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

THE COMMISSIONER: Good morning.

PROFESSOR MAY: Good morning.

MR GLOVER: Thank you, Commissioner, we convene this morning to take some evidence from Professor Jennifer May, who, as you will have now observed, is on the screen and ready to go.

<JENNIFER ANN MAY, SWORN [10.02 am]

<EXAMINATION BY MR GLOVER

THE COMMISSIONER: Thank you, Mr Glover.

MR GLOVER: Professor May, can you see and hear me okay?
A. I can't see you. I can see the Commissioner, but I can't see you. But I can hear you well.

Q. All right. Well --

THE COMMISSIONER: It's probably better off that way.

MR GLOVER: -- it's probably for your benefit that way, yes. I think the Commissioner beat me to it.
A. Right, now I've got you.

THE COMMISSIONER: I'm kidding, but - yes.

MR GLOVER: I'm not. To the extent at any stage you can't hear me or the connection breaks up, just let us know; okay?
A. Thank you.

Q. Can you tell us your full name, please?
A. Jennifer Ann May, M-a-y.

Q. And you're currently the director of rural health at the University of Newcastle; is that right?
A. I am. I live in Tamworth, northern New South Wales.

Q. Thank you. To assist the Commission in its work, yesterday you made a statement; correct?
A. I did. Correct.

Q. For the benefit of the transcript, it's [SCI.0011.0384.0001]. Now, if I take you to paragraph 28

of your statement. I understand there's a correction that you would wish to make in relation to the document described as annexure E; is that right?
A. Correct.

Q. What I'll do is I'll have the operator bring up on the screen [SCI.0011.0393.0001], and hopefully in a moment, Professor May, on your screen will appear a document. Can you see that document?
A. It has, yes.

Q. And is that the document that should be annexure E?
A. Yes.

Q. Rather than the one that was originally attached to your statement; is that right?
A. Correct. That's the document alluded to in that paragraph. Thank you.

Q. And, other than that correction, is your statement true and correct to the best of your knowledge and belief?
A. To the best of my knowledge.

THE COMMISSIONER: Does that mean I've got the wrong annexure E?

MR GLOVER: Yes. The effect of that, Commissioner, is that the annexure E that was originally attached has been substituted for the document on the screen, and I'll hand you a copy of the correct one for your exhibit.

THE COMMISSIONER: Thanks.

MR GLOVER: Commissioner, given that we only have a few documents this morning, I tender the statement and the annexures now. I'm told we are at exhibit M1.

THE COMMISSIONER: The folder I've got has gone up to exhibit E.

MR GLOVER: Yes.

THE COMMISSIONER: Then there's some other documents.

MR GLOVER: Yes, those documents --

THE COMMISSIONER: No, annexure F, sorry. Annexure F.

MR GLOVER: It should go to G.

THE COMMISSIONER: G. Then there's a supply and demand study for general practitioners.

MR GLOVER: Yes. That's not annexed to the statement, but I'll be taking the Professor to it shortly.

THE COMMISSIONER: Right. Okay. So is that part of the tender?

MR GLOVER: It will be, yes, but separately from the statement.

THE COMMISSIONER: Got it. Okay. Thanks.

MR GLOVER: So I tender the statement and annexures now, and I'm told that it should be marked exhibit M1.

THE COMMISSIONER: And the "Supply and demand study, general practitioners in Australia, August 2024" will get a separate exhibit number.

MR GLOVER: And, if convenient, I'll do it now as M2.

Q. Professor, you've got a copy of your statement there with you?
A. I do.

Q. All right. And I'll start with paragraph - before I do that, in paragraph 3 you tell us that you oversee the rural health multidisciplinary training program?
A. Correct.

Q. Can you tell us a little bit about that program? What does it involve?
A. Indeed. It's a Commonwealth-funded program that works through education. So it's a grant program that is given to universities by the Commonwealth Department of Health, and it is to - I call it the gain, train, retain program, but its specific intent is to affirmatively support rural recruitment and return of health professionals. But it does it through supporting university education and training, and the development of infrastructure in rural areas to support high-quality delivery of services.

Q. So, in terms of it being directed to rural recruitment and return of health professionals, what sort of initiatives does your program implement with that funding to achieve that aim?
A. So as part of the Commonwealth KPIs of that program we are asked and we happily ensure that up to 30 per cent of the entrants into the joint medical program run by UON and UNE are of rural origin. So one of the things we know is predictive of rural return is rural origin. So there's a 30 per cent target there. But the majority of our program is focused on I guess incentivising and affirming rural training. So positive rural exposure of more than 12 months is a greater predictor of rural return. The longer, probably the better, although the evidence around more than two years is probably less clear at this point.

