

**Special Commission of Inquiry
into Healthcare Funding**

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

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

Wednesday, 28 August 2024 at 10.00am

(Day 49)

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 Ms Emily Aitken for NSW Health

1 THE COMMISSIONER: Good morning.
2
3 PROFESSOR MAY: Good morning.
4
5 MR GLOVER: Thank you, Commissioner, we convene this
6 morning to take some evidence from Professor Jennifer May,
7 who, as you will have now observed, is on the screen and
8 ready to go.
9
10 <JENNIFER ANN MAY, SWORN [10.02 am]
11
12 <EXAMINATION BY MR GLOVER
13
14 THE COMMISSIONER: Thank you, Mr Glover.
15
16 MR GLOVER: Professor May, can you see and hear me okay?
17 A. I can't see you. I can see the Commissioner, but
18 I can't see you. But I can hear you well.
19
20 Q. All right. Well --
21
22 THE COMMISSIONER: It's probably better off that way.
23
24 MR GLOVER: -- it's probably for your benefit that way,
25 yes. I think the Commissioner beat me to it.
26 A. Right, now I've got you.
27
28 THE COMMISSIONER: I'm kidding, but - yes.
29
30 MR GLOVER: I'm not. To the extent at any stage you can't
31 hear me or the connection breaks up, just let us know;
32 okay?
33 A. Thank you.
34
35 Q. Can you tell us your full name, please?
36 A. Jennifer Ann May, M-a-y.
37
38 Q. And you're currently the director of rural health at
39 the University of Newcastle; is that right?
40 A. I am. I live in Tamworth, northern New South Wales.
41
42 Q. Thank you. To assist the Commission in its work,
43 yesterday you made a statement; correct?
44 A. I did. Correct.
45
46 Q. For the benefit of the transcript, it's
47 [SCI.0011.0384.0001]. Now, if I take you to paragraph 28

1 of your statement. I understand there's a correction that
2 you would wish to make in relation to the document
3 described as annexure E; is that right?
4 A. Correct.
5
6 Q. What I'll do is I'll have the operator bring up on the
7 screen [SCI.0011.0393.0001], and hopefully in a moment,
8 Professor May, on your screen will appear a document. Can
9 you see that document?
10 A. It has, yes.
11
12 Q. And is that the document that should be annexure E?
13 A. Yes.
14
15 Q. Rather than the one that was originally attached to
16 your statement; is that right?
17 A. Correct. That's the document alluded to in that
18 paragraph. Thank you.
19
20 Q. And, other than that correction, is your statement
21 true and correct to the best of your knowledge and belief?
22 A. To the best of my knowledge.
23
24 THE COMMISSIONER: Does that mean I've got the wrong
25 annexure E?
26
27 MR GLOVER: Yes. The effect of that, Commissioner, is
28 that the annexure E that was originally attached has been
29 substituted for the document on the screen, and I'll hand
30 you a copy of the correct one for your exhibit.
31
32 THE COMMISSIONER: Thanks.
33
34 MR GLOVER: Commissioner, given that we only have a few
35 documents this morning, I tender the statement and the
36 annexures now. I'm told we are at exhibit M1.
37
38 THE COMMISSIONER: The folder I've got has gone up to
39 exhibit E.
40
41 MR GLOVER: Yes.
42
43 THE COMMISSIONER: Then there's some other documents.
44
45 MR GLOVER: Yes, those documents --
46
47 THE COMMISSIONER: No, annexure F, sorry. Annexure F.

1
2 MR GLOVER: It should go to G.
3
4 THE COMMISSIONER: G. Then there's a supply and demand
5 study for general practitioners.
6
7 MR GLOVER: Yes. That's not annexed to the statement, but
8 I'll be taking the Professor to it shortly.
9
10 THE COMMISSIONER: Right. Okay. So is that part of
11 the tender?
12
13 MR GLOVER: It will be, yes, but separately from the
14 statement.
15
16 THE COMMISSIONER: Got it. Okay. Thanks.
17
18 MR GLOVER: So I tender the statement and annexures now,
19 and I'm told that it should be marked exhibit M1.
20
21 THE COMMISSIONER: And the "Supply and demand study,
22 general practitioners in Australia, August 2024" will get a
23 separate exhibit number.
24
25 MR GLOVER: And, if convenient, I'll do it now as M2.
26
27 Q. Professor, you've got a copy of your statement there
28 with you?
29 A. I do.
30
31 Q. All right. And I'll start with paragraph - before
32 I do that, in paragraph 3 you tell us that you oversee the
33 rural health multidisciplinary training program?
34 A. Correct.
35
36 Q. Can you tell us a little bit about that program? What
37 does it involve?
38 A. Indeed. It's a Commonwealth-funded program that works
39 through education. So it's a grant program that is given
40 to universities by the Commonwealth Department of Health,
41 and it is to - I call it the gain, train, retain program,
42 but its specific intent is to affirmatively support rural
43 recruitment and return of health professionals. But it
44 does it through supporting university education and
45 training, and the development of infrastructure in rural
46 areas to support high-quality delivery of services.
47

1 Q. So, in terms of it being directed to rural recruitment
2 and return of health professionals, what sort of
3 initiatives does your program implement with that funding
4 to achieve that aim?

5 A. So as part of the Commonwealth KPIs of that program we
6 are asked and we happily ensure that up to 30 per cent of
7 the entrants into the joint medical program run by UON and
8 UNE are of rural origin. So one of the things we know is
9 predictive of rural return is rural origin. So there's a
10 30 per cent target there. But the majority of our program
11 is focused on I guess incentivising and affirming rural
12 training. So positive rural exposure of more than
13 12 months is a greater predictor of rural return. The
14 longer, probably the better, although the evidence around
15 more than two years is probably less clear at this point.
16

17 What we know is that rural origin and positive rural
18 exposure are synergistic in improving the chances of rural
19 return. But those two efforts on their own are clearly not
20 enough, and what is very evident is that multiple
21 strategies are always required if you are trying to
22 incentivise a certain outcome in your workforce. So a
23 concentration in postgraduate training and, if you like,
24 the opportunities that are beyond the remit of the
25 traditional from the medical school point of view are also
26 supported through this program. So the regional training
27 hub portion of the program works specifically at supporting
28 new medical officers in our regional areas and supporting
29 rural training and rural careers.
30

31 Q. Thank you. Could I take you to paragraph 6 of your
32 statement. There you tell us a little about the state of
33 the general practitioner workforce and some trends. Do you
34 see that?

35 A. Yes.
36

37 Q. And then in paragraph 12 you tell us that your view is
38 that:

39
40 *The current health workforce, particularly*
41 *the general practitioner workforce, is*
42 *challenged to meet the needs of the New*
43 *South Wales population having regard to*
44 *current distribution patterns, population*
45 *growth and increasing service demand.*
46

47 Do you see that?

1 A. I do.

2

3 Q. Can you just describe in general terms what those
4 challenges are as you see it?

5 A. So - and I think the GP supply and demand study also
6 alluded to this - what we see is insufficient inflows into
7 general practitioner training. We see some changing
8 demographics and workforce preferences, we see a reduction
9 in the number of hours, and we see demand for services
10 going faster than population growth.

11

12 In addition, in the rural context the expected scope
13 of practice of general practitioners is wider, and the
14 requirement and the need to provide procedural services
15 and, I guess, more thought of as secondary services within
16 our district hospitals is an additional role which
17 increases the number and the requirement for general
18 practitioners in rural areas. It is in that area in
19 particular that we've seen workforce challenge to this
20 point, and obviously where we've seen some initiatives of
21 recent times to try and redress that retention of that
22 specific workforce.

23

24 Q. And is this a trend that you have observed over a
25 relatively long period of time or has it accelerated in
26 recent years?

27 A. So it's a trend that's been observed over probably
28 40 years. There's evidence going back to 1987 of a
29 reduction in the proportion of general practitioners versus
30 other non-GP specialists being trained in our system. So
31 these are long-term trends, and they're not even just
32 Australian trends. These are international trends. So the
33 move away from generalism and towards specialism has been
34 longstanding.

35

36 The issue is that the impact of those trends in our
37 rural areas is greater, and so I think I would describe
38 rural as the canary in the coal mine in many ways in terms
39 of that trend and the impact, as I said, being
40 substantially greater on residents.

41

42 Q. Can I take you briefly to the supply --

43

44 THE COMMISSIONER: It's probably always been the case,
45 hasn't it, that a general practitioner that practises in a
46 regional and particularly in a rural area is probably - he
47 or she has always probably been required to have a more

1 expansive scope of practice than a city-based GP; correct?

2 A. Correct.

3

4 Q. Yes.

5 A. And I guess the acceptability and the attractiveness
6 of that skill set within our medical workforce has reduced
7 over time. So the attraction of specialism over that
8 generalism has reduced over time.

9

10 Q. Yes, but the clinicians in the regional centres have
11 consistently told us, I think, that it's - general practice
12 in rural, remote, regional areas is just a different form
13 of general practice than if you're a city GP because you're
14 going to be called upon to do a whole - just by dint of
15 there not being someone with specialisation available,
16 you're going to have to do a lot more procedures than you
17 would if you were a GP in Mosman or Edgecliff or Newtown?

18 A. Correct. And the other aspect of it is the number of
19 hours.

20

21 Q. Yes.

22 A. So whereas in a city practice you can close the door
23 or suggest that someone go down the street because you know
24 that there are options for them in terms of accessing care,
25 if you're one of a small number of practitioners in a rural
26 area, that's very difficult, particularly if you're living
27 where you're working.

