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, 16 October 2024 at 12 noon

(Day 056)

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

Also present:

Mr Richard Cheney SC with Mr Hilbert Chiu SC and Ms Emily Aitken for NSW Health

Mr Scott Chapman for Dr Michael Bonning

THE COMMISSIONER: Good afternoon.

MR MUSTON: The first panel of witnesses we have today are both from Advanced Pharmacy Australia.

A copy of the statement that they have prepared, Commissioner, you will find behind tab L13, it is exhibit L13.

THE COMMISSIONER: I have that, thanks.

MR MUSTON: Starting on your left is Jerry Yik, and next to him is Jonathan Penm. I think Mr Yik will take an affirmation and Mr Penm will take an oath.

<JERRY YIK, affirmed: [12.01pm]

<JONATHAN PENM, sworn:

MR MUSTON: Starting with you, Mr Yik, would you state your full name for the record, please.

MR YIK: Yes, my name is Mr Jerry Yik.

MR MUSTON: You are the head of policy and advocacy at Advanced Pharmacy Australia?

MR YIK: That's correct.

MR MUSTON: Mr Penm, could you state your full name for the record, please.

DR PENM: Yes, I'm Jonathan Penm.

MR MUSTON: You are the vice chair of the New South Wales branch committee of Advanced Pharmacy Australia?

DR PENM: Correct.

MR MUSTON: Also a member of the faculty pharmacy of the University of Sydney.

THE COMMISSIONER: Is it Dr Penm?

DR PENM: Yes.

MR MUSTON: Dr Penm.

You have both prepared a statement dated 26 September 2024 to assist the Inquiry with its work. Do you have a copy of that with you?

MR YIK: I do, yes.

DR PENM: Yes.

MR MUSTON: Have you each had an opportunity to review it before giving your evidence today?

MR YIK: Yes.

DR PENM: We have.

MR MUSTON: Are you satisfied, to the best of your knowledge, that its contents are true and correct?

MR YIK: Yes.

DR PENM: Yes.

MR MUSTON: That will form part of the tender in due course.

THE COMMISSIONER: Yes.

MR MUSTON: Can I take you to page 4 of your statement where you set out for us a number of key issues. In fact before going to that, could I ask you for the benefit of we laypeople just to explain the typical role of a hospital pharmacist within a public hospital setting?

MR YIK: Yes, sure. Hospital pharmacists are very, very important to the supply of medicines to patients in hospitals, all the way from the - upon entry into hospital, where we might be in the emergency department, all the way through to your entire inpatient journey, upon discharge from hospital, and then as well as any community care that might be provided or any transitions of care services that might be provided as well.

Now, supply of medicines is a core part of what pharmacists do. As we all might be very familiar with, we tend to see pharmacists as the people that give us our medicines. That is very, very true and that is a very

important task where various checks are required to make sure that you've got the right patient, the right medicine, the right dosage, the right route of administration, so that nothing goes wrong with the medicine that you take.

MR MUSTON: Pausing there, to the extent that we might all understand if you are an outpatient or an inpatient within a hospital and a doctor prescribes a particular medication, the hospital pharmacist will receive that prescription, probably electronically these days, and collect and administer - distribute whatever the product is?

MR YIK: Yes, that's right. What you have described there is a fairly reactive model, so the pharmacist is at the very end reviewing everything, and what - but in the acute setting, what is best practice, as described in our standards, is that you actually have pharmacists embedded in the wards providing bedside medication management services where you can actually review the medication chart, make sure that the prescribing or charting of that medicine is safe and appropriate for the patient before the nurse then orders that medicine.

The pharmacist should be involved in that prescribing and charting process alongside the doctor so that even before it makes it down to the dispensary for the pharmacist to supply it, it's already been deemed to be a safe and appropriate prescription for that patient. So that is probably the more clinical and cognitive service that should be provided and what hospital pharmacists should be able to provide, and which is, you know, an extremely value-adding area.

MR MUSTON: Going back to the point of admission, we've heard some evidence and heard some discussion on some of our regional trips about medication reconciliation as a role that pharmacists have within a hospital setting. Could you just explain to us, say from the perspective of a hypothetical patient who enters the hospital system, what that involves?

MR YIK: Yes. I think yes, medication reconciliation is an activity that requires pharmacists to undertake a history of what medicines that patient is on prior to entering hospital, so that when they are admitted, they can have all their regular medicines from home being charted and/or their reason for admission to hospital might be

medication related as well. So this has actually been, you know, a subject across various inquiries in New South Wales, but a typical patient in a hospital might take anywhere from 2 to 5 to 10 medicines depending upon the patient profile. In that medicine profile there might be some medicines that are very, very appropriate for the patient but, at some point, there might have been an unintentional overdose, there might have been a doubling up of some medicines because a patient hasn't had a review for a while.

So they might come into hospital and be taking the wrong medicines and the pharmacist who does the medication reconciliation can find that out. But even if there's nothing wrong with the patient's medicines, there is still a duty of the hospital to make sure the patient is taking the medicines that they were on prior to home.

So if you're a patient that's using something to lower your blood pressure, something to lower your cholesterol, taking an anti-depressant, some pain medicines as well, you should expect that in your five-day inpatient stay, that you should have access to those medicines as well and continue that therapy. You shouldn't have to stop taking those medicines for five or six days while you are in hospital. And to make sure that pharmacists and the hospital can provide the right medicines, that's where that medication reconciliation occurs, to make sure that we are taking an accurate medication history, because if it's not done, then the patient goes without medicines or, worse, might be prescribed the wrong medicines.

MR MUSTON: When you say "prescribed the wrong medicines", do you mean prescribed something which is inconsistent with or reacts adversely with something that the patient is or has been taking?