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

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

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

The current health workforce, particularly the general practitioner workforce, is challenged to meet the needs of the New South Wales population having regard to current distribution patterns, population growth and increasing service demand.

Do you see that?

A. I do.

Q. Can you just describe in general terms what those challenges are as you see it?
A. So - and I think the GP supply and demand study also alluded to this - what we see is insufficient inflows into general practitioner training. We see some changing demographics and workforce preferences, we see a reduction in the number of hours, and we see demand for services going faster than population growth.

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

Q. And is this a trend that you have observed over a relatively long period of time or has it accelerated in recent years?
A. So it's a trend that's been observed over probably 40 years. There's evidence going back to 1987 of a reduction in the proportion of general practitioners versus other non-GP specialists being trained in our system. So these are long-term trends, and they're not even just Australian trends. These are international trends. So the move away from generalism and towards specialism has been longstanding.

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

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

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

expansive scope of practice than a city-based GP; correct?
A. Correct.

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

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

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

Q. Yes.

MR GLOVER: Can I take you brief --

THE COMMISSIONER: And by dint of the population size you're well known in the area?
A. And I do allude to that in my statement, and that is one of the challenges in recruitment and retention, is the drawing of professional and personal boundaries, and obviously people differ in their comfort and often in their life stages as to how well they can tolerate or would want the sort of exposure that one necessarily gets.

Q. Yes.

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

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

significantly underdone.

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

Q. Yes.
A. -- we can't - you know, there are real challenges in --

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

Q. Okay. Thank you.

MR GLOVER: So is the effect of that exchange, Professor, that you have some concern that the assessment of need might not - might underrepresent actual need within the community?
A. Correct.

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

Q. On page 5 and 6 there is some detail concerning the models used, and if one looks about halfway down the page of page 5, the demand modules --
A. So this links to the Commissioner's concern about the chronic disease and health service utilisation, which are assumptions that they have tried to make in this modelling, and, as I said, I would regard them as fraught. The question is: is there a better question or a better way of doing it? And certainly demand modelling - most people are very uncomfortable about demand modelling. Far easier to demand, supply or actual. But trying to model demand particularly in the view of technological change, which may - whilst making health service delivery more efficient, technological change is offering us so many greater options for the way we manage many of our illnesses or injuries, and I do stroke prevention as a good example. We are now

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

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

THE COMMISSIONER: I imagine - I mean, I'm not for a moment suggesting this report isn't useful, but if you were determined to produce a study about what might be needed to - what might be needed in terms of the GP workforce primary care health services to reduce the rates of chronic disease and the length of time that the population suffers from chronic disease, that would be a massive undertaking to do that work, wouldn't it? It wouldn't be - it would be a really long-term, difficult job with a huge amount of time spent on the methodology that was going to be used and the modelling that was going to be used?
A. Absolutely. And I guess it also goes to some of the assumptions around access.

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

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

then you've got to do the big, difficult study to work out exactly how that would best be targeted and exactly what levels of GP/primary care are likely to be needed to in 30 years time or 20 years time find out you have reduced the rates of chronic disease and thereby prevented people going to hospital and thereby reduced the growth in the health spend?
A. Yes, I affirm that, Commissioner. Absolutely.

Q. Okay.

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

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

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

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

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

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

Q. So the number of practitioners to close that gap would be - it would be reasonable to assume a lot or - I'll withdraw that and start again. On that basis it would be reasonable to assume that the number of practitioners required to close the 230 FTE gap as it stands at the moment would be higher than 230 clinicians; correct?
A. Indeed. I would qualify that, and there is a qualification in this document that talks about a difference between Australian-trained medical graduates and their FTE and international medical graduates who come into New South Wales on an obligatory pathway where their visa dictates them being in a non-metropolitan area for a period of time, and what we see is that those practitioners, and understandably, will have a higher FTE while they're in their obligated practice.

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

THE COMMISSIONER: Thanks.

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

Q. Do you have a view about the effect on the healthcare system as a whole if that gap eventuates as predicted?
A. I expect that our models of primary care delivery will need to change in order to make that figure, you know, not the case. It is inconceivable to think that the system could work well with an undersupply of 2300 FTE by 2048, but it is my observation that there are a number of changes occurring which will change the scope of practice and the balance of activity within primary care that will need to go some way to alleviating that sort of shortage.