28

29 Q. Yes.

30

31 MR GLOVER: Can I take you brief --

32

33 THE COMMISSIONER: And by dint of the population size
34 you're well known in the area?

35 A. And I do allude to that in my statement, and that is
36 one of the challenges in recruitment and retention, is the
37 drawing of professional and personal boundaries, and
38 obviously people differ in their comfort and often in their
39 life stages as to how well they can tolerate or would want
40 the sort of exposure that one necessarily gets.

41

42 Q. Yes.

43

44 MR GLOVER: Operator, can we bring on the screen, please,
45 the supply and demand study. It's [SCI.0011.0392.0001].
46 Can we just go to page 12 of that document, please,
47 internal page 12. I think the coding matches on this one.

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THE COMMISSIONER: Could we go to page 8 first?

MR GLOVER: Yes, of course.

THE COMMISSIONER: Okay. That's not - at page 8. Yes, that's the one. Could I just ask for your help, Professor, in relation to these definitions of baseline demand and unmet demand. So baseline demand is defined as the number of GPs that are needed to meet the current and future health needs of the community. How have the current and future health needs of the community been defined or who's determined that and how it that --

A. Indeed. I affirm your concern about that particular statement or how it might have been --

Q. The reason I'm asking is it could be based on just utilisation, but that may not reflect what the need is and there might be - I mean, it really depends. If the current and future health needs mean keeping the population with the same general health as it has now, that might be one thing. But if there's chronic disease in that community and you want to reduce the rates, intervene earlier, have people with average - spending average - a lower average number of years with chronic disease or seek to prevent it entirely, then the number of GPs might be - that are needed might be higher?

A. I would heartily agree.

Q. Okay.

A. I think you'll see that sense where it actually appears to be calculated on current GP service utilisation levels --

Q. Yes, that's what I - where I've looked at unmet demand, it uses that term "utilisation level". So I've assumed that it's based on the people - data about how many people are going to GPs, at what sort of frequencies. But it may not be what's actually required if you want to, for want of a better expression, promote the health of a particular population. By "promote" I mean improve it.

A. And, Commissioner, if I could just add to that that this calculation assumes that we are at, you know, a stable one equals one state.

Q. Yes.

A. I would contend to you that in rural areas we are

1 significantly underdone.

2

3 Q. Yes.

4 A. And, as I've said, I've provided some circumstantial
5 evidence for that, like waiting times and access, because
6 measuring unmet need is very difficult. We can't go on
7 vacancy rates --

8

9 Q. Yes.

10 A. -- we can't - you know, there are real challenges
11 in --

12

13 Q. So by what you're saying there should I take it to
14 mean that utilisation levels in a particular population
15 where the GP market is thin is not the best guide?

16 A. I can affirm that observation.

17

18 Q. Okay. Thank you.

19

20 MR GLOVER: So is the effect of that exchange, Professor,
21 that you have some concern that the assessment of need
22 might not - might underrepresent actual need within the
23 community?

24 A. Correct.

25

26 Q. All right.

27 A. I understand that any of this methodological
28 calculations are fraught, and I applaud the authors for
29 having a go. But I think we need to question some of the
30 assumptions.

31

32 Q. On page 5 and 6 there is some detail concerning the
33 models used, and if one looks about halfway down the page
34 of page 5, the demand modules --

35 A. So this links to the Commissioner's concern about the
36 chronic disease and health service utilisation, which are
37 assumptions that they have tried to make in this modelling,
38 and, as I said, I would regard them as fraught. The
39 question is: is there a better question or a better way of
40 doing it? And certainly demand modelling - most people are
41 very uncomfortable about demand modelling. Far easier to
42 demand, supply or actual. But trying to model demand
43 particularly in the view of technological change, which
44 may - whilst making health service delivery more efficient,
45 technological change is offering us so many greater options
46 for the way we manage many of our illnesses or injuries,
47 and I do stroke prevention as a good example. We are now

1 looking at clot retrieval as one of the best practice
2 treatments for stroke. Well, clearly 10 years ago that was
3 not even in any demand modelling for the types of
4 professionals we might need if we were going to supply a
5 clot retrieval service. So I think it's just that real
6 challenge about how we model going forward in the demand
7 space.

8
9 I think my other concern is this idea that we're
10 starting in a steady state in 2024, where I believe there
11 are quite a lot of circumstantial evidence that suggest,
12 although we have a head count of general practitioners that
13 is greater than we had before, the actual capacity of
14 residents to access general practice services may not be as
15 good as it was, say, five to 10 years ago.

16
17 THE COMMISSIONER: I imagine - I mean, I'm not for a
18 moment suggesting this report isn't useful, but if you were
19 determined to produce a study about what might be needed
20 to - what might be needed in terms of the GP workforce
21 primary care health services to reduce the rates of chronic
22 disease and the length of time that the population suffers
23 from chronic disease, that would be a massive undertaking
24 to do that work, wouldn't it? It wouldn't be - it would be
25 a really long-term, difficult job with a huge amount of
26 time spent on the methodology that was going to be used and
27 the modelling that was going to be used?

28 A. Absolutely. And I guess it also goes to some of the
29 assumptions around access.

30
31 Q. Yes.

32 A. So this modelling doesn't take into - or the - some of
33 the issues around access include the acceptability of
34 access, the affordability of access and the availability of
35 access. So we're just thinking if there's a GP - if
36 there's, you know, a body that reports to APRA as a GP in a
37 certain residential area that that equates to access, and
38 I think there are some other factors that would need to be
39 considered when we were considering whether we were
40 undersupplied for population need.

41
42 Q. Sure. I guess my point is you can read any number of
43 Treasury or intergenerational reports that say we have to
44 intervene earlier and shorten the time that people suffer
45 from chronic disease if we're going to get - we're going to
46 reduce the rate of the growth in the budget spend on health
47 care, but if you're actually really determined to do that

1 then you've got to do the big, difficult study to work out
2 exactly how that would best be targeted and exactly what
3 levels of GP/primary care are likely to be needed to in
4 30 years time or 20 years time find out you have reduced
5 the rates of chronic disease and thereby prevented people
6 going to hospital and thereby reduced the growth in the
7 health spend?

8 A. Yes, I affirm that, Commissioner. Absolutely.

9
10 Q. Okay.

11
12 MR GLOVER: And part of that must include, must it not, a
13 detailed assessment of the likely health service needs of
14 the population both in the short, near and long term?

15
16 A. Yes. And I guess the challenge for us all is that
17 chronic diseases take 20 to 30 years to develop. So we're
18 actually coasting on the coattails of the health care we
19 received 20 to 30 years ago, and it's going to take that
20 long for potential lack of access to impact on some of
21 those - the incidence and prevalence of some of those
22 diseases.

23
24 Q. Accepting the concerns about the modelling, but
25 proceeding on the basis, I think I've understood you
26 correctly, that those concerns would lead to a conclusion
27 that the estimates in this study are conservative; have
28 I understood you correctly?

29 A. Correct.

30
31 Q. All right. If we go to page 12 - internal page 12,
32 thank you, Operator - and you'll see under the heading "New
33 South Wales" these are the New South Wales projections. At
34 the moment the baseline gap is around 230 FTE; do you see
35 that?

36 A. Yes.

37
38 Q. And one of the features of the changes in medical
39 practice, not only for general practitioners but across the
40 board, that you've told us about is changes in work
41 patterns that clinicians seek; correct?

42 A. Yes.

43
44 Q. And so it may be that one practitioner no longer, to
45 the extent it ever did, equates to one FTE?

46 A. Correct.

47

1 Q. So the number of practitioners to close that gap would
2 be - it would be reasonable to assume a lot or - I'll
3 withdraw that and start again. On that basis it would be
4 reasonable to assume that the number of practitioners
5 required to close the 230 FTE gap as it stands at the
6 moment would be higher than 230 clinicians; correct?

7 A. Indeed. I would qualify that, and there is a
8 qualification in this document that talks about a
9 difference between Australian-trained medical graduates and
10 their FTE and international medical graduates who come into
11 New South Wales on an obligatory pathway where their visa
12 dictates them being in a non-metropolitan area for a period
13 of time, and what we see is that those practitioners, and
14 understandably, will have a higher FTE while they're in
15 their obligated practice.

16
17 Q. For the benefit of the transcript, that qualification
18 appears on page 21.

19
20 THE COMMISSIONER: Thanks.

21
22 MR GLOVER: You'll then see on page 12, Professor, the
23 projected increase in the gap between baseline demand and
24 the number of clinicians available, and it increases rather
25 rapidly between now and 2028, and then between 2028 and
26 2048; do you see that?

27 A. I do.

28
29 Q. Do you have a view about the effect on the healthcare
30 system as a whole if that gap eventuates as predicted?

31 A. I expect that our models of primary care delivery will
32 need to change in order to make that figure, you know, not
33 the case. It is inconceivable to think that the system
34 could work well with an undersupply of 2300 FTE by 2048,
35 but it is my observation that there are a number of changes
36 occurring which will change the scope of practice and the
37 balance of activity within primary care that will need to
38 go some way to alleviating that sort of shortage.

39
40 Q. What are those changes that you're observing?