MR YIK: So it could be they are prescribed the wrong medicine or the wrong dosage compared to what they were on at home and, yes, it has potential to be one that they might have an adverse reaction to. Why that might occur sometimes is if you don't have a pharmacist doing the medication reconciliation - and evidence proves and suggests that pharmacists are the best clinicians to do a medication history for medication reconciliation - where you rely upon a doctor or a nurse who has a lot of other things to do to take a really basic medication

reconciliation that's not comprehensive and may not be entirely accurate, then charting and prescribing decisions made on those types of medication reconciliation activities by nurses and doctors can lead to some discrepancies and errors.

So without a pharmacist doing a really comprehensive and accurate medication reconciliation, that's what might precipitate the issues that you have described.

MR MUSTON: You refer to a "comprehensive and accurate reconciliation". What, in a practical sense, does that involve beyond asking a patient to the extent that they are capable of responding, "What are you taking"?

MR YIK: Many activities - and as you said, it's not just asking the patient and as we know unfortunately patients, certainly when they are in the acute environment, can be poor historians. So we have to make sure we are checking other sources. That could include the My Health Record; could be calling up their usual community pharmacies as well to look for dispensing records, and that might - and some patients might have more than one pharmacy, which makes it more complicated; contacting their prescribers as well, so their GP or GP practice; any specialists as well that they might have; carers as well. Yes, so there is a variety of sources that we can use to get that accurate medication history and often we do need to do that. But as you can imagine, that's quite a significant amount of time to do an accurate and comprehensive medication history that you just would not expect a nurse or a doctor to do.

MR MUSTON: That would obviously require a sufficient workforce within a pharmacy department to be performing that task in relation to patients as they come in to the facility.

MR YIK: Yes, absolutely. You require pharmacists to be staffed on all those wards, especially in general medicine wards, in emergency medicine where you are getting the high flow of patients, to do that medication history. Unfortunately, there are many, many, I would probably say the vast majority of New South Wales hospital pharmacy departments and their wards won't have a continual and regular clinical pharmacist service at those wards.

MR MUSTON: In relation to that reconciliation process,

would it be right to assume that there's a spectrum in terms of the rigour that one needs to apply to that task depending on the nature of the patient and the reason for their presentation? So, for example, if a fit and well patient turned up to have some stitches put in to a gash on their arm and was going to be prescribed some painkillers to go away from the emergency department with, you would probably not need to be quite as rigorous in terms of your reconciliation, as, for example, an aged care facility patient who comes in with a mystery bag of foil tablets and --

MR YIK: Yes, absolutely. I think we always obviously apply risk assessments and we provide our services on a risk-based approach, so looking at patient profiles, and that could be age-related factors, can be their medical history, can be the number of medicines that they are on. It can be the types of medicines that they are on. There are many patients who are taking 15, 20 medicines, and they can be completely appropriate, but you might have patients who are only taking five and they are all inappropriate or can have the propensity to cause an adverse reaction.

So we aim to provide medication review to every single patient. There is no way that is occurring in New South Wales based on the funding issues that we've explored, and even applying a risk-based approach and even trying to ensure that we only review our high-risk patients, even that service level is not able to be met in New South Wales in many, many departments.

MR MUSTON: When you say it is not able to be met for funding reasons, are you essentially telling us that there are insufficient hospital pharmacists employed within facilities to enable that process to be undertaken with respect to the patients that, at least in the view of pharmacists, it ought to be undertaken in relation to?

MR YIK: Yes, I am. So as we present in our evidence, the number of hospital pharmacists in New South Wales is - you know, comparatively speaking to Victoria and Queensland, when you're looking at the number of hospital pharmacists to the number of hospital beds that you have, New South Wales is far, far behind.

So in that scenario, how do we - how do New South Wales pharmacy departments apportion their pharmacists and

their workforce to the services that they have to provide? Unfortunately, a lot of them can't put pharmacists on to the wards providing those clinical and cognitive services and preventing medication errors from occurring, preventing prescribing errors from occurring. Where they are being forced to provide most of the services is at the very tail end of - simply because we only have so many pharmacists, we have to focus all our efforts on the supply of medicines and it's only when they are asked to supply medicine, they receive a prescription and we find out, "Hold on, there are errors here. Why has this been allowed to go on for X number of days when it should have been detected at the very beginning?"

Best practice dictates that you detect these errors at the very beginning, as other states are able to do because they do have enough workforce, but in New South Wales, in many areas, that error may only be detected at the very end when the pharmacist is asked to supply that medicine, if at all.

THE COMMISSIONER: The ratios that you have given in the table on page 2 - any questions I ask, and also this applies to Mr Muston, both of you should feel free to chip in and answer if you want to - why is New South Wales so much different to Victoria and Queensland? Funding might be one issue, but are there any other reasons that you're aware of?

MR YIK: Look, I think funding is a - it probably comes down to funding, at the end of the day. I think there are other areas around workforce investment as well, so there is a workforce shortage across not just healthcare sectors but every sector at the moment but historically, New South Wales hospital pharmacy departments have been underfunded. We aren't funding enough internships for pharmacy students to come into the hospital setting. We know that hospital - the hospital setting is the most desirable setting for pharmacy students, but I think New South Wales currently only offers 40-odd, according to our submission.

In Victoria, we've got over 100. So if you are only getting 40 new interns each year and you want them to continue, then you've got a fairly limited pool. So I think funding is probably what it comes down to. Recognition from the LHDs about what pharmacy departments provide and the services that they provide and providing

requisite funding, that's a conversation that we hear from various hospitals and pharmacy departments is - it's probably not taken seriously. So our pharmacy departments are asked to do --

THE COMMISSIONER: Sorry, what is not taken seriously?

MR YIK: A lot of our pharmacy departments are asked to do a lot of extra activities to respond to the needs of the state healthcare system. We're like, of course, we want to do that, we want to make sure that we're providing the best care possible but when we then say, "Well, we're going to need this amount of pharmacy technicians, this amount of pharmacists", the response from various levels within the ministry or the LHD is that, "Well, sorry, we can't. We can't fund that. You're just going to have to make that happen", and so that's when it comes to, "Well, what can we cut or what can we rearrange?" And I was speaking to someone who was job was rearranged at some point during his career due to these funding decisions.