Q. What are those changes that you're observing?
A. So currently there's a scope of practice review under way with the Commonwealth government where allied health professionals - well, scopes of practice are being revisited to understand where there are complementary scopes of practice or where primary care responsibility can be shared and collaborated on across the health care team. So there's a focus on multidisciplinary care. So one would

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

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

Q. By distribution do you mean the maldistribution of clinicians of all kinds --
A. Correct.

Q. -- heavily weighted towards metropolitan areas?
A. That's exactly what I mean.

Q. Although you have some reservations about how far it will go, do we understand you, though, to be of the view that having clinicians operate to the top of their scope of practice wherever possible is one mechanism that may alleviate some of the workforce challenges posed by maldistribution?
A. I do, and that includes getting our rural GPs working to the top of their scope and rural generalism and the increased focus on training for rural generalism, and that is extra scopes of practice - well, expanded scopes of practice with obstetrics, anaesthetics, mental health, paediatrics as well as a baseline in emergency is required in order to deliver those services in a distributed capacity.

THE COMMISSIONER: That scope of practice review I think you've just touched on might not just recommend clinicians working to the full scope of their practice but it might recommend an expanded scope of practice for people with skills that - where they could have an expanded scope of practice with some change of legislation, for example?
A. Yes, I think that's a likely outcome.

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

it's possible, a greater utilisation of virtual medicine, virtual consultations, could that be a means of bridging this gap between supply and demand?
A. Somewhat. But the thing that --

Q. Not as a complete answer, but as an aid?
A. Absolutely, and virtual care is already an important part of health care delivery in rural and remote, and I think it's - the way the models evolve it will have an even greater role. What we've got to do is also when we're thinking about these projections, in 2048 what is the technological capacity going to be of our system? What will health care look like? You know, I wonder whether we will be interacting with a virtual care, artificially intelligent assistant who will be monitoring by wearables our various health --

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

Q. It's funny you should say that. I was talking to the team the other day. I've just read a book called "The patient will see you now" by someone called I think it's Topol, a cardiologist in America. It was published in 2015, but it sort of predicts what you were just talking about, the virtual assistant for your health care would be widely available by now, which we're not quite there, I don't think, although we can wear rings and watches that monitor various of our - our heart rates and those sorts of things and our sleep. But that book is very much predicting the sort of virtual assistant particularly for monitoring a chronic condition and all sorts of solutions that you were just talking about. Have you come across that book yourself?
A. I have not, and I will - I'll seek to find it. I'm very interested in making sure that we're open to the way health care is going to go, and unless - and I guess my personal concern is and my focus is on equity. I think these changes will be fabulous for rural and remote citizens. But in order for them to have access we will need ubiquitous broadband, and we will need the co-design or the influence of people who live in rural communities. But it's coming, and we - you know, 2048, general practice is going to look a lot different.

Q. Yes, yes.

MR GLOVER: Consideration of expansion of scope of practice or in providing environments where clinicians can operate to the top of scope of practice apply equally across other specialists as well in addition to GPs, do they not?
A. Absolutely. And the changes will be as rapid in non-GP specialist practice as specialist practice, and that's what I was alluding to. I think you'll find this absolute explosion in opportunities for different treatments, for much more detailed - individually detailed, genomically profiled treatments, and that will - so we have to accommodate it as we're looking forward in this health system to see how access will be organised to what are going to be highly specialised scopes of practice.

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

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

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

Q. Why is it important to build the general clinician capacity within hospitals, in your view?
A. So, just as I've alluded to, in regional centres subspecialty practice is challenging. Because being on

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

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

Q. Is there also a need to build a generalist clinician workforce within metropolitan hospitals?
A. Well, I believe so, and I believe so on the basis of efficiency. So my question is generalists can manage probability and manage uncertainty, whereas the more specialist you are the more filtered, if you like, your patients need to be and the lesser capacity to manage across the continuum and particularly with patients with multi-morbidity or chronic and multiple problems.

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

Q. Can I take you back to your statement, please, and to paragraph 30.
A. Yes.

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

and primary care to reduce unnecessary usage of acute facilities, and then in the next sentence you tell us recent collaborations around urgent care would appear useful in this shared approach. What are the collaborations that you're referring to, firstly?
A. So the urgent care program announced - there was two urgent care programs announced, one through the Commonwealth and one through the state jurisdiction. Now, I guess this is one of the first initiatives that talks about shared responsibility or shared concern about timely access. So I guess it's a recognition that there has been an increase in waiting time and patients visiting emergency departments, and I guess this to me represented an effort to consider access from the patient's point of view and try and find a way forward.