41 A. So currently there's a scope of practice review under
42 way with the Commonwealth government where allied health
43 professionals - well, scopes of practice are being
44 revisited to understand where there are complementary
45 scopes of practice or where primary care responsibility can
46 be shared and collaborated on across the health care team.
47 So there's a focus on multidisciplinary care. So one would

1 expect that with that focus on multidisciplinary care and
2 some sharing of the general practice workload that we would
3 be going some way to ameliorating that shortage.
4

5 Do I think that scope of practice is likely to
6 completely meet that level of unmet demand? I don't, and
7 the reasons for that are that our distribution of nurses is
8 not unlike our distribution of GPs, and our distribution of
9 other allied health professionals is also not unlike our
10 distribution of GPs. So this may be a solution in
11 metropolitan areas, but my concerns are that we're not
12 starting with a workforce that has huge excess capacity
13 that we could work with sharing the sorts of
14 responsibilities that we will need to if primary care is to
15 change.
16

17 Q. By distribution do you mean the maldistribution of
18 clinicians of all kinds --

19 A. Correct.
20

21 Q. -- heavily weighted towards metropolitan areas?

22 A. That's exactly what I mean.
23

24 Q. Although you have some reservations about how far it
25 will go, do we understand you, though, to be of the view
26 that having clinicians operate to the top of their scope of
27 practice wherever possible is one mechanism that may
28 alleviate some of the workforce challenges posed by
29 maldistribution?

30 A. I do, and that includes getting our rural GPs working
31 to the top of their scope and rural generalism and the
32 increased focus on training for rural generalism, and that
33 is extra scopes of practice - well, expanded scopes of
34 practice with obstetrics, anaesthetics, mental health,
35 paediatrics as well as a baseline in emergency is required
36 in order to deliver those services in a distributed
37 capacity.
38

39 THE COMMISSIONER: That scope of practice review I think
40 you've just touched on might not just recommend clinicians
41 working to the full scope of their practice but it might
42 recommend an expanded scope of practice for people with
43 skills that - where they could have an expanded scope of
44 practice with some change of legislation, for example?

45 A. Yes, I think that's a likely outcome.
46

47 Q. Yes. Is a greater utilisation - to the extent that

1 it's possible, a greater utilisation of virtual medicine,
2 virtual consultations, could that be a means of bridging
3 this gap between supply and demand?

4 A. Somewhat. But the thing that --

5
6 Q. Not as a complete answer, but as an aid?

7 A. Absolutely, and virtual care is already an important
8 part of health care delivery in rural and remote, and
9 I think it's - the way the models evolve it will have an
10 even greater role. What we've got to do is also when we're
11 thinking about these projections, in 2048 what is the
12 technological capacity going to be of our system? What
13 will health care look like? You know, I wonder whether we
14 will be interacting with a virtual care, artificially
15 intelligent assistant who will be monitoring by wearables
16 our various health --

17
18 Q. Yes.

19 A. So that system is going to interact differently with,
20 you know, the professionals on the ground, and it may
21 change where people need to be in order to support those
22 sorts of models.

23
24 Q. It's funny you should say that. I was talking to the
25 team the other day. I've just read a book called "The
26 patient will see you now" by someone called I think it's
27 Topol, a cardiologist in America. It was published in
28 2015, but it sort of predicts what you were just talking
29 about, the virtual assistant for your health care would be
30 widely available by now, which we're not quite there,
31 I don't think, although we can wear rings and watches that
32 monitor various of our - our heart rates and those sorts of
33 things and our sleep. But that book is very much
34 predicting the sort of virtual assistant particularly for
35 monitoring a chronic condition and all sorts of solutions
36 that you were just talking about. Have you come across
37 that book yourself?

38 A. I have not, and I will - I'll seek to find it. I'm
39 very interested in making sure that we're open to the way
40 health care is going to go, and unless - and I guess my
41 personal concern is and my focus is on equity. I think
42 these changes will be fabulous for rural and remote
43 citizens. But in order for them to have access we will
44 need ubiquitous broadband, and we will need the co-design
45 or the influence of people who live in rural communities.
46 But it's coming, and we - you know, 2048, general practice
47 is going to look a lot different.

1
2 Q. Yes, yes.

3
4 MR GLOVER: Consideration of expansion of scope of
5 practice or in providing environments where clinicians can
6 operate to the top of scope of practice apply equally
7 across other specialists as well in addition to GPs, do
8 they not?

9 A. Absolutely. And the changes will be as rapid in
10 non-GP specialist practice as specialist practice, and
11 that's what I was alluding to. I think you'll find this
12 absolute explosion in opportunities for different
13 treatments, for much more detailed - individually detailed,
14 genomically profiled treatments, and that will - so we have
15 to accommodate it as we're looking forward in this health
16 system to see how access will be organised to what are
17 going to be highly specialised scopes of practice.

18
19 One of my challenges, and you'll see this in my
20 statement, is that maintaining a generalist specialist
21 focus in our regional centres - and when I say regional
22 centres I'm talking about Wagga, Albury, Dubbo, Nowra,
23 Tamworth, Armidale, Coffs Harbour, Port Macquarie, our
24 regional centres that act as a hub-and-spoke model. Now,
25 at the moment we're asking the specialists in those areas
26 to be what I call specialist generalists, so to again have
27 a wider scope of practice than many of their metropolitan
28 colleagues, who are able to subspecialise and become, you
29 know, super expert in quite narrow scopes of practice.

30
31 Now, maintaining that focus certainly for the next
32 five to 10 years appears to me absolutely crucial if we're
33 to keep our health system running efficiently and not
34 expecting that we're going to be referring very large
35 numbers of patients centrally for care.

36
37 Q. I'll come back to this a little later, but one of the
38 priorities of the National Medical Workforce Strategy is to
39 build the generalist capacity. That includes both general
40 practitioners and general clinicians within hospitals;
41 correct?

42 A. Correct.

43
44 Q. Why is it important to build the general clinician
45 capacity within hospitals, in your view?

46 A. So, just as I've alluded to, in regional centres
47 subspecialty practice is challenging. Because being on

1 call is such a major aspect of the delivery of health care
2 in regional centres, if you are a subspecialist are we
3 going to have that person on call 24/7 seven days a week or
4 are we going to have a generalist physician on call taking
5 people from the area with heart attacks, strokes, you know,
6 sore tummies and then those being handed on to
7 subspecialists when and if appropriate. So the demands of
8 the on-call nature of those regional centres, where we
9 cannot - we do not have a critical mass of subspecialists
10 for every single specialty, then that's where I see the
11 generalist specialist workforce as really important.
12

13 So it's an issue in general surgery. It's an issue in
14 medicine. It's an issue in paediatrics. It's an issue in
15 obstetrics. We need people who have a wide scope of
16 practice across the continuum of their specialty because we
17 need them to be able to manage the sorts of emergencies
18 that come in from a catchment or a hub-and-spoke model
19 close to their regional centre.
20

21 Q. Is there also a need to build a generalist clinician
22 workforce within metropolitan hospitals?

23 A. Well, I believe so, and I believe so on the basis of
24 efficiency. So my question is generalists can manage
25 probability and manage uncertainty, whereas the more
26 specialist you are the more filtered, if you like, your
27 patients need to be and the lesser capacity to manage
28 across the continuum and particularly with patients with
29 multi-morbidity or chronic and multiple problems.
30

31 So, if you come into hospital under the respiratory
32 physician because you've got a cough but in fact your
33 urological plumbing isn't so good or your kidneys aren't
34 working so well, the whole concept of being able to be
35 managed with a generalist approach and prioritising those
36 issues - and I guess that's what geriatricians do with our
37 over 65-year-olds. In other words, they're not
38 specialising in one system. They're providing that
39 holistic overlook and prioritising the issues for the
40 patient's quality of life and outcome.
41

42 Q. Can I take you back to your statement, please, and to
43 paragraph 30.

44 A. Yes.
45

46 Q. Whilst we're on the topic of GPs, in paragraph 30 you
47 tell us there's a need to support rural general practice

1 and primary care to reduce unnecessary usage of acute
2 facilities, and then in the next sentence you tell us
3 recent collaborations around urgent care would appear
4 useful in this shared approach. What are the
5 collaborations that you're referring to, firstly?

6 A. So the urgent care program announced - there was two
7 urgent care programs announced, one through the
8 Commonwealth and one through the state jurisdiction. Now,
9 I guess this is one of the first initiatives that talks
10 about shared responsibility or shared concern about timely
11 access. So I guess it's a recognition that there has been
12 an increase in waiting time and patients visiting emergency
13 departments, and I guess this to me represented an effort
14 to consider access from the patient's point of view and try
15 and find a way forward.

16
17 So, whilst I'm not suggesting that I - that the model
18 might be - and the model is different as it's been applied
19 depending on who the jurisdictional - where the funding is
20 coming from. I think the idea of collaborating and
21 understanding the impact of primary care - the inability of
22 primary care currently to provide timely access is welcome
23 if it increases the collaboration between the two sectors.

24
25 Q. And do you see scope for further collaboration on that
26 issue?

27 A. I do. I think there are some preconditions which are
28 around data sharing and I guess the building of trust
29 between the two sectors to ensure that it's patient centred
30 and that it's relatively seamless. We could face an issue
31 where with notes not being shared there was extensive
32 duplication, and that feedback and that - yes, feedback to
33 primary care from specialty care I think needs to be
34 enhanced in order for these models to move forward.