DR PENM: I would just quickly add to it. We have lots of people wanting to work in hospital. We just don't have enough positions for them to have. And then those that are in there, the pay structure doesn't reward them for their contribution. When you're talking about the restructuring, we often get those requests that say this hospital is implementing a new service, implementing more emergency department beds, implementing more wards. They will tell us how amazing those new facilities are, the new doctors they will hire for it, the new nurses they will hire for it. But in the pharmacy, we go, "So, are we getting anything?" "No". Pharmacy is generally not considered when it comes to new services and we've just been taking that load on and on and on and we've just got to this point now that our ratios just seem vastly lower than other states.

THE COMMISSIONER: By having the one to eight hospital bed ratio in Victoria and Queensland as distinct from one to 13 in New South Wales metro and then the one to 18, one to 14 versus one to 27 for regional hospitals, what are the consequences you think for having - in relation to the different ratios? In other words, what different services are able to be provided in the metro or regional hospitals in Victoria or Queensland that can't be provided in New South Wales because of those ratios, and what risks are

being mollified in those other states that aren't in New South Wales because of those ratios?

MR YIK: As I described earlier, it probably comes down to the ability to provide clinical pharmacy services at the ward.

THE COMMISSIONER: On the ward.

MR YIK: Yes, on the ward. So say you've got a junior doctor who wants to chart a medicine for a patient and they want to find out, well, is this the correct dose given this patient's renal function, where is a pharmacist to ask that question? In other states, you will have a pharmacist who is there, that can provide that junior doctor some advice on that. In New South Wales, there isn't, and so that error or - is then detected at the end.

THE COMMISSIONER: Potential error.

MR YIK: The potential error is then potentially detected by the pharmacist at the very end, if they're asked to supply that medicine.

DR PENM: We do have some evidence for that on page 11 where we talk about the partnered pharmacist medication charting model. That is a model that is implemented in the other states because they have the pharmacists to deliver that service. That's just an extension of what Mr Yik talked about with pharmacists --

THE COMMISSIONER: Sorry, this is what you call the PPMC?

DR PENM: That's correct. So once the pharmacist does the medication reconciliation, the pharmacist then charts those medications, because they have the time and the ability to do so, and they have done the medication reconciliation because they have the staff to do so, and they show by doing that they have now reduced that length of stay by 10 per cent, they have reduced the errors per patient by 62.4 per cent. That's a service that you can only do if you have the staffing to do it.

THE COMMISSIONER: Sure.

MR YIK: That's a really good example again of where our pharmacy departments are being asked to do more but without

the resources to do that. So that PPMC program, we gave evidence on that at the ramping inquiry, and we're really grateful to the New South Wales Government for accepting that recommendation and putting it into the report.

The status of that is the Ministry of Health is progressing this program and they have put out - we understand that they have put out an EOI to various hospitals and LHDs to ask, "Who wants to participate?" There is lots of interest from many, many LHDs but what we understand is they have also been told there won't be any additional money to fund this service.

THE COMMISSIONER: So this is recommendation 8?

MR YIK: In the ramping inquiry?

THE COMMISSIONER: Yes.

MR YIK: Yes, that's right.

THE COMMISSIONER: We find that - do you have your whole statement?

MR YIK: Yes, I do, yes.

THE COMMISSIONER: So this is the New South Wales Government response to the ramping inquiry, just call it that, page 5 --

MR YIK: So they've accepted that.

THE COMMISSIONER: -- that the New South Wales Government will provide funding to increase the number of hospital pharmacists so that their availability better matches operating hours, et cetera. That's supported in principle.

MR YIK: Yes, and we are still waiting for that investment. But the PPMC is just one of many different, you know, additional requirements or initiatives that we all want to do for the benefits of New South Wales patients, but we keep being told continually that there is no extra funding to provide that.

MR MUSTON: Just to pick up on something, Mr Yik, you said a bit earlier, the position in many facilities is, if I've understood you correctly, that the pharmacy workforce that

is employed is effectively detained full time keeping up with the distribution of medication from the pharmacy department in response to prescriptions that come down from the wards.

MR YIK: Yes. I would say so, that the core service of a pharmacist is to supply medicines and, you know, their role in the hospitals is to make sure that patients receive medicines. That's a really, really important part of what we do. But in an environment where we are meeting our own professional standards, we are not just supplying medicines, we are also making sure that the charting and prescribing of those medicines is safe and appropriate before it even reaches the pharmacy to dispense a prescription.

So we should be detecting the errors or assessing it for its appropriateness as early as possible, not at the very end when we are in the basement, when we don't have access to the nurse or the doctor to get things changed.

MR MUSTON: Just working through this hypothetical patient, if we put to one side the workforce challenges and assume the hypothetical patient appears at a hospital that has a hypothetical workforce where pharmacists can provide the best level of service you think they're able to provide, it starts with a thorough reconciliation of their existing medication. In relation to that, is that a task that can usually be performed by a relatively junior pharmacist, not wanting to downplay the importance of it, but --

MR YIK: Yes, absolutely. These are, you know, key competencies for pharmacists and certainly undertaking medication reconciliation, medication histories, is something that we train students and interns to do as well so that once they are registered, they are more than competent to do that independently.

I might throw to Dr Penm, who actually trains students and interns who do these activities.

DR PENM: Yes, so we've got some data from Sydney University showing that pharmacy students, pharmacy interns, pharmacists, all of them are able to do it, and they do in a way that is more accurate than doctors and nurses. That's not to downplay their knowledge base; it

just shows that we have a different focus when we do it and we are particularly conscious of things around strengths, formulations, things that we see every day, and we know that doctors and nurses have other things that they need to prioritise and they don't see. It's a core competency, something that the more junior workforce can do.

I will also just talk to your point about how do we provide that value. When we're doing these tasks, it's often obvious to us that if you solve the problem at the beginning, it saves a lot of problems at the end.