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

Q. And do you see scope for further collaboration on that issue?
A. I do. I think there are some preconditions which are around data sharing and I guess the building of trust between the two sectors to ensure that it's patient centred and that it's relatively seamless. We could face an issue where with notes not being shared there was extensive duplication, and that feedback and that - yes, feedback to primary care from specialty care I think needs to be enhanced in order for these models to move forward.

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

Q. Just in practice how might that work?
A. So the concept that you could second an employee of New South Wales Health, perhaps someone skilled with chronic disease management or interested in supporting a chronic disease program that has a preventive focus, those

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

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

Q. And do you see initiatives like that as being one lever that might be pulled to ensure the community has access to the type of care they need within the community, firstly?
A. I do, and I would welcome such initiatives. It is of concern to me that, without that consideration of the health system as a whole, presentations to acute facilities may continue to rise.

Q. You've anticipated the next part of my question. Do you see that as having a positive effect on keeping people out of emergency departments who may not need to be there?
A. I do, and I welcome - so if I think about what works well in rural and regional, and I'll go to small rural because I think that's probably a better - the earlier you can intervene and the more seamless your intervention, and particularly if there is continuity of care or continuity of management, then I think the outcomes are better. So if we can link up those initiatives particularly around prevention then I do believe that that will work to the patient's benefit and I do think that will avoid hospitalisations in the long run.

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

To support the system, training needs to occur outside acute hospitals to ensure that we are training the whole workforce we need.

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

on or had terms like that and were positively disposed.

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

THE COMMISSIONER: The PGPPP has come up or has been mentioned in some of our various regional site travels. What did it stand for again?
A. Post - can't remember.

Q. Take that on notice.
A. I'll get back to you. Prevocational --

Q. We'll find out. Don't worry.
A. Prevocational general practice training program, I think.

Q. What did it involve again? What was --
A. So it was a 10-week term rotation into general practice.

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

Q. And it has been spoken of - well, the only time it's come up, the person talking about it has spoken about it in positive terms. When I asked - in terms of its benefit. When I've asked why did it end I think I was told it ended when a government ended and new government came in. Was there any more to it than that as to why it ended?
A. I'm not aware of exactly why it ended. I think programs such as that are expensive --

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

Q. It sounded like it simply was a program that it didn't end because it wasn't thought to be working; it ended because the new government thought things had to be cut and that was one of the things they cut?
A. I think there may have been a fiscal weighing up, yes.

Q. Yes. Okay. Thank you.

MR GLOVER: Do I take it from your experience and understanding of that program, though, it was a beneficial one to attracting clinicians to rural generalist practice?
A. Nearly - a large proportion of the GPs that I speak to who are now, you know, 10 years into practice, they will speak of that program being quite pivotal in their decision to undertake general practice training.

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

MR GLOVER: I won't say anything to that.
A. But I guess, Commissioner - I need to be careful - not one particular - one initiative is going to fix this.

THE COMMISSIONER: No, of course not.
A. We've got a status issue for primary care and generalism versus specialism that I've alluded to, we've got a lack of exposure to community settings in some of our university courses, and certainly in our postgraduate training in hospitals, and we've got some salary and remuneration issues, and we've got this whole thing about generalism manages uncertainty and probability, and it's a bit more messy, whereas specialty training, once you've actually, you know, affirmed and got some really high-level fabulous skills, you are in a position not to have to, you know, accept some of the messiness that general practice and deep-end general practice can have.

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

might in the long term, given we're talking about health care, actually far exceed the cost. Who knows?
A. Look, and to me --

Q. You won't know if you cut it, that's for sure.
A. Positive exposure is the key thing.

Q. Yes.
A. So the exposure's got to be positive because it's got to entice. But my second point is, just in terms of medical training, understanding the environment of general practice and primary care, even if you end up in a specialist training career, has to be beneficial that you understand how the system works and you understand what it is that the patients, you know, experience in the primary care environment.