35
36 Q. In paragraph 31 you tell us that there's further scope
37 for the LHDs to support access to primary care, and you
38 give an example in paragraph 32 of extending work locations
39 to have LHD-employed clinicians routinely attend community,
40 aged care and primary care settings; do you see that?

41 A. I do.

42
43 Q. Just in practice how might that work?

44 A. So the concept that you could second an employee of
45 New South Wales Health, perhaps someone skilled with
46 chronic disease management or interested in supporting a
47 chronic disease program that has a preventive focus, those

1 people could be situated in general practice as opposed to
2 link into general practice.

3
4 I think the other area that I think is ripe for
5 support is LHD health service professionals who are
6 involved in scopes of practice related to aged care, is in
7 reaching to provide care within aged care settings, and
8 there are some really excellent programs that have been
9 piloted looking at that exchange of personnel. But, again,
10 it comes down to communication and that approach of being
11 able to effectively data share and work as a
12 multidisciplinary team.

13
14 Q. And do you see initiatives like that as being one
15 lever that might be pulled to ensure the community has
16 access to the type of care they need within the community,
17 firstly?

18 A. I do, and I would welcome such initiatives. It is of
19 concern to me that, without that consideration of the
20 health system as a whole, presentations to acute facilities
21 may continue to rise.

22
23 Q. You've anticipated the next part of my question. Do
24 you see that as having a positive effect on keeping people
25 out of emergency departments who may not need to be there?

26 A. I do, and I welcome - so if I think about what works
27 well in rural and regional, and I'll go to small rural
28 because I think that's probably a better - the earlier you
29 can intervene and the more seamless your intervention, and
30 particularly if there is continuity of care or continuity
31 of management, then I think the outcomes are better. So if
32 we can link up those initiatives particularly around
33 prevention then I do believe that that will work to the
34 patient's benefit and I do think that will avoid
35 hospitalisations in the long run.

36
37 Q. Can I take you to paragraph 14 of your statement,
38 please, and in this section of your statement you identify
39 some potential solutions to the workforce challenges that
40 we've been discussing. We've touched on some of them, in
41 particular grow-your-own type initiatives. In paragraph 16
42 you tell us:

43
44 *To support the system, training needs to*
45 *occur outside acute hospitals to ensure*
46 *that we are training the whole workforce we*
47 *need.*

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Could I just invite you to expand on the concept that you're drawing to the Commissioner's attention in that sentence?

A. So I'm specifically drawing your attention to the fact that medical training in particular is very hospital focused and yet we have this expectation that 50 per cent or more of the trainees involved in postgraduate year 1 and 2 training within our hospitals will end up in the community. It is of concern to me that the exposure of those - both students and postgraduate year 1 and 2 trainees, if their exposure is not to community settings, then I think it reduces the chance of them being positively disposed to careers in that direction.

So as one of the ways of training the workforce we need, which is more than just the people who are going to have a hospital-based practice, then the better exposure and the better training that reaches out from acute hospitals I believe would better place trainees to take on some of those careers.

Anecdotally, talking to trainees who are in hospitals, leaving the hospital is a leap of faith, and particularly if they have not been exposed to much primary care or community-based practice then it is obviously more enticing to look at a salaried hospital job that will lead to a consultant position in a specialist - or following a specialist training program.

Q. Are there any initiatives, either current or former, that you're aware of that have been directed to that particular issue?

A. Yes, and over time some of those initiatives have come and gone, and, as I mentioned, the lead time for our training - medical training in particular - is so long that we're reaping the benefits or disbenefits of initiatives that occurred 10 years ago, because it takes that long from the medical student end for people to enrol in training programs and finish their training and end up in a location of choice or otherwise.

So some of those initiatives relate to primary care, and there was a program way back called the PGPPP which rotated trainees, PGY1 and 2 trainees, into general practice. That ceased a number of years ago. But when I talked to some of my current GPs they - many of them were

1 on or had terms like that and were positively disposed.

2
3 We now have the John Flynn training program, which is
4 rurally focused, and we've had considerable success locally
5 in identifying and supporting terms in Scone, Gloucester,
6 Moree, and we're just hoping to get a term like that up at
7 Manilla Hospital, and the reason for that is expressly to
8 expose our trainees to those locations and to that style of
9 practice with a hope of incentivising them to undertake
10 rural generalism or rural general practice as a career.

11
12 THE COMMISSIONER: The PGPPP has come up or has been
13 mentioned in some of our various regional site travels.
14 What did it stand for again?

15 A. Post - can't remember.

16
17 Q. Take that on notice.

18 A. I'll get back to you. Prevocational --

19
20 Q. We'll find out. Don't worry.

21 A. Prevocational general practice training program,
22 I think.

23
24 Q. What did it involve again? What was --

25 A. So it was a 10-week term rotation into general
26 practice.

27
28 Q. Yes.

29 A. And it occurred both metro and rural. It was
30 available across the state. The Commonwealth provided the
31 funding for it to backfill the positions. So New South
32 Wales Health was able to release those residents into
33 general practice terms.

34
35 Q. And it has been spoken of - well, the only time it's
36 come up, the person talking about it has spoken about it in
37 positive terms. When I asked - in terms of its benefit.
38 When I've asked why did it end I think I was told it ended
39 when a government ended and new government came in. Was
40 there any more to it than that as to why it ended?

41 A. I'm not aware of exactly why it ended. I think
42 programs such as that are expensive --

43
44 Q. Yes.

45 A. -- and it was - it was scale. So it was - those terms
46 were available to most trainees in the system, so --

47

1 Q. It sounded like it simply was a program that it didn't
2 end because it wasn't thought to be working; it ended
3 because the new government thought things had to be cut and
4 that was one of the things they cut?

5 A. I think there may have been a fiscal weighing up, yes.

6
7 Q. Yes. Okay. Thank you.

8
9 MR GLOVER: Do I take it from your experience and
10 understanding of that program, though, it was a beneficial
11 one to attracting clinicians to rural generalist practice?

12 A. Nearly - a large proportion of the GPs that I speak to
13 who are now, you know, 10 years into practice, they will
14 speak of that program being quite pivotal in their decision
15 to undertake general practice training.

16
17 THE COMMISSIONER: Perhaps I should make the generous
18 assumption that it wasn't cut because it was beneficial.
19 But who knows?

20
21 MR GLOVER: I won't say anything to that.

22 A. But I guess, Commissioner - I need to be careful - not
23 one particular - one initiative is going to fix this.

24
25 THE COMMISSIONER: No, of course not.

26 A. We've got a status issue for primary care and
27 generalism versus specialism that I've alluded to, we've
28 got a lack of exposure to community settings in some of our
29 university courses, and certainly in our postgraduate
30 training in hospitals, and we've got some salary and
31 remuneration issues, and we've got this whole thing about
32 generalism manages uncertainty and probability, and it's a
33 bit more messy, whereas specialty training, once you've
34 actually, you know, affirmed and got some really high-level
35 fabulous skills, you are in a position not to have to, you
36 know, accept some of the messiness that general practice
37 and deep-end general practice can have.

38
39 THE COMMISSIONER: I entirely accept, as you say, one
40 initiative is not going to fix this. But the fact that a
41 program is beneficial, it might mean that it costs a lot
42 and it's of benefit, but the benefit is either marginal or
43 it's better than marginal but it still costs a lot. But
44 the fact that a program is beneficial might also mean that
45 it should be scaled to a larger degree and, even though
46 it's expensive, you've got to weigh that with the benefit
47 it's producing and they might either net out or the benefit

1 might in the long term, given we're talking about health
2 care, actually far exceed the cost. Who knows?
3 A. Look, and to me --
4
5 Q. You won't know if you cut it, that's for sure.
6 A. Positive exposure is the key thing.
7
8 Q. Yes.
9 A. So the exposure's got to be positive because it's got
10 to entice. But my second point is, just in terms of
11 medical training, understanding the environment of general
12 practice and primary care, even if you end up in a
13 specialist training career, has to be beneficial that you
14 understand how the system works and you understand what it
15 is that the patients, you know, experience in the primary
16 care environment.
17
18 Q. Can I ask you this about the PGPPP - whatever quite
19 that means; we'll find out. Has it been replaced, in your
20 opinion, by a better program for exposing medical trainees
21 to general practice and in particular general practice in,
22 say, the regions?
23 A. So the John Flynn junior doctor prevocational training
24 program, or whatever its acronym is, has certainly been
25 beneficial from my perspective as someone who has been
26 involved in setting up some of those terms. But clearly
27 we've selected --
28
29 Q. It's a similar thing with a different name, is it, or?
30 A. I would think so.
31
32 Q. Yes.
33 A. So I feel that this is a really important program.
34 It's not at the same scale that PGPPP was.
35
36 Q. I see. Right.
37 A. So it's not as available.
38
39 Q. Yes.
40 A. But, again, anecdotally I hear very positive reports
41 of the exposure, and from my point of view, as I said,
42 people need to walk the walk and understand the environment
43 that they may be choosing to train for.
44
45 Q. Sure.
46
47 MR GLOVER: Considerations of that kind also apply to

1 training of specialist clinicians, do they not?

2 A. Correct, and that's why in I think it's section 16 I'm
3 drawing your attention to the importance if we understand
4 the need for having a distributed specialist workforce,
5 non-GP specialist workforce, and I suggest that their
6 presence in our regional centres is imperative to the
7 working of the New South Wales health system, that we need
8 to train people in those environments with a specific
9 understanding that that positive exposure again is likely
10 to be our major recruiter and our succession planner into
11 clinicians able to manage those roles.