So when we had that reactive model Mr Yik was talking about earlier, we were just identifying that a lot of the problems could have been sorted out much quicker, much faster if a pharmacist was involved, which is why we have become involved earlier, and that then speaks to the point on page 9 that every dollar spent on pharmacy comes to $23 of savings, because the kinds of things we're fixing are actually easy to be fixed at the beginning versus trying to fix them at the end.

MR MUSTON: So working through that process, obviously money spent on a thorough reconciliation of someone's medication has the potential to produce better or quicker or at least less adverse outcomes, which has a financial benefit attached to it. What is the next role for a well-provisioned pharmacy department in terms of the journey of this hypothetical patient who has been admitted? You have completed your reconciliation of their medication, they're receiving some medical treatment or a medical assessment is being made of them by a doctor - what's the pharmacist's role there?

MR YIK: I guess inpatients is probably the next, you know, journey for that patient, and so as an inpatient, depending on what you are diagnosed with, it could be - you are likely to be prescribed some new medicines, they could be - just say you have got an infection that is really resistant to a lot of anti-microbials, so even choosing the right anti-microbial, making sure that's at the right dose for you, that any all your issues - that any adverse affects are addressed and detected appropriately as well, interpreting your cultures and sensitivity testings to guide anti-microbial selection, looking at your renal and hepatic function as well to inform the dosing of that medicine, making sure that medicine is compounded correctly

as well by the pharmacy department, and making sure the nurse knows how to administer that medicine appropriately, whether that be by infusion or injection, because again, even the administration can cause issues as well.

So I guess there's a lot of - for that inpatient, it's any changes to their medicines, be it a new medication being charted, an old medicine being ceased or withdrawn because that's causing harm or has the propensity to cause harm, and any other additional medicines to treat side effects, such as nausea, vomiting, pain - all these things require a pharmacist to review daily and to inform the charting and prescribing of those medicines as well.

MR MUSTON: And so that presumably is a role that would be done collaboratively with the doctor who is treating the patient?

MR YIK: That's right.

MR MUSTON: What is the extra that the pharmacist brings to that collaboration that one might not ordinarily expect of a doctor who is treating the patient?

MR YIK: So there is a lot of - because the patient's health and their status in the acute setting is changing continually, it does require extra focus on the medicines to make sure that those medicines and the dosages are appropriate for the patient, because the next day your patient might be having acute renal failure and that would require review of all the medicines to make sure that those medicines aren't going to make that worse.

We also recognise that a lot of the prescribing and charting in the hospital setting is done by junior doctors who are less experienced with charting and prescribing of medicines as well, and so having a pharmacist who is a bit more experienced around the medicines can really improve the quality and accuracy of prescribing as well.

Charting of medicines on a medication chart, it's not just writing down the drug and the dose. There are also other - that you're getting the mode of administration right, any variable dosing issues as well, having to get that right as well. Annotating, you know, making sure any medication orders that might need to be withheld because a patient has a procedure the next day or in the next two

days. I guess there's a lot more - the patients aren't in a stable setting, their health status isn't stable, and so there's a lot of factors that go into the safe and quality prescribing of medicines that requires a lot more attention than, say, when you do have a stable patient in a community setting.

DR PENM: I'll just add, there are at least two other main things to focus on where pharmacists do provide value. One is we do a lot more training on medications. Our knowledge of medications is vaster because of that, but we have a very generalist view. So, for instance, say a cardiologist - cardiologists will know all their cardiology medications very well, but they might not know the psychiatric medicines as well. A pharmacist will be aware that, "Actually, that has a lot of side effects, so they need to be monitored; they interact." So it is a really good partnership. Doctors will know what is best to treat them in front of them, and we know whether it does actually fit within the context of the patient, from that broader perspective. That's often the types of issues that we identify - drug interactions that we identify - earlier on.

Another part of it is just that pharmacy sees things. We really like the detail. We love about - the doses matter to us. The formulations really, really matter, getting the right dose for a patient with renal impairment, that gets us excited. We want to make sure they get the right dose, and that's often not the things that get doctors excited. They have a lot of other things that get them excited and they can do it, they're capable of doing it, but they're just not high priority tasks and they get skipped, they get missed.

That's where the errors happen because it is hard to do tasks that you don't like to do. I know that's a generalisation, but generally, pharmacy really enjoys making medication safety a priority, we really like to do that, we do it well because of that. So it's just a really good partnership, and that is constantly seen when we ask doctors, "Do you like having a pharmacist?" They go, "We love it, they do the stuff I don't want to do and they do it well." And pharmacy go, "And we love doing it". So to just not have that combination, it seems like you're just missing out.

MR YIK: And to make sure we are not putting our doctors in disrepute, it is not that they don't like doing it --

THE COMMISSIONER: I didn't assume that.

MR YIK: But it's also they --

THE COMMISSIONER: The lack of excitement only means that they're happy for you to do it.

MR YIK: They don't have the time to do it as well. They also just don't have the time to do it as well. A lot of junior doctors, certainly from other states, they have been brought up in a system where they do have a pharmacist that does a lot of these things for them and then they come to New South Wales and go, "Where is the pharmacist?"

DR PENM: I think the PPMC model that we talked about earlier highlights that, that all the medical profession really enjoy us doing that task. They actually say "This is great".

MR MUSTON: You tell us a little bit in your statement about the advanced skills training for pharmacists in the various different strands of advanced skills that pharmacists can pursue. Presumably where a pharmacist has obtained some advanced skill training and experience in a particular area, whether it be, you know, chemotherapy medication or any of the other wide array of advanced skills that you have identified by reference to those nice little icons in your statement, that pharmacist will be able to bring a particular degree of skill and experience to the table when dealing with issues like this, and perhaps significantly more than a junior doctor, who is just starting on their professional journey.

MR YIK: Yes, absolutely. I think what Dr Penm's talked about, us being specialists but also generalists, is a really good example, because say you're in a psychiatry ward, you've got the psychiatry consultant and the registrar, who might be really laser focused on the psychiatry medicines, and rightly they should be, but the pharmacist will also take that holistic view and look at, well, how does it impact their medicines for their cholesterol, how does it impact their medicines for their blood pressure?