Q. Can I ask you this about the PGPPP - whatever quite that means; we'll find out. Has it been replaced, in your opinion, by a better program for exposing medical trainees to general practice and in particular general practice in, say, the regions?
A. So the John Flynn junior doctor prevocational training program, or whatever its acronym is, has certainly been beneficial from my perspective as someone who has been involved in setting up some of those terms. But clearly we've selected --

Q. It's a similar thing with a different name, is it, or?
A. I would think so.

Q. Yes.
A. So I feel that this is a really important program. It's not at the same scale that PGPPP was.

Q. I see. Right.
A. So it's not as available.

Q. Yes.
A. But, again, anecdotally I hear very positive reports of the exposure, and from my point of view, as I said, people need to walk the walk and understand the environment that they may be choosing to train for.

Q. Sure.

MR GLOVER: Considerations of that kind also apply to

training of specialist clinicians, do they not?
A. Correct, and that's why in I think it's section 16 I'm drawing your attention to the importance if we understand the need for having a distributed specialist workforce, non-GP specialist workforce, and I suggest that their presence in our regional centres is imperative to the working of the New South Wales health system, that we need to train people in those environments with a specific understanding that that positive exposure again is likely to be our major recruiter and our succession planner into clinicians able to manage those roles.

Q. What needs to be done, in your view, to get to that stage?
A. So the National Medical Workforce Strategy would suggest that it is that really sincere collaboration between colleges and the way that they design their curriculums and the way that they value generalist skill sets within colleges. It involves New South Wales Health, and it involves probably a networking of training. But we've got to decide whether we're going to prioritise those locations for training and whether we are going to identify that they get filled first and that they are an inreach model or whether they were simply an outreach model from a metropolitan centre, where obviously the focus is on training for the scope of practice that can be seen in that specialty training centre.

Q. By inreach and outreach do you mean inreach in the sense that the trainee is primarily located in the regional location?
A. Correct.

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

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

Q. You spoke of collaboration, and that is a key feature or theme within the National Medical Workforce Strategy. What can be done, if anything, to improve that process of collaboration, given the fragmented nature of the system?
A. I think the most positive thing for me was that

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

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

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

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

Q. And do you see there to be a larger role that they could be playing than is currently the case?
A. I do, and I understand that it is that the - if you think about it, that the rural LHDs are a smaller voice potentially in this than the metropolitan LHDs.

Q. So coordination --
A. A quieter voice, maybe.

Q. Coordination of effort not only is required at the national level but at the state and territory jurisdictional level; correct?
A. That's correct. And it's a prioritisation. It's saying, "This is what we need to do if we want a workforce

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

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

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

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

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

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

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

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

Q. How might expectations of that kind be taken into account in service and workforce planning activities?
A. I think it's very challenging. I think there's been a reticence to identify, and this is related to rural areas, a baseline level of access to services, and I share the reticence, because obviously the reason to define it is to then say that - or to then understand where the gaps are, where that isn't being delivered, but the other concern for me is that the baseline is changing. So how are we going to keep up with a changing expectation in particularly the timeliness of access, and, as I said, that's one of the things that I'm thinking moving forward is going to be a real challenge, and that's why I allude to the challenges in scoping demand, for instance.

Q. Is one part of responding to that challenge in health services engaging in conversations with their communities about the level of service that might be able to be delivered and delivered safely in particular areas?
A. Indeed. And the method of that service delivery, and I'm alluding to the need to staff some emergency department in our district hospitals and in our areas with virtual emergency services, and the challenge for some of our rural residents around that access and, as you said, the conversations with the community about what is acceptable, affordable and available access.

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

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

Q. Difficult conversations but important ones nonetheless?
A. Yes.

Q. And important to engage in regularly?
A. And to be transparent about those conversations.

Q. What do you mean --
A. That they are trade-offs and, you know, that what's at play in having - you know, in those decisions.

Q. By trade-offs, tell me if this is an example of something you had in mind; that perhaps there is an emergency department at a small rural facility that does not see a high volume of patients both as to number and acuity but, if that funding was diverted to dialysis chairs, the needs of the community might be able to be better met in a safe way; is that what you have in mind, something like that?
A. That's exactly what I had in mind and it's that transparency about that trade-off and that trade-off being visible.

Q. We've heard in other hearings that the rural population doesn't necessarily expect everything to be on their doorstop and they accept some of the limitations. Is that also your perception?
A. That is absolutely correct. So when I'm in Moree they don't say to me, "Why haven't I got a cancer centre in Moree, you know, and a PET scanner." There is an absolute understanding that some of these services do need to be centrally or regionally delivered. What I think consumers want is access to adequate and reasonable health care commensurate with the health needs of the community. So those residents in Moree are delighted because they've got a chemotherapy service that's working out of that particular town. So their sick patients don't need to go regionally; they can be managed locally. So it's that sort

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

Q. Can I take you now to the National Medical Workforce Strategy. If you have a hard copy there, Professor?
A. I do. Well, I've got some of it, yes.