12
13 Q. What needs to be done, in your view, to get to that
14 stage?

15 A. So the National Medical Workforce Strategy would
16 suggest that it is that really sincere collaboration
17 between colleges and the way that they design their
18 curriculums and the way that they value generalist skill
19 sets within colleges. It involves New South Wales Health,
20 and it involves probably a networking of training. But
21 we've got to decide whether we're going to prioritise those
22 locations for training and whether we are going to identify
23 that they get filled first and that they are an inreach
24 model or whether they were simply an outreach model from a
25 metropolitan centre, where obviously the focus is on
26 training for the scope of practice that can be seen in that
27 specialty training centre.

28
29 Q. By inreach and outreach do you mean inreach in the
30 sense that the trainee is primarily located in the regional
31 location?

32 A. Correct.

33
34 Q. And goes to the metro to the extent necessary?
35 A. Yes.

36
37 Q. As opposed to how it is at least weighted at the
38 moment, with the majority of specialist training occurring
39 in metropolitan regions with perhaps some short time in the
40 regions?

41 A. Exactly.

42
43 Q. You spoke of collaboration, and that is a key feature
44 or theme within the National Medical Workforce Strategy.
45 What can be done, if anything, to improve that process of
46 collaboration, given the fragmented nature of the system?

47 A. I think the most positive thing for me was that

1 states, all the jurisdictions, the Commonwealth, the
2 colleges, the medical schools and many of the industrial
3 bodies all endorsed the National Medical Workforce
4 Strategy. So at that level I appreciate that we have a
5 shared vision, a common goal in rebalancing some of the
6 aspects of our workforce in order to achieve a better
7 distribution.

8
9 On that basis, the issues relate to what colleges see,
10 and often appropriately so, are accreditation barriers,
11 supervision barriers. Some of that is related to the need
12 to rethink some of those things with virtual care and other
13 modalities. But I think it's that prioritising about what
14 is it that the whole system wants.

15
16 So I absolutely understand that where you have a
17 metropolitan training program and where you have a high
18 volume and a high population and a high density of work
19 that having someone out in the periphery perhaps with a
20 slightly different scope of practice and different
21 supervision arrangement, but what we've got to do is make
22 that everybody's main business. I think it has to be a
23 collaboration, and I think even me talking about it today
24 and putting it on the Commission's radar is I think about
25 trying to get those levers in order and get that greater
26 focus on regionalised training.

27
28 Q. Do the system managers of the state and territory
29 health systems have a role to play in engaging with the
30 colleges to rethink how training might be delivered outside
31 of metropolitan areas?

32 A. Absolutely.

33
34 Q. And do you see there to be a larger role that they
35 could be playing than is currently the case?

36 A. I do, and I understand that it is that the - if you
37 think about it, that the rural LHDs are a smaller voice
38 potentially in this than the metropolitan LHDs.

39
40 Q. So coordination --

41 A. A quieter voice, maybe.

42
43 Q. Coordination of effort not only is required at the
44 national level but at the state and territory
45 jurisdictional level; correct?

46 A. That's correct. And it's a prioritisation. It's
47 saying, "This is what we need to do if we want a workforce

1 for the future, and that means that we prioritise those
2 posts and we prioritise that as part of the network. They
3 should be filled first and they should be given the status
4 they need," and that involves things like the right sort of
5 inreach to get the skills to pass the training programs,
6 and, as I said, that's a whole of - a whole effort that
7 involves not only the colleges but the jurisdictions and
8 the - I guess, the importance placed on that sort of
9 training aim.

10
11 Q. And from your earlier observation do I take it that
12 you are of the view that individual rural LHDs or their
13 equivalents across the country are perhaps not best placed
14 to achieve that as opposed to a whole-of-jurisdiction type
15 approach?

16 A. They need help.

17
18 Q. I'll come to the detail - some of the detail of the
19 National Medical Workforce Strategy in a moment, but just
20 finally can I take you ahead to paragraph 36 of your
21 statement, please, and there you tell us that most LHDs are
22 facing population pressure and aging population, changing
23 consumer expectations and expanding health horizons. In
24 that is an increased prevalence of chronic disease;
25 correct?

26 A. Correct.

27
28 Q. Where you refer to changing consumer expectations what
29 did you have in mind?

30 A. I think there's been a change in what some of our
31 consumers regard as access, and I'll use the watch example.
32 Now that you can have a watch on your arm and that that
33 tells you that you might have a little funny heartbeat,
34 that now means - well, that's obviously raised a level of
35 anxiety and expectation of care that is somewhat greater
36 than it used to be. So I think as diagnostics moves closer
37 to the patients we've also got these changing expectations
38 about how we should be fulfilling them, and how accessible
39 and timely our health service might need to be. So it's a
40 comment on primary care as opposed to secondary care. But
41 obviously there's an overflow into secondary care as a
42 result.

43
44 I think the other thing is that we've seen a lot of
45 change related to changing policies, and what I mean by
46 that is with the advent, for instance, of the National
47 Disability Insurance Scheme we've seen a real need for

1 patients to access paediatric assessment services to
2 understand their eligibility, for instance, for entry into
3 the NDIS.
4

5 Now, parents would see that as time critical because
6 there is very good evidence that early intervention is
7 important with developmental conditions. So that's now put
8 quite a significant pressure on the system and a change in
9 expectations of those parents who are looking to try and
10 adequately access a whole plethora of assessment services
11 in order to seek the care that they need.
12

13 So it's all of those things that are in many ways
14 external to the delivery of the health system that I think
15 are changing, and that's what I meant by changing consumer
16 expectations.
17

18 Q. How might expectations of that kind be taken into
19 account in service and workforce planning activities?

20 A. I think it's very challenging. I think there's been a
21 reticence to identify, and this is related to rural areas,
22 a baseline level of access to services, and I share the
23 reticence, because obviously the reason to define it is to
24 then say that - or to then understand where the gaps are,
25 where that isn't being delivered, but the other concern for
26 me is that the baseline is changing. So how are we going
27 to keep up with a changing expectation in particularly the
28 timeliness of access, and, as I said, that's one of the
29 things that I'm thinking moving forward is going to be a
30 real challenge, and that's why I allude to the challenges
31 in scoping demand, for instance.
32

33 Q. Is one part of responding to that challenge in health
34 services engaging in conversations with their communities
35 about the level of service that might be able to be
36 delivered and delivered safely in particular areas?

37 A. Indeed. And the method of that service delivery, and
38 I'm alluding to the need to staff some emergency department
39 in our district hospitals and in our areas with virtual
40 emergency services, and the challenge for some of our rural
41 residents around that access and, as you said, the
42 conversations with the community about what is acceptable,
43 affordable and available access.
44

45 Q. Dealing with that example that you raised, do you
46 think there could be improvements as to how those
47 conversations are had at the moment?

1 A. I welcome those conversations. They're difficult
2 conversations. And, you know, I'm someone who has grown up
3 in a medical system where I was taught about humanity in
4 health and the laying on of hands. And I think that there
5 are also generational differences in the acceptability of
6 some of the care options that are on the table in rural New
7 South Wales. And I think those conversations are relevant,
8 but I do understand that they're difficult.

9

10 Q. Difficult conversations but important ones
11 nonetheless?

12 A. Yes.

13

14 Q. And important to engage in regularly?

15 A. And to be transparent about those conversations.

16

17 Q. What do you mean --

18 A. That they are trade-offs and, you know, that what's at
19 play in having - you know, in those decisions.

20

21 Q. By trade-offs, tell me if this is an example of
22 something you had in mind; that perhaps there is an
23 emergency department at a small rural facility that does
24 not see a high volume of patients both as to number and
25 acuity but, if that funding was diverted to dialysis
26 chairs, the needs of the community might be able to be
27 better met in a safe way; is that what you have in mind,
28 something like that?

29 A. That's exactly what I had in mind and it's that
30 transparency about that trade-off and that trade-off being
31 visible.

32

33 Q. We've heard in other hearings that the rural
34 population doesn't necessarily expect everything to be on
35 their doorstep and they accept some of the limitations. Is
36 that also your perception?

37 A. That is absolutely correct. So when I'm in Moree they
38 don't say to me, "Why haven't I got a cancer centre in
39 Moree, you know, and a PET scanner." There is an absolute
40 understanding that some of these services do need to be
41 centrally or regionally delivered. What I think consumers
42 want is access to adequate and reasonable health care
43 commensurate with the health needs of the community. So
44 those residents in Moree are delighted because they've got
45 a chemotherapy service that's working out of that
46 particular town. So their sick patients don't need to go
47 regionally; they can be managed locally. So it's that sort

1 of conversation that leads to outcomes that are clear and
2 obvious to the community.

3
4 Q. Can I take you now to the National Medical Workforce
5 Strategy. If you have a hard copy there, Professor?

6 A. I do. Well, I've got some of it, yes.

7
8 Q. All right. I'll have it brought up on the screen.
9 It's previously been tendered as exhibit H26 but it's also
10 attachment D, I think it is, to the professor's statement.

11
12 And, Professor, you were the co-chair of the Medical
13 Workforce Reform Advisory Committee that was involved in
14 the preparation of this strategy; correct?

15 A. Correct. I was just about to tell you that, so that
16 I have a very significant interest in this document.

17
18 Q. All right.