These are all important factors for us to all consider, so the pharmacist will take that viewpoint in there. I think you are right about the need for advanced skills and specialisation as well. What we do know with health care is that patients are coming into hospital more unwell, more advanced in their disease state and so that also then requires your practitioners, including your pharmacists, to make sure that they have the right skills to provide care for these patients. So we do try to specialise pharmacists where we can. If you've got an oncology ward in New South Wales or a psychiatry ward in New South Wales, you don't just put every pharmacist - sorry, any pharmacist in that ward; you want to make sure that the pharmacist you're putting into that ward already has the skills in oncology, in psychiatry, so that they're providing the best and safest and highest quality health care to that patient wherever possible. That's not being done at the moment in many parts of New South Wales, but it's certainly what patients should be expecting from us.

MR MUSTON: So in terms of those forms of advanced training, in smaller regional and rural facilities which offer a general array of services to their patients, obviously whilst a pharmacist might choose to pursue some advanced training, the real skill that they bring to bear in that setting is going to be that slightly more general skill set; would that be right?

MR YIK: Yes, that's right. I think there are some - you'll have general pharmacists and general medicine pharmacists in all hospitals, whether it be rural, regional or metropolitan areas, but I think that there is going to be more and more demands from patients to have specialist services outside of metropolitan areas.

Around the country, there is a need for this as well. We are ready, our workforce, to provide the services through different models of care. So be that outreach or telehealth or remote services, these can be provided and these will only proliferate even more in the coming years.

MR MUSTON: Just in relation to that, dealing, for example, with cancer treatment and the delivery of chemotherapy to people closer to where they live, is there scope for a well-provisioned pharmacy workforce to enhance in any way the ability to deliver, in perhaps more regional and remote settings, treatment of that type to patients

where you might not actually have an on-the-ground workforce that's well experienced and skilled in the delivery of that type of care, the chemotherapy kind of care?

MR YIK: Look, that is progressing and that has been rolled out, certainly in WA for a telehealth chemotherapy service. In New South Wales there is the Virtual Clinical Pharmacy Service, or VCPS, that has actually won a few awards, where they are providing pharmacy services to patients electronically and via telehealth.

At the outset, it is important for us to state that in-person services are of the highest quality, but because of the workforce shortage, a lot of hospitals have been forced to look at providing services digitally and via telehealth means, and that has bridged a massive access gap in access to pharmacists, pharmacist services, the Med Rec counselling by a pharmacist, where it otherwise would simply just not have been provided at all due to funding or due to not having a pharmacist living in the area. So these means have now bridged that gap and some of these cancer services, you now can actually have an oncology pharmacist speak to a cancer patient, look at the medication chart, making sure that that oncology medicine is charted appropriately, it's the right dose, it's calculated appropriately, before it's then compounded and administered to the patient.

MR MUSTON: Continuing to walk through this hypothetical patient's journey, decisions around prescribing are dealt with collaboratively in an ideal situation, charting is then done by a pharmacist in the ideal situation. Pausing there, I'm assuming that having regard to the competing pressures on doctors' times, that, to be blunt, having a pharmacist deal with things like the charting is a more cost effective way of dealing with that problem from the system's point of view, than having the doctor do that? Would that be a fair assumption?

DR PENM: It's not just cost effective; it's more accurate and safer.

MR MUSTON: Better in almost every respect?

DR PENM: Best practice.

MR YIK: The evidence that we've provided, it's been evaluated multiple times and it's been shown to reduce the admission length because the administering is more accurate. There's dramatic reduction in the errors as well, and the qualitative feedback that we've got from doctors, from a variety of states, is that they have more time to spend with patients and to do other things. So where you have a pharmacist taking over a lot of that charting, it just - it's quite a big relief to a lot of the doctors involved.

MR MUSTON: In this hypothetical well-resourced facility where the patient is discharged, what's the pharmacist's role at the point of discharge if they have one?

DR PENM: Yes, so we know discharge and transitions of care is a high-risk scenario. A lot of medication-related harm happens at transitions of care, and some of these patients come back to hospital. That happens for a variety of reasons: one, it's not just the clinical decisions that are being made, what's best for them, but there's a lot of coordination to make sure that the primary care, both physician and community pharmacy, are aware of what's happening and that those medicines are actually available outside and they can do it in a timely manner.

Within New South Wales, we're not part of the pharmaceutical benefits reform and so we don't have access to the Pharmaceutical Benefits Scheme medication quantities that all the other states in Australia do, so we generally discharge patients with about five to seven days' worth, and that means that they've got to see their GP in that short amount of time to get more medicines, otherwise they just go without until they do. That's part of it.

We've got the clinical decisions, that the right medicines are prescribed, the labs have all been monitored, they're not getting side effects from those, they're getting the right response.

Then we've got to coordinate that everyone knows what they should be on, including the patient. That often - well, not often but can sometimes be missed, and then that comes with patient education, counselling, producing patient medication lists, so it's also written down, because we know, no matter how much I tell you, you're not going to remember everything, and that applies to all of

us.

It just takes time to do all of those things, and without pharmacists, it doesn't happen. That's why transitions of care is such a high-risk area, it is considered a priority area, the Australian Commission have already said it's a priority area because it's continually failing our patients in that space.

MR MUSTON: Do I infer from what you said a moment ago --

THE COMMISSIONER: Sorry, the Australian Commission is?

DR PENM: Quality of care.

MR YIK: That's the Australian Commission on Quality and Safety in Healthcare.

THE COMMISSIONER: Thanks.

MR MUSTON: Do I infer from something you said a moment ago that the risks associated with that discharge and transition period are exacerbated in New South Wales by the fact that it's not a party to the PBS arrangements such that there is necessarily going to be a very narrow window within which that transition has to happen and some other external party will have to engage with whatever the patient's walked away with and understand it sufficiently to make sure that the medication that the patient should be taking continues in the way that it should continue?