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

And, Professor, you were the co-chair of the Medical Workforce Reform Advisory Committee that was involved in the preparation of this strategy; correct?
A. Correct. I was just about to tell you that, so that I have a very significant interest in this document.

Q. All right.
A. And I have been involved closely in its development.

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

Q. Can you just tell us a little bit about the alliance?
A. So the alliance is a fascinating organisation. It's an alliance of up to about 40 organisations whose member bodies have significant interests in rural and remote health. It ranges between professional organisations, and I was the Rural Doctors of Australia representative on the National Rural Health Alliance, but also involves organisations that are involved in health but not directly. So we've got the Isolated Parents Association, we've got the CWA, we've also got provider organisations such as RFDS, Frontier Nursing, and Aboriginal organisations such as the national community controlled sector and representatives of nursing, allied health and other bodies.

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

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

Q. And there were a number of members of this committee, weren't there, the Medical Workforce Reform Advisory Committee?
A. No. So the Medical Workforce Advisory Committee is made up of the jurisdictions, the universities, the industrial organisations such as AMA doctors in training. Now it's also - since it's been reformed as MWRAC, it's also got quite a lot of worker type bodies on it and nursing and midwifery and allied health representation. But the national Medical Workforce Advisory Committee, when I was co-chair, which was - I finished on 30 June 2024, our major effort was to develop this strategy, and that was done, as I said, because the players from across the sector were at the table.

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

THE COMMISSIONER: 73, yes.

MR GLOVER: In general terms, Professor, acknowledging that this was a significant piece of work, can you just describe the process that was engaged in to develop the strategy?
A. So the process occurred over about three years. Initially there was some scoping and there was a consultant brought in to, I guess, scope what the issues were. An issues paper was generated which then went out to the sector broadly, and then came back. And, again, the membership of MWRAC was absolutely key to the development of the strategy because it does straddle the myriad of organisations that have levers in our medical workforce training and development.

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

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

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

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

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

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

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

In particular, specialist trainee numbers can no longer be primarily driven by clinical service requirements for registrars that dominant many current care models.

Do you see that?
A. Yes.

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

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

Q. And is the concept that that growth is driven by the need to fill positions as opposed to the need to deliver that particular type of care to the community?
A. That is one of the drivers.

Q. Can I take you ahead in the strategy to page 20, please. I want to take you to some parts of this page, Professor, but if you just take a moment to refresh your memory about it and let me know and, if you need more time to read it, at any stage just let me know?
A. No, I'm happy for you to ask.

Q. All right. In a couple of your earlier answers you've mentioned status of generalist practice, and on this page a number of suggestions are made as to what medical leadership can do to address some of those issues. Who would you put in the category of medical leadership in this context?
A. That is such a good question.

Q. I'm glad I got one out.
A. That's very challenging.

Q. For the transcript, the Commissioner gave me a thumbs up.
A. Traditionally, I would say it's the industrial organisations, it's the Australian Medical Associations, it's probably, you know, Rural Doctors Association. So I think they are certainly key to changing the culture. But I have to say that I think leadership in hospitals and in hospital networks also need to have that helicopter view which is that the health system will benefit if we're training more generalist doctors and generalist doctors that will have roles and responsibilities outside the acute health system. So, whilst I understand the need and the preference for training in the acute sector and for the acute sector, clearly we need to increase the status of generalism and general practice if we are to better distribute our population - our medical workforce.

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

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

Q. Is there anything that the state and territory health systems can do to overcome that perception and bias?
A. I believe so. I wonder - well, I'll just give you an example. If you are a VMO on a fee for service rate in a hospital you're paid, I don't know, $285 an hour or whatever the going rate is. I'm not across because I haven't claimed. The GP rate is somewhat lower. So, I mean, you've got a message straight out there that a consultant general practitioner is worth less than a specialist practitioner. I would ask if they're doing a job that is of significant benefit to the health system why is there a difference.

Q. So what you have in mind is creating positions or conditions that recognise the benefit of rural generalist practitioners in those areas as a method of perhaps overcoming some of that stigma; is that right?
A. Indeed, and levelling the playing field. And that will not be lost on our medical students and junior doctors.

