you set it out clearly
30 in this paragraph that the various awards are outdated,
31 ambiguous, overly prescriptive and can place limits on the
32 ability to engage and retain an agile and contemporary work
33 fours. Then throughout your statement you set out some
34 examples. Is one of the reasons why they're outdated,
35 ambiguous, overly prescriptive and, importantly, place
36 limits on the ability to engage and retain an agile and
37 contemporary workforce, the fact that, as we've discussed
38 earlier, the rates of pay available to various medical
39 allied health and nursing staff under those awards have not
40 kept pace with other jurisdictions?
41 A. That's a hard question for me to answer. Why I say
42 that is I think it's, as I have said, factual that
43 NSW Health is not competitive with other states, but the
44 government, I guess, makes - the government of the day
45 makes a wages offer and they use - and that is considered
46 in their broader budgetary context, so I think the wages
47 are limited by that process.

1
2 Q. Let's just assume for the moment that I accept that
3 you didn't put in place the wages offer. You would accept,
4 though, and I think you have accepted in your evidence
5 earlier, that New South Wales is not keeping pace with its
6 competitors in other Australian jurisdictions for
7 significant parts of its health workforce; correct?
8 A. That's - yes, correct.
9
10 Q. Do you also accept that that fact limits the ability
11 of NSW Health to engage and retain an agile and
12 contemporary workforce?
13 A. Yes, but I think there's more context around it.
14 I think, as we said earlier, wages are one factor.
15 I think, as I said, I'm not saying that people aren't
16 leaving New South Wales, but I don't think it is an acute
17 problem. I think when we look at our retention rate, our
18 turnover rate and our attrition rate - and that's obviously
19 for the whole workforce - we're not doing particularly
20 badly.
21
22 I think when you look at, I guess, what an employer
23 would like to see, is their retention rate in the 90s,
24 I think, off the top of my head, we're sitting at about 92,
25 93 per cent. Turnover, I think we're about - we can get
26 you these exact figures. I can't recall them off the top
27 of my head, but our turnover is relatively competitive, as
28 is our attrition. So I think wages are one factor, but
29 I guess our experience in terms of those other things is
30 that we're not - there's not an acute problem. It's
31 certainly a problem, workforce supply is a problem, but
32 wages are one factor.
33
34 Q. Any process of award or condition reform and
35 modernisation must include a review of wages and allowances
36 available under those awards?
37 A. Yes.
38
39 Q. Finally, if I can take you to a document, a table at
40 [MOH.0010.0454.0001]?
41 A. Yes.
42
43 Q. Are you familiar with this table?
44 A. Yes.
45
46 Q. Did you prepare it?
47 A. Yes, with assistance from people in my team.

1
2 Q. And does it add to the descriptions of limitations in
3 various awards and instruments that you set out in
4 your July statement?
5 A. Yes. I think the statement tries to put some examples
6 to those comments.
7
8 Q. And in the third paragraph on the first box, starting
9 "It should be noted" - do you see that?
10 A. Yes.
11
12 Q.
13 *It should be noted that such enhancements*
14 *would come at considerable cost, all of*
15 *which are unfunded.*
16
17 That is, the enhancements that you describe in this table
18 would come at considerable cost and at the moment are
19 unfunded?
20 A. That's right.
21
22 Q. So from that do we take it that for enhancements of
23 this kind, leaving aside to enhancement to wages, further
24 funding from treasury would be required to be given to the
25 department or the ministry to fund those enhancements?
26 A. That's right.
27
28 MR GLOVER: No further questions of this witness,
29 Commissioner
30
31 THE COMMISSIONER: Thank you, Mr Cheney, do you have any
32 questions?
33
34 MR CHENEY: No, Commissioner.
35
36 THE COMMISSIONER: Thank you very much for coming in,
37 Ms Collins, we're very grateful for your time. You are
38 excused.
39
40 THE WITNESS: Thank you, and I apologise to the court
41 reporters.
42
43 THE COMMISSIONER: No, no, they have done a great job as
44 usual, I'm sure
45
46 THE WITNESS: I tried not to be too fast.
47

1 THE COMMISSIONER: You're fine.
2
3 **<THE WITNESS WITHDREW**
4
5 MR GLOVER: 10 o'clock.
6
7 THE COMMISSIONER: We will adjourn until 10 o'clock
8 tomorrow.
9
10 **AT 3.33PM THE SPECIAL COMMISSION OF INQUIRY WAS ADJOURNED**
11 **TO TUESDAY, 6 AUGUST 2024 AT 10AM**
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