MR YIK: Yes, that's right. So because New South Wales and the ACT government aren't signatories to the pharmaceutical reform agreements, they are unable to prescribe and therefore dispense one month's worth of medicines or the PBS quantities worth of medicines to patients on discharge.

That is something the New South Wales Government has been wanting to do and has, I understand, made multiple representations to the federal government to enact or to enter into an agreement, so my understanding is that the ball is in the federal government's court. New South Wales Government has adopted that policy or that position to want to have one, but I think it requires the federal government to support that.

MR MUSTON: Putting to one side whatever financial benefits or dis-benefits might be associated with entering into an agreement like that, from a patient's point of view and the patient safety point of view, giving that period of a month within which --

MR YIK: Very important.

MR MUSTON: -- follow-up care, primary care givers are able to see a patient, assess their needs, understand and make inquiries about the medication, changes in medication and new medications that might have been introduced, is important.

MR YIK: Yes, absolutely. After an acute admission, you would have had quite a - you know, often for patients, it is a major life event to go into hospital because you have had a heart attack, you have had a stroke, and so those first few days back at home you are recovering, you're getting all your life administration all sorted. The last thing you want to have to think about is, "I'm running out of medicines in three or five days. Where do I get more?"

This issue is even more pronounced in areas where there are GP shortages. It's impossible to see a GP within seven days, so having the ability to have a month's worth of medicines just gives you that extra time to settle back at home, take the medicines that you need to have and not miss any days, because if you are only being given seven days and you can't see your GP within those seven days, well, what's going to happen? I think we all know this is occurring, but this is the reality that we live in.

MR MUSTON: So in terms of that reality, you ask the rhetorical question, what's going to happen? There would seem to be two possible answers to that: one is you don't take the medication that you need to be taking, which has potentially adverse consequences for the patient?

MR YIK: Absolutely, yes. So you can have a readmission if you're not taking the right medicine.

A really good example of this, where a patient missed out on medicine at the transitions of care - so this isn't really related too much to the pharmaceutical reform agreement but again it goes to the broader issue around transitions of care and why you need pharmacists - four

years ago New South Wales had an inquiry into the rural and regional remote health based off a 60 Minutes story where a patient was being transferred, I understand, from a public to a private facility, and they were on a really important medicine, apixaban, to prevent them from having another stroke. In that transitions of care there wasn't a pharmacist providing a service, there wasn't a pharmacist calling up the private hospital to say, "Hey, this patient is on apixaban. Please make sure that they are going to chart that medicine in the private hospital when we hand them over to your care so that they don't have another stroke." That medicine was missed, I understand from the report, by five to seven days and they then later had a fatal stroke.

So it's these types of issues that are - we know that they're going to occur before they even occur, because we know this is what's going to occur. If someone has just had a stroke, they've been put on these new medicines to prevent them from having another stroke, it is so important that they have access to these medicines. But without a pharmacist at the discharge, at the transitions of care, no-one is thinking about that. It is no fault against the nurse or the doctor, but you need a pharmacist whose sole focus is on those medicines to be the advocate for the patient so that they have a safe transitions of care.

That issue, you know, without requisite investment into the pharmacy workforce, it's going to happen again. I don't know how else to say that, but it's going to happen again.

In the last four years since that report, where that inquiry originated from a medicine-related issue, still not much has really been done to support the funding of pharmacy departments to make sure that we do have pharmacists on discharge, at transitions of care, providing that cognitive and clinical pharmacy service.

MR MUSTON: Not taking the medication that they need is one possible answer to your rhetorical question. The other one is, if you can't get into your GP, you will re-present at the hospital, presumably through emergency, to say, "I haven't been able to get my medicine. Could you please give me a script for a little bit more while I wait to see the GP?"

MR YIK: Yes, and I think that does occur, too. We have been seeing more and more presentations to EDs because patients don't have enough medicines, and that can be from, as you've described, not being given enough on discharge. There are also obviously other issues around medication shortages at the moment as well that are also causing some ED presentations as well.

MR MUSTON: So coming to some of the solutions, I think we understand the importance of pharmacists within the hospital setting and the potential challenges that you identify if there are not sufficient of them from a pathway - a pipeline point of view, but equally within the workforce. The first is an increase - you propose an increase in the number of pharmacy intern positions.

MR YIK: Yes.

MR MUSTON: Perhaps, Dr Penm, you are best placed to answer this, but could you just explain what is the intern - what role does an internship play in the career progression and education of a pharmacist, and what do you think increasing hospital pharmacy intern positions would do from a workforce point of view within New South Wales?

DR PENM: Yes. So once a pharmacy student completes their degree and has a registerable degree, every one of them needs to complete a one-year internship before they can practise independently. That comes with both supervised hours and an exam at the end. So that's every pharmacy student who has to do that.

At my own university, the University of Sydney, we have around 350 students coming out every year. As you can see, we only have 40 hospital internships, which is very small for the amount that's applying, that's that top 10 per cent, and we have data that 80 per cent of students want to go to a hospital.

If people don't get that initial entry level into the hospital - they apply, they don't get it - it definitely turns them off wanting to come in, but those who do get it they can see their skills in practice, they get mentorship, which we know is extremely important in the early years of development for a healthcare professional, and if you have a very positive experience early on, that will keep people for a long time. That's the retention strategy.

But we're finding they're very attracted to hospital because that's where their medication knowledge will be used the most, in the most complex patients environment, but if we don't look after them, then they're going to leave. So increasing the number will definitely attract more people to see the joys of hospital, to see - for patients to get those benefits that we've talked about, which is really good, and I think we have interns or students wanting those positions. But we also want to make sure we look after them once they're in.

MR MUSTON: Looking after them once they're in requires sufficient workforce to enable mentorship and support to be provided to the interns, presumably.

DR PENM: Yes. Looking after them is having those resident training programs afterwards to then facilitate the specialised skills that they need if they want to progress their career. It needs to be rewarding them for those skills and to recognise the value they have - that comes from the healthcare awards, so that also needs to be looked at, and then having the educators and mentorship that we've talked about.