Q. Is that because of a perception that rural generalism or general practice is not a true specialty compared to other subspecialties?
A. I guess so. It's certainly assumed to be less valuable.

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

There is a stigma about medical practice in rural and remote Australia.

A. M'hmm.

Q. Is that something that you've observed?
A. Absolutely, and we have a term for it now. We call it geographic narcissism.

Q. Again, is there anything that the state and territory health systems can do to overcome that geographic narcissism, in your view?
A. Absolutely. Absolutely. And it's the perception

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

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

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

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

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

Q. Can I take you ahead to page 28 of the strategy, please.

THE COMMISSIONER: Is this a new topic?

MR GLOVER: Yes.

THE COMMISSIONER: Is it best to take the break now then?

MR GLOVER: Yes.

THE COMMISSIONER: Professor, we're going to have a short morning break now. Don't feel as though you have to sit in front of your computer screen, but could you be back in front of it at 11.50?

THE WITNESS: Sure. Commissioner, how long after that is it likely to go, because I'll just need to do some organisation.

THE COMMISSIONER: I'll just ask Mr Glover that.

MR GLOVER: 20 minutes, thereabouts.

THE COMMISSIONER: 20 minutes. So let's say we should be finished by 12.20.

THE WITNESS: Terrific. I'll be back at 11.50.

THE COMMISSIONER: Thank you. We'll see you at 11.50. We'll adjourn until then. Thank you.

SHORT ADJOURNMENT

THE COMMISSIONER: We'll continue, thanks, Mr Glover.

MR GLOVER: Thank you, Commissioner. Professor, just before we go back to the workforce strategy I just want to go back to an answer you gave earlier, and I'm grateful to my learned friend for drawing this to my attention. It's transcript page 5122 and the Commissioner asked you a question, and I'm just going to see if I can have that brought up on the screen rather than me read text at you, Professor. It might be easier.

THE COMMISSIONER: 5122, line?

MR GLOVER: Starting at line 18, Commissioner.

THE COMMISSIONER: Yes.

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

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

And then you answered:

> *Correct. And I guess the acceptability and the attractiveness of that skill set within our medical workforce has reduced over time.*

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

> *So the attraction of specialism over that generalism has reduced over time.*

I think the effect of the rest of your evidence is that it's the attractiveness of generalism that has reduced at the expense of a greater tendency to drift towards specialisation and subspecialisation; is that right?
A. That's correct. That's exactly what I meant.

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

Q. And in planning for what your future workforce need

might be is an important part of that an assessment of what your health care needs of your community both in the immediate, medium and long-term part of that process?
A. I would agree.

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

Q. And do you think there are improvements that can be made in the system as it stands at the moment to achieve that goal?
A. I do. Workforce planning - because, as mentioned, the number of players in our health system, and we haven't even talked about our private health system, as well as our public health system, as well as our community - so the variety of funding into that system, clearly there is no single source of data and particularly around workforce numbers that has been satisfactory to plan on by any individual entity.

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

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

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

A. Absolutely.

Q. Because --
A. And that is not a feature of the system as we currently see it operating.

Q. And is there any consequence, to your mind, of the system not operating in that way at the moment?
A. So the significant consequence is that we struggle to understand the impacts of our current distribution challenge and in that we - and, as I've mentioned, the impact of our distribution challenge is somewhat greater rurally because of the sparsity of practitioners and alternate entities. We also struggle to have a good rationale for our planning if our data is inaccurate and it's not linked up.

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

Q. And as part of a workforce plan driven from the bottom up would that include such things as planning for training places, whether recent graduates or those on specialist pathways?
A. It would, and it requires that local knowledge to make that accurate because we have a propensity of pathways and systems that may be contributing to that workforce that are not visible at a jurisdictional or a national level.

Q. So local knowledge of the need for clinicians, including specialist clinicians, planning for that against the needs of the community in the short, medium and long-term; correct?
A. Would be highly valued. I think there will be discussion about whether that's at an SA3 or an SA4 level or at a modified Monash. So there may be some important considerations about how local that is, and I draw your attention to particularly the specialist catchment concept. So currently obviously if you have an ophthalmologist in Tamworth they will service patients from Moree. So actually in terms of workforce planning if that's the model, and I'm suggesting to you that hub and spoke for

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

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

Q. Which summarises in table form the particular specialties and their capacity to both practice and train at various modified Monash levels?
A. Correct.