19 A. And I have been involved closely in its development.

20
21 Q. I don't need to ask you whether you're familiar with
22 it then. That role of co-chair was because you were the
23 representative of the National Rural Health Alliance on
24 that committee; is that right?

25 A. Correct.

26
27 Q. Can you just tell us a little bit about the alliance?

28 A. So the alliance is a fascinating organisation. It's
29 an alliance of up to about 40 organisations whose member
30 bodies have significant interests in rural and remote
31 health. It ranges between professional organisations, and
32 I was the Rural Doctors of Australia representative on the
33 National Rural Health Alliance, but also involves
34 organisations that are involved in health but not directly.
35 So we've got the Isolated Parents Association, we've got
36 the CWA, we've also got provider organisations such as
37 RFDS, Frontier Nursing, and Aboriginal organisations such
38 as the national community controlled sector and
39 representatives of nursing, allied health and other bodies.

40
41 So the great thing about the National Rural Health
42 Alliance is that its interests are more sector issues, not
43 professional issues between, you know, doctors and
44 mid-wives or whatever, whatever; but there are things about
45 bringing the sector forward. So they've been very
46 interested over the years in the provision of broadband,
47 ubiquitous broadband, to rural areas because we know that

1 that's a precondition for the availability of health care,
2 particularly going forward, and involved in issues such as
3 trying to determine the minimal level of standard of health
4 service care that I've just mentioned. So those are the
5 sorts of very useful contributions that the National Rural
6 Health Alliance have been able to make to the rural sector.

7
8 Q. And there were a number of members of this committee,
9 weren't there, the Medical Workforce Reform Advisory
10 Committee?

11 A. No. So the Medical Workforce Advisory Committee is
12 made up of the jurisdictions, the universities, the
13 industrial organisations such as AMA doctors in training.
14 Now it's also - since it's been reformed as MWRAC, it's
15 also got quite a lot of worker type bodies on it and
16 nursing and midwifery and allied health representation.
17 But the national Medical Workforce Advisory Committee, when
18 I was co-chair, which was - I finished on 30 June 2024, our
19 major effort was to develop this strategy, and that was
20 done, as I said, because the players from across the sector
21 were at the table.

22
23 Q. Thank you. And, Commissioner, for your benefit,
24 there's a list of committee members on page 73.

25
26 THE COMMISSIONER: 73, yes.

27
28 MR GLOVER: In general terms, Professor, acknowledging
29 that this was a significant piece of work, can you just
30 describe the process that was engaged in to develop the
31 strategy?

32 A. So the process occurred over about three years.
33 Initially there was some scoping and there was a consultant
34 brought in to, I guess, scope what the issues were. An
35 issues paper was generated which then went out to the
36 sector broadly, and then came back. And, again, the
37 membership of MWRAC was absolutely key to the development
38 of the strategy because it does straddle the myriad of
39 organisations that have levers in our medical workforce
40 training and development.

41
42 And then as a result of the workforce strategy there
43 were some specific pieces of work also that occurred, one
44 being looking at the service registrar group, who are a
45 group in our medical workforce that was identified as not
46 being on anybody's radar, I guess, initially. So this is a
47 group of clinicians who haven't chosen any specialty

1 training pathway and who are working often in hospitals,
2 and often in private hospitals. And the concern was did
3 they have - were they a homogeneous group and what were
4 their likely long-term intentions or were they a group that
5 should be supported to, I guess, remain and stay as, if you
6 like, a hospitalist, stay with a career in a hospital that
7 didn't involve a vocational outcome. That's just an
8 example of one of the working groups that occurred. And it
9 came back and it was for revision by all members of MWRAC,
10 and then it was finally endorsed, I think, end of 2022.

11
12 Q. Yes. I'll come back to the service registrars in a
13 moment, but can I take you - you'll see in the bottom
14 corners of the pages there some page numbers, and if I go
15 to page (vi), which is the foreword by the then secretary
16 of the Commonwealth department. If you don't have it in
17 the hard copy, the operator will bring it on the screen.
18 A. Yes.

19
20 Q. Thank you. And, Operator, if we scroll down a little
21 because the passage I want to take the professor to extends
22 over the page. So keep going. Yes. Just there. Thank
23 you.

24
25 Professor, can I invite you to read the paragraph
26 starting, "Implementation of this strategy" just to
27 yourself and let me know when you've done that.

28 A. Yes.

29
30 Q. These are the words of the then secretary, but do
31 I take it you agree with the concepts that he's describing
32 there?

33 A. Absolutely.

34
35 Q. And do you see in the last line on (vi):

36
37 *In particular, specialist trainee numbers*
38 *can no longer be primarily driven by*
39 *clinical service requirements for*
40 *registrars that dominant many current care*
41 *models.*

42
43 Do you see that?

44 A. Yes.

45
46 Q. Do you understand the concept to which he was
47 referring there?

1 A. I do. He was really referring to the increase in
2 annual compound growth in some of the specialist training
3 numbers which is so much greater than that into our
4 generalism or our general practice training numbers.

5

6 Q. And is the concept that that growth is driven by the
7 need to fill positions as opposed to the need to deliver
8 that particular type of care to the community?

9 A. That is one of the drivers.

10

11 Q. Can I take you ahead in the strategy to page 20,
12 please. I want to take you to some parts of this page,
13 Professor, but if you just take a moment to refresh your
14 memory about it and let me know and, if you need more time
15 to read it, at any stage just let me know?

16 A. No, I'm happy for you to ask.

17

18 Q. All right. In a couple of your earlier answers you've
19 mentioned status of generalist practice, and on this page a
20 number of suggestions are made as to what medical
21 leadership can do to address some of those issues. Who
22 would you put in the category of medical leadership in this
23 context?

24 A. That is such a good question.

25

26 Q. I'm glad I got one out.

27 A. That's very challenging.

28

29 Q. For the transcript, the Commissioner gave me a thumbs
30 up.

31 A. Traditionally, I would say it's the industrial
32 organisations, it's the Australian Medical Associations,
33 it's probably, you know, Rural Doctors Association. So
34 I think they are certainly key to changing the culture.
35 But I have to say that I think leadership in hospitals and
36 in hospital networks also need to have that helicopter view
37 which is that the health system will benefit if we're
38 training more generalist doctors and generalist doctors
39 that will have roles and responsibilities outside the acute
40 health system. So, whilst I understand the need and the
41 preference for training in the acute sector and for the
42 acute sector, clearly we need to increase the status of
43 generalism and general practice if we are to better
44 distribute our population - our medical workforce.

45

46 Having said that, unfortunately it is the attitude of
47 our students and our junior doctors who have heard or taken

1 on some of that bias, I guess, towards subspecialty
2 training and hospital based training because of their
3 exposure or because it is a bias that we see significantly
4 in the medical community.

5
6 Q. Is there anything that the state and territory health
7 systems can do to overcome that perception and bias?

8 A. I believe so. I wonder - well, I'll just give you an
9 example. If you are a VM0 on a fee for service rate in a
10 hospital you're paid, I don't know, \$285 an hour or
11 whatever the going rate is. I'm not across because
12 I haven't claimed. The GP rate is somewhat lower. So,
13 I mean, you've got a message straight out there that a
14 consultant general practitioner is worth less than a
15 specialist practitioner. I would ask if they're doing a
16 job that is of significant benefit to the health system why
17 is there a difference.

18
19 Q. So what you have in mind is creating positions or
20 conditions that recognise the benefit of rural generalist
21 practitioners in those areas as a method of perhaps
22 overcoming some of that stigma; is that right?

23 A. Indeed, and levelling the playing field. And that
24 will not be lost on our medical students and junior
25 doctors.

26
27 Q. Is that because of a perception that rural generalism
28 or general practice is not a true specialty compared to
29 other subspecialties?

30 A. I guess so. It's certainly assumed to be less
31 valuable.

32
33 Q. On that page, the second dot point, do you see there:

34
35 *There is a stigma about medical practice in*
36 *rural and remote Australia.*

37
38 A. M'hmm.

39
40 Q. Is that something that you've observed?

41 A. Absolutely, and we have a term for it now. We call it
42 geographic narcissism.

43
44 Q. Again, is there anything that the state and territory
45 health systems can do to overcome that geographic
46 narcissism, in your view?

47 A. Absolutely. Absolutely. And it's the perception

1 that, if you work in the country, you mustn't have been
2 able to make it in the city. You know, I live in Tamworth.
3 Well, couldn't I get a job in the city? There is this - a
4 lot of it is not - like many sort of biases, it's not
5 malicious. It's not - it's just an assumption made that
6 the quality of the care or the service provision must be of
7 second grade or lesser than the opportunity in the city.

8
9 Now, in terms of opportunity, so say we take something
10 like lab based research, well, there's absolutely no doubt
11 that if you want to be involved in expensive and research
12 that requires large amounts of infrastructure that will not
13 be reproducible in anywhere outside a large metropolitan
14 centre. And so if that's the career of need then clearly
15 then the importance is that you locate and you champion
16 that career. What we've got to be careful of is that
17 inadvertently by general practice and generalism not being
18 seen in an acute facility that there's a necessary bias
19 that it's of lesser value.

20
21 Q. The third dot point on that page speaks of the need to
22 invest in understanding and championing cultural safety, in
23 particular in the context of growing the Aboriginal and
24 Torres Strait Islander workforce; do you see that?

25 A. I do.

26
27 Q. Is that a particular need in rural and regional
28 locations?