MR MUSTON: Just before we come to the educators and mentorship again, can I ask, in your statement on page 6 you refer to the situation in Victoria where intern positions are 60 per cent funded by the state government. Could I just ask you to expand, does that mean that they are 40 per cent funded from somewhere else, or they are not - you only get 60 per cent of an income if you're an intern?

MR YIK: It is certainly not that we get only 60 per cent of the wage. In Victoria they have a fairly centralised recruitment and funding model for hospital pharmacy interns in Victorian hospitals. That government does take the entry pipeline into workforce fairly seriously and so the Victorian government provides 60 per cent of the intern pharmacist's salary to the hospital and health service, and so the hospital only has to pay - find 40 per cent of the intern's wage from their own budget.

In New South Wales, the way that it works is without that funding, without dedicated funding from the government, they have to find 100 per cent of the wage, and

that might be the case in other states as well, but I think the results from Victoria are really clear. They take entry and workforce pipeline fairly seriously, and they know that hospitals themselves cannot fund it alone. So providing that support to Victorian hospitals means that they can hire even more interns. I think the results speak for themselves.

DR PENM: One example of that is that one of the largest hospitals in New South Wales doesn't take any interns. Even though it's a teaching hospital, it's one of the largest, in some sense probably needs it the most, they don't, because it comes 100 per cent out of their budget and they say, "Well, we're struggling to deliver the service as it is, we're just going to hire four pharmacists." The consequence is you're filling in holes and you're going to cause more problems for yourself in the future.

MR YIK: In Victoria your major teaching hospitals take anywhere between 7 to 10 interns each year. I think in New South Wales it would range from zero to four.

DR PENM: Zero to two. You don't see four very often these days.

THE COMMISSIONER: What is the hospital you are referring to in New South Wales?

DR PENM: That would be Westmead Hospital.

MR MUSTON: So do you see value in the centralised recruitment process which is operated through Victoria? Putting to one side the way the funding works, of the salaries, what do you see is the value of that centralised recruitment process, say starting from the perspective of the student?

DR PENM: Centralised recruitment would mean that the job applications are centralised, the whole process of interviews and putting in your preferences. That comes with two main benefits. One is it means you can prioritise all your efforts on making one application good, as opposed to putting in 40 applications that often have mistakes, which is very, very exhausting for students.

I see, once they go into a job interview, there will

be over 150 applicants for one position. Their chance of being rejected is high. But when they get an interview and they get rejected not just once, they get rejected twice, three times, four times, they don't want to keep applying. It's emotionally, mentally exhausting, because it's not centralised. They've got to apply for each place, and you can only take so much rejection while doing full-time study, while also working, making sure exams are okay and trying to get a job next year, so I find our students would value a lot from that.

The other part is they have to really prioritise that, so they can't really say, "I just want this for the leverage"; it's, "Which hospitals are worth my time?" For a lot of people based in the general metro region they will generally go to a large hospital but that means our smaller regional hospitals suffer for that.

We have people who are probably happy to work there but they just don't have the capacity to apply for it, they have to prioritise their time. So we do see in some places people who will apply to a regional/rural hospital, or they might want to, but because they are waiting out for the larger hospital to do their advertisement, they're just not going to apply until that does. So there are just multiple add-on effects around distribution and equity of positions in New South Wales by not having it centralised.

MR MUSTON: Something you said a moment ago about waiting for a larger hospital to advertise, is it also the case at the moment in New South Wales that pharmacy positions are advertised as and when they are required, including intern positions; there's not a season where everyone who wants a pharmacist this year puts out an ad and says, "We want a pharmacist"?

DR PENM: I think they all try to, but the priorities mean that everyone will start to advertise in the second half of the year, but that can range -it can be a difference of one to four months, and every HR group seems to have a different timeline, you know, how they advertise it. So we do know we need them for next year, but it's not like this month they all happen; it can happen in a four- to six-month period.

MR MUSTON: Do I gather from what you've told us that at least your view is from the perspective of students, if not

the system, a centralised recruitment process for pharmacists entering into at least into their intern year would be a sensible idea?

DR PENM: I think students would love it, would be very positive towards it.

MR MUSTON: No doubt pharmacists within facilities who are having to review multiple applications and interview candidates who they are not going to give the job to would probably also appreciate it. Mr Yik, as someone who practices in a hospital perhaps not doing that work, do you have a comment on that?

MR YIK: I think what Dr Penm has described is very accurate. It's not just good, as you've described, for the students but also for the hospital, where they're not sifting through, you know, more applications than they need to. So through that central applicant process you can give your top, you know, three preferences and then you get matched according to that, so then everyone has less work to do but it's much more targeted and appropriate and more efficient for everyone.

MR MUSTON: Increasing the number of intern positions by 100 FTE would have two benefits, presumably: the first is it would increase the pharmacy workforce at the junior end who is able to do some of that junior work, like reconciliation, easy dispensing and the like --

MR YIK: Mmm.

DR PENM: Mmm.

MR MUSTON: -- which would relieve the pressure on existing pharmacy workforce - yes?

MR YIK: Yes, absolutely. So obviously intern pharmacists still need to be supervised by pharmacists during their intern year, but they are able to undertake a lot of those activities under the supervision of pharmacists that can contribute to making sure that patients get medication reconciliation, they get some medication chart review, they get counselling by a pharmacy professional as well.

MR MUSTON: Whilst there is a burden of the supervision, by increasing the number of interns you would, in effect,

be increasing the workforce or the realistic workforce - that is to say, more work could be done by increasing the number of interns? It's not just that they would be watching, adding more strain on the resources of existing pharmacy workforce?

MR YIK: Yes. It certainly does increase the output, the clinical output that a pharmacy department can provide. It certainly makes the care more comprehensive and safer and higher quality as well.

MR MUSTON: From a pipeline point of view, it would seem logical that increasing the number of intern positions would improve the strength of the pipeline of pharmacists coming into hospitals, but is that assumption sound?