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

Q. So if we use about three-quarters of the way down the page under "Physician, paediatrician, cardiology" as an example, there the table suggests that cardiologists can both practice to their full scope and train at modified Monash 2 and 3, but under the system that you're envisaging they would then provide services out to modified Monash 4 plus areas from that regional centre?
A. Correct. And therefore the assessment of the need needs to be based on the catchment.

Q. The catchment being the catchment from that regional centre from where the clinician will practice?
A. Correct.

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

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

Do you see that?
A. I do.

Q. Do you have a view as to why it's important that that local level planning involve, firstly, the Indigenous community and the ACCHO sector?
A. It goes back to my comments about what is the access that we're attempting to provide and it's about the accessibility and availability of that access. So, unless that workplace plan is co-designed with Aboriginal and Torres Strait Islander community, we may have physical access but we may not have honest acceptability or availability, and it's that nuancing and that understanding of what the access that we're attempting to provide that is intrinsic in a shared planning framework.

Q. What about local government? That's referred to in that paragraph too.
A. So local government remains extraordinarily important in practice in the provision of health services, but there is an understandable debate about how much of the local government budget should be partitioned towards health service delivery and whether that is a local or a regional responsibility.

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

MR GLOVER: Not specifically.

THE COMMISSIONER: No.

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

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

Q. And between generalist and specialist clinicians; correct?
A. M'hmm.

Q. Do you have a view about the benefits to the system as a whole if that imbalance could be ameliorated?
A. It's a forward-thinking benefit as opposed to necessarily the present. As I said, I think right at the moment we're still managing because we have a system where we do have a reasonable number of generalists in our workforce, particularly in our regional centres. And I think it's thinking forward as to how that imbalance may become worse and the impacts on the efficiency and the cost of care if we end up with a mainly sub-specialised workforce, particularly in our regional centres.

Q. What you're describing there is a concept that the benefits of change and reform might not be seen in the near term but are necessary to produce the health system that the community will need into the future?
A. Indeed, and at a cost and a complexity that the community would want as opposed to an increase in both of those.

Q. Can we go ahead to page 41, please, and this is part of the strategy that addresses the service registrar medical workforce that you touched on earlier. Service registrars are sometimes referred to as unaccredited registrars or career medical officers perhaps; is that right?
A. Yes, that's right, or hospital registrars.

Q. Are they an important part of the delivery of healthcare services in hospitals?
A. Increasingly. The data that I shared at some point, and I'll just report it from the medical student outcome database, showed in one particular cohort that at postgraduate year 13 20 per cent of our medical workforce did not have a vocational training outcome. That means that they weren't - they hadn't fulfilled the criteria for

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

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

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

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

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

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

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

Q. And from the answer that you gave earlier do we take it that you would see this cohort as being one which could be the target of measures to promote generalist positions, both inside and outside of hospital settings?
A. Yes. Well, we have a group of doctors who have not decided on a training pathway. So, to me, that is an opportunity to look at generalist training pathways. And where they are situated in non-metropolitan areas surely they also, if provided with opportunity, may choose to embark on a training pathway that prior to this they did not feel that they were able to apply for.

Q. Provided with opportunity and the recognition of the kind that we spoke of earlier --
A. Indeed.

Q. -- be it particular position description and also conditions; correct?
A. A first-class training pathway.

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

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

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

We've spoken about the PGPPP and the John Flynn type approach. Was there anything else, other changes or strategies, that you see to support that initiative?
A. The most important part of that is that last sentence about continuing most of their vocational training in rural areas. So if I can take my current location in Tamworth. You can train for rural general practice after PGY3 and above here. You can do quite a lot of your emergency medicine training here. But for most of the other specialties you will need to network and move away with the intent of perhaps being able to select some of your training being allocated back to Tamworth.

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

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

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

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

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

Mr Cheney, do you have any questions?

MR CHENEY: No, Commissioner.

THE COMMISSIONER: Professor, thank you very much for your time. We're very grateful. And all the best for the new position.

THE WITNESS: Thank you very much, Commissioner, and it's been an honour to present. Thank you.

THE COMMISSIONER: Okay. Thank you very much. You're excused.

<THE WITNESS WITHDREW

THE COMMISSIONER: So we adjourn until what date?

MR GLOVER: 17 September.

THE COMMISSIONER: Tuesday, the 17th.

AT 12.16PM THE SPECIAL COMMISSION OF INQUIRY WAS ADJOURNED TO TUESDAY, 17 SEPTEMBER 2024

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