29 A. It is a particular need in rural and remote locations,
30 and it's a particularly challenging issue because, as we
31 have large numbers of international health graduates who
32 are also providing really required clinical services in
33 rural areas, they may not have worked in systems where the
34 cultural safety of our Aboriginal and Torres Strait
35 Islander patients hasn't been understood or privileged. So
36 I'm very keen that we continue to work to support
37 championing cultural safety, and that's why those words are
38 I think good words, and that requires significant
39 orientation and support to people in coming into health
40 system and I think also in coming into localities.

41
42 So cultural safety doesn't look the same in every
43 location, and it's being aware enough and checking yourself
44 to wonder whether you are practising in a culturally safe
45 way and whether you're checking yourself to see whether
46 your patients or the people that you're interacting with
47 are comfortable in the way that you are providing care.

1
2 Q. Can I take you ahead to page 28 of the strategy,
3 please.
4
5 THE COMMISSIONER: Is this a new topic?
6
7 MR GLOVER: Yes.
8
9 THE COMMISSIONER: Is it best to take the break now then?
10
11 MR GLOVER: Yes.
12
13 THE COMMISSIONER: Professor, we're going to have a short
14 morning break now. Don't feel as though you have to sit in
15 front of your computer screen, but could you be back in
16 front of it at 11.50?
17
18 THE WITNESS: Sure. Commissioner, how long after that is
19 it likely to go, because I'll just need to do some
20 organisation.
21
22 THE COMMISSIONER: I'll just ask Mr Glover that.
23
24 MR GLOVER: 20 minutes, thereabouts.
25
26 THE COMMISSIONER: 20 minutes. So let's say we should be
27 finished by 12.20.
28
29 THE WITNESS: Terrific. I'll be back at 11.50.
30
31 THE COMMISSIONER: Thank you. We'll see you at 11.50.
32 We'll adjourn until then. Thank you.
33
34 **SHORT ADJOURNMENT**
35
36 THE COMMISSIONER: We'll continue, thanks, Mr Glover.
37
38 MR GLOVER: Thank you, Commissioner. Professor, just
39 before we go back to the workforce strategy I just want to
40 go back to an answer you gave earlier, and I'm grateful to
41 my learned friend for drawing this to my attention. It's
42 transcript page 5122 and the Commissioner asked you a
43 question, and I'm just going to see if I can have that
44 brought up on the screen rather than me read text at you,
45 Professor. It might be easier.
46
47 THE COMMISSIONER: 5122, line?

1
2 MR GLOVER: Starting at line 18, Commissioner.

3
4 THE COMMISSIONER: Yes.

5
6 MR GLOVER: Bear with me, Professor, I'll just read it.
7 The Commissioner asked you a question:

8
9 *It's probably always been the case, hasn't*
10 *it, that a general practitioner that*
11 *practices in a regional and particularly in*
12 *a rural area is probably - he or she has*
13 *probably always been required to have a*
14 *more expansive scope of practice than a*
15 *city-based GP; correct?*

16
17 And then you answered:

18
19 *Correct. And I guess the acceptability and*
20 *the attractiveness of that skill set within*
21 *our medical workforce has reduced over*
22 *time.*

23
24 And this is the bit I want to draw to your attention:

25
26 *So the attraction of specialism over that*
27 *generalism has reduced over time.*

28
29 I think the effect of the rest of your evidence is that
30 it's the attractiveness of generalism that has reduced at
31 the expense of a greater tendency to drift towards
32 specialisation and subspecialisation; is that right?

33 A. That's correct. That's exactly what I meant.

34
35 Q. Thank you. If we go back to the workforce strategy
36 and to page 28, please. I'll just have it brought up on
37 the screen for you, Professor. This is priority one,
38 headline, to collaborate on planning and design. We've
39 touched on some of these concepts, but I just want to
40 approach it in a general way with you, if I can. Do I take
41 it that you would agree with the proposition that the
42 concepts set out in this priority, although pitched at a
43 national level, apply equally to local and state level
44 planning?

45 A. That's correct.

46
47 Q. And in planning for what your future workforce need

1 might be is an important part of that an assessment of what
2 your health care needs of your community both in the
3 immediate, medium and long-term part of that process?

4 A. I would agree.

5
6 Q. And is it building on that assessment that then one
7 can start to interrogate with a little bit more certainty,
8 accepting precise certainty or absolute certainty is not
9 possible, what your future workforce demand might be both
10 as to numbers and, importantly, location?

11 A. Yes.

12
13 Q. And do you think there are improvements that can be
14 made in the system as it stands at the moment to achieve
15 that goal?

16 A. I do. Workforce planning - because, as mentioned, the
17 number of players in our health system, and we haven't even
18 talked about our private health system, as well as our
19 public health system, as well as our community - so the
20 variety of funding into that system, clearly there is no
21 single source of data and particularly around workforce
22 numbers that has been satisfactory to plan on by any
23 individual entity.

24
25 So the whole concept of developing a national medical
26 workforce data strategy is to enhance the collaboration
27 between particularly jurisdictions, the Commonwealth and
28 colleges, who each hold datasets that would inform that
29 workforce planning. So what we find is that if we count
30 things through the Commonwealth using MBS or the national
31 workforce dataset we'll come up with the number A. If we
32 add in the acute care sector we'll come up with part B.
33 And then when we go to the specialist colleges we'll find
34 parts C and D.

35
36 So this is a plea to collaboration on that workforce
37 planning and agreement with, I'd like to say, a data
38 dictionary of what things mean. So, as you've seen in the
39 GP demand and supply, agreed definitions about full-time
40 equivalents, about head counts and about, you know, per
41 population ratios, there are multiple ways in which we
42 don't necessarily count things the same way.

43
44 Q. And in developing any workforce plan or strategy would
45 you agree that in inputting the data that data and needs
46 analysis should be driven by local level up rather than
47 system level down?

1 A. Absolutely.

2

3 Q. Because --

4 A. And that is not a feature of the system as we
5 currently see it operating.

6

7 Q. And is there any consequence, to your mind, of the
8 system not operating in that way at the moment?

9 A. So the significant consequence is that we struggle to
10 understand the impacts of our current distribution
11 challenge and in that we - and, as I've mentioned, the
12 impact of our distribution challenge is somewhat greater
13 rurally because of the sparsity of practitioners and
14 alternate entities. We also struggle to have a good
15 rationale for our planning if our data is inaccurate and
16 it's not linked up.

17

18 Q. And is one feature of a system down type approach that
19 one can look at the system and say, "We need 36 more
20 general surgeons between now and 2034," but that doesn't
21 ultimately give one a clear path to plan for the workforce
22 needs across the jurisdiction, that is where are those
23 surgeons required and when and to meet what need?

24

A. Absolutely.

25

26 Q. And as part of a workforce plan driven from the bottom
27 up would that include such things as planning for training
28 places, whether recent graduates or those on specialist
29 pathways?

30

A. It would, and it requires that local knowledge to make
31 that accurate because we have a propensity of pathways and
32 systems that may be contributing to that workforce that are
33 not visible at a jurisdictional or a national level.

34

35 Q. So local knowledge of the need for clinicians,
36 including specialist clinicians, planning for that against
37 the needs of the community in the short, medium and
38 long-term; correct?

39

A. Would be highly valued. I think there will be
40 discussion about whether that's at an SA3 or an SA4 level
41 or at a modified Monash. So there may be some important
42 considerations about how local that is, and I draw your
43 attention to particularly the specialist catchment concept.
44 So currently obviously if you have an ophthalmologist in
45 Tamworth they will service patients from Moree. So
46 actually in terms of workforce planning if that's the
47 model, and I'm suggesting to you that hub and spoke for

1 specialist delivery of services is often the right model
2 because there is not the work or the infrastructure outside
3 regional centres in our smaller centres, but if we take
4 that as a model then we probably need to look at catchment
5 planning that probably is an SA4 level as opposed to an
6 SA3. And certainly those debates are, you know, live with
7 the difficulty of what is local and what is, I guess,
8 regional or catchment.

9
10 Q. Can I take you to page 79 of the strategy as
11 illustrating that concept perhaps. This is appendix D.

12 A. Yes.

13
14 Q. Which summarises in table form the particular
15 specialties and their capacity to both practice and train
16 at various modified Monash levels?

17 A. Correct.

18
19 Q. That's the type of issue that you're speaking of?

20 A. That's exactly the type of issue, and that particular
21 document has formed the basis of some of the discussions
22 being had about how we - and you would be potentially aware
23 that there's been a recent review into our classifications,
24 and this particular document has been utilised for
25 consideration about how we might think about distribution
26 priority areas or districts of workforce shortage and where
27 we would be incentivising international health graduates to
28 go based on scope of practice and location.

29
30 Q. So if we use about three-quarters of the way down the
31 page under "Physician, paediatrician, cardiology" as an
32 example, there the table suggests that cardiologists can
33 both practice to their full scope and train at modified
34 Monash 2 and 3, but under the system that you're envisaging
35 they would then provide services out to modified Monash 4
36 plus areas from that regional centre?

37 A. Correct. And therefore the assessment of the need
38 needs to be based on the catchment.

39
40 Q. The catchment being the catchment from that regional
41 centre from where the clinician will practice?

42 A. Correct.

43
44 Q. Can I go back in the strategy to page 29, please,
45 Operator, and the foot of the page. Do you see there,
46 Professor:

47

1 Where applicable, local level workforce
2 planning must be co-designed with the local
3 Aboriginal and Torres Strait Islander
4 community, local government and the
5 Aboriginal and Torres Strait Islander
6 Community Controlled Health Sector.