MR YIK: Look, it is sound to an extent, because you are increasing the knowledge base of pharmacy professionals in New South Wales that are appropriate and trained in the hospital setting. As we've presented in our evidence, I think up to - some hospitals are reporting up to 90 per cent of their applicants for hospital pharmacy jobs are just inappropriate or not suitable or not suitably qualified for the job, because all of their experience has been in the community pharmacy setting.

That's transferrable to the hospital setting to an extent. There's still significant retraining and training requirements for the hospital setting, and where you are already a short-staffed workplace, it's a lot to take on, and so we just end up in this cycle where we end up not recruiting anyone.

So increasing the number of intern placements can probably - well, will likely increase the available workforce pool that is appropriate to work in the hospital pharmacy setting without significant retraining required, but I think we also want to keep them in that hospital setting at the end of their intern year.

We don't want to spend - unfortunately, this is the case for a lot of states and a lot of hospitals where we spend a whole year spending money or spending our workforce on training the intern, our doctors and nurses help train that intern as well, and then at the end of the year, "Sorry, there's no funding for your position, even though we would really like to keep you on this ward, so we're

going to have to let you go back out into the community." The hospitals rightly train students from all healthcare disciplines and have a duty to do so, but why are we not keeping them in the system at the end?

MR MUSTON: In terms of that training and the way in which it's delivered, you've talked about educators in your statement and the importance of having a workforce of educators who actually assist in guiding that training both at an intern level but also through advanced skills training. Do you see value in that process being centralised within the ministry - that is to say, the training workforce to potentially be a part of, say, a central pillar of the ministry that's also involved in recruiting the interns?

MR YIK: Yes, look, I think we're certainly very open to that. I think at this point we would take any attention or funding from the ministry that looks at the education and training of pharmacy professionals beyond internship. I think as we've described in our evidence, in Australia there are resident pharmacist and registrar pharmacist training programs that are convened by AdPha. So far, we've got over 800 pharmacists who have either undertaken or have completed a training program, yet only 50 of them - sorry, less than 50 of them are from New South Wales, and that is because there is no capacity and no funding to fund those positions for residents or registrar pharmacists. Even for hospitals that do want to provide these training programs and think, "Well, I've got an oncology ward and I need an oncology pharmacist, I want to train a pharmacist in the area", again, the lack of educators can often be a barrier as well.

So even when we want to try and hire education pharmacists within our hospitals, that can be really difficult to get approval and clearance from the LHD.

In what you've described, where it's a more centralised process and you could have pharmacy educators that are employed by the ministry and deployed to various LHDs where there is need, I think - I can't speak for all hospitals, but it would certainly be better than what we have now, because at the moment, it's quite sparse. The education pharmacist network in New South Wales is - yes, it is quite sparse, and so any more funding via various means would be very, very welcome.

MR MUSTON: That education workforce - you've mentioned the value, obviously, of face-to-face pharmacy when dealing with patients as potentially being better than remotely delivered pharmacy, but remotely is better than nothing. What about education? Is there scope for remotely delivered education through pharmacist educators who are not necessarily on the ground, particularly in smaller facilities in rural and regional areas?

MR YIK: Yes. I think there absolutely is a capacity for that and it's something that we would be very, very happy to explore. As we've talked about, these resident pharmacists and registrar pharmacist training programs, we want to deliver them in rural and regional healthcare settings but, of course, you may not have the education pharmacists there on site because they don't happen to live there, but that should not be the rate-limiting step as to why a young pharmacy professional can't undertake those training programs.

So we are very open to having mentors or education pharmacists delivering the services remotely or via, you know - we all have Zoom and Teams nowadays, and every time that we accredit those sites to undertake and deliver those training programs, as long as you can demonstrate that you can provide that service, then that should be fine. So if that is to be delivered electronically or via telehealth - via Zoom or Teams - we would facilitate that and accredit that program.

MR MUSTON: The ability to know where it's needed and where that outreach or remote teaching might best be delivered requires some level of centralised control or coordination over the process, though, presumably?

MR YIK: It would and it would require the attention and knowledge of what pharmacy educators provide and the importance to ensuring the quality of clinical placements for pharmacy students and for interns and for developing your current pharmacist workforce as well.

MR MUSTON: In terms of those pharmacists who have obtained those advanced skills training, you tell us in the statement - I assume I've understood it correctly - that to the extent that there are benefits associated with pharmacists being involved in the delivery of care in terms

of reducing errors, enhancing outcomes, those benefits are enhanced even further where a pharmacist with some advanced skills training is operating within an area of that particular - where they have that skill?

MR YIK: Yes. Absolutely, and we have developed these programs so that patients are receiving services from the most appropriately trained pharmacists.

Going back to, you know, two decades ago, if you were walking into an infectious diseases ward or an oncology ward, the pharmacist that was being put into that ward may have just been a general pharmacist who may not have received training, but because there were just no formalised training programs at all, there was an expectation, or it was a standard, really, that you would just learn on the job.

So you did that model for a number of years, for decades, because there was no other model to ensure that pharmacists were ready, educated and prepared, before they stepped into that ward. And this is what this program aims to provide, because it's just much safer and more appropriate for the patient.

MR MUSTON: Given the relatively small number of people in New South Wales who are passing through this program, do I infer from what you said a moment ago that, at least in New South Wales, as distinct, perhaps, from other states, we're still doing things the same way as we were doing them decades ago?

MR YIK: If at all, and I guess we go back to our very early evidence, that there are still many wards that don't have pharmacists on them at all. But I guess as you've suggested, even when you do have a pharmacist on that ward in New South Wales, they may not be the most appropriately trained or - sorry, they may not have sufficient training compared to practitioners and their peers in other states.

MR MUSTON: Just in relation to what you tell us about the resident pharmacist positions and resident training programs, what is in the context of a pharmacist's educational and professional journey, a resident position? Is it a particular assignation of position or is it more you are a full-time pharmacist working in a facility who then wants to get some more training?

MR YIK: A resident pharmacist position is aimed at pharmacists who are entering at the start of their career, it is to consolidate and expand the skills that they have obtained in the intern year. For a resident pharmacist