7
8 Do you see that?

9 A. I do.

10
11 Q. Do you have a view as to why it's important that that
12 local level planning involve, firstly, the Indigenous
13 community and the ACCHO sector?

14 A. It goes back to my comments about what is the access
15 that we're attempting to provide and it's about the
16 accessibility and availability of that access. So, unless
17 that workplace plan is co-designed with Aboriginal and
18 Torres Strait Islander community, we may have physical
19 access but we may not have honest acceptability or
20 availability, and it's that nuancing and that understanding
21 of what the access that we're attempting to provide that is
22 intrinsic in a shared planning framework.

23
24 Q. What about local government? That's referred to in
25 that paragraph too.

26 A. So local government remains extraordinarily important
27 in practice in the provision of health services, but there
28 is an understandable debate about how much of the local
29 government budget should be partitioned towards health
30 service delivery and whether that is a local or a regional
31 responsibility.

32
33 THE COMMISSIONER: It's not in the Local Government Act,
34 is it, anything about providing health care?

35
36 MR GLOVER: Not specifically.

37
38 THE COMMISSIONER: No.

39
40 MR GLOVER: And I think, Professor, you're referring to
41 the debate that some local councils would step into the
42 breach, as it were, to support and fund the delivery of
43 healthcare services, others would take the view that that's
44 not a matter for them or their rate and other grant
45 revenue?

46 A. Correct.

47

1 Q. Can we go ahead to page 33, please. This is the
2 priority two to rebalance supply and distribution. We
3 touched on some of this earlier, but the imbalance is seen
4 in a number of ways. The maldistribution of clinicians
5 between metro and rural areas; correct?

6 A. Correct.

7

8 Q. And between generalist and specialist clinicians;
9 correct?

10 A. M'hmm.

11

12 Q. Do you have a view about the benefits to the system as
13 a whole if that imbalance could be ameliorated?

14 A. It's a forward-thinking benefit as opposed to
15 necessarily the present. As I said, I think right at the
16 moment we're still managing because we have a system where
17 we do have a reasonable number of generalists in our
18 workforce, particularly in our regional centres. And
19 I think it's thinking forward as to how that imbalance may
20 become worse and the impacts on the efficiency and the cost
21 of care if we end up with a mainly sub-specialised
22 workforce, particularly in our regional centres.

23

24 Q. What you're describing there is a concept that the
25 benefits of change and reform might not be seen in the near
26 term but are necessary to produce the health system that
27 the community will need into the future?

28 A. Indeed, and at a cost and a complexity that the
29 community would want as opposed to an increase in both of
30 those.

31

32 Q. Can we go ahead to page 41, please, and this is part
33 of the strategy that addresses the service registrar
34 medical workforce that you touched on earlier. Service
35 registrars are sometimes referred to as unaccredited
36 registrars or career medical officers perhaps; is that
37 right?

38 A. Yes, that's right, or hospital registrars.

39

40 Q. Are they an important part of the delivery of
41 healthcare services in hospitals?

42 A. Increasingly. The data that I shared at some point,
43 and I'll just report it from the medical student outcome
44 database, showed in one particular cohort that at
45 postgraduate year 13 20 per cent of our medical workforce
46 did not have a vocational training outcome. That means
47 that they weren't - they hadn't fulfilled the criteria for

1 a specialty training program or a general practice training
2 program. Now, that's quite a large component of our
3 workforce. Now, clearly that component are not all of
4 the same, and the specialist registrar working group
5 identified three particular groups within that group, and
6 I think it's important that I just give you some detail
7 about that --

8
9 Q. Please do.

10 A. -- because rather than thinking that this is just a
11 large number of trainees who are sitting in our acute
12 hospitals, both public and private, who are all the same.
13 So what we see is that there's a group of those
14 unaccredited registrars who are in the system with the
15 plans of getting on their training program of choice. But,
16 as we know, some of those training programs are very highly
17 competitive and it may take them up to 10 years to get on
18 to that program. So there's one group who are working in
19 the system in an unaccredited position, gaining experience
20 and building their CVs or hoping that they will get on
21 their training program of choice.

22
23 The second group are a group who are in the system but
24 perhaps are undecided about their future; so not sure
25 whether they want to undertake a specialist training
26 program and are not unhappy to be sitting in the system
27 with a job but with no clear vocational path currently
28 ahead of them.

29
30 And the third group are those that have decided for a
31 variety of reasons that a hospitalist based practice or a
32 career medical officer based practice is suitable for them
33 as a longish-term strategy. And it's for those registrars
34 in particular that I think we need to understand that if
35 they remain an important part of the system they need
36 better support.

37
38 One of the things that has come in more recently is
39 the provision of continuing professional development for
40 all medical practitioners, not just those who have attained
41 fellowship. So these registrars will now be subject to
42 continuing professional development, which I think is a
43 very positive sign to assisting them on a pathway either to
44 a scope of practice and an agreed set of jobs within an
45 acute hospital framework or on a training program or with a
46 scope of practice that is somewhat different.

47

1 So we've got a large number of doctors in this group.
2 This group also represents a lot of our locum population in
3 our junior medical officer or non-vocationally trained
4 locum pool, which is increasingly being utilised with our
5 distributional challenges. Many of them will choose, as
6 I said, to stay in this pool because, as I said, there is
7 no clear training pathway of choice and, if I'm honest,
8 locum rates and the capacity to be involved at your own
9 level within this hospital, you know, dictate your own
10 hours or identify contracts that suit is very - is quite
11 appealing to some of our junior medical officers.
12

13 Q. And doctors in this cohort are a necessary part of
14 hospital services to deliver the type of 24/7 care that is
15 expected by communities, both metro and rurally; correct?

16 A. Correct. Absolutely correct.
17

18 Q. And from the answer that you gave earlier do we take
19 it that you would see this cohort as being one which could
20 be the target of measures to promote generalist positions,
21 both inside and outside of hospital settings?

22 A. Yes. Well, we have a group of doctors who have not
23 decided on a training pathway. So, to me, that is an
24 opportunity to look at generalist training pathways. And
25 where they are situated in non-metropolitan areas surely
26 they also, if provided with opportunity, may choose to
27 embark on a training pathway that prior to this they did
28 not feel that they were able to apply for.
29

30 Q. Provided with opportunity and the recognition of
31 the kind that we spoke of earlier --

32 A. Indeed.
33

34 Q. -- be it particular position description and also
35 conditions; correct?

36 A. A first-class training pathway.
37

38 Q. Finally, Professor, could I take you ahead to page 48
39 of the strategy. We've touched on a lot of these concepts
40 about training, but I just wanted to explore with you at
41 the very foot of page 48 - we've spoken in detail about
42 rural origin, but in the last sentence of that paragraph
43 the strategy says:
44

45 *Changes are needed to enable students who*
46 *have an interest in rural practice to have*
47 *a positive rural experience in PGY1 and*

1 *PGY2, and then continue most of their*
2 *vocational training in rural areas.*

3

4 We've spoken about the PGPPP and the John Flynn type
5 approach. Was there anything else, other changes or
6 strategies, that you see to support that initiative?

7 A. The most important part of that is that last sentence
8 about continuing most of their vocational training in rural
9 areas. So if I can take my current location in Tamworth.
10 You can train for rural general practice after PGY3 and
11 above here. You can do quite a lot of your emergency
12 medicine training here. But for most of the other
13 specialties you will need to network and move away with the
14 intent of perhaps being able to select some of your
15 training being allocated back to Tamworth.

16

17 So if you were choosing a - you know, you had a
18 location, you were connected to this area, then the only
19 career options that you can do from a regional centre are
20 general practice and emergency medicine. If you have an
21 interest in training in most of the other specialties you
22 would need to be planning on leaving, moving away and then
23 rotating back when possible.

24

25 That's the gap that I see. If we are motivated to and
26 we regard vocational training in place as an important
27 predictor of rural return, and we're interested in making
28 sure that we populate our regional centres as hub-and-spoke
29 models for specialty training and providing support to a
30 catchment, then to me we need to be incentivising and
31 supporting that vocational training occurring in regional
32 centres.

33

34 Q. And, as we've discussed, it's an important part of a
35 future workforce plan to meet the needs of the community
36 into the future?

37

38

39 MR GLOVER: Thank you, Professor. I have no further
40 questions, Commissioner.

41

42 THE COMMISSIONER: Just for the benefit of the transcript,
43 the PGPPP we've been referring to is prevocational general
44 practice placement program.

45

46

47

Mr Cheney, do you have any questions?

1 MR CHENEY: No, Commissioner.
2
3 THE COMMISSIONER: Professor, thank you very much for your
4 time. We're very grateful. And all the best for the new
5 position.
6
7 THE WITNESS: Thank you very much, Commissioner, and it's
8 been an honour to present. Thank you.
9
10 THE COMMISSIONER: Okay. Thank you very much. You're
11 excused.
12
13 <THE WITNESS WITHDREW
14
15 THE COMMISSIONER: So we adjourn until what date?
16
17 MR GLOVER: 17 September.
18
19 THE COMMISSIONER: Tuesday, the 17th.
20
21 **AT 12.16PM THE SPECIAL COMMISSION OF INQUIRY WAS ADJOURNED**
22 **TO TUESDAY, 17 SEPTEMBER 2024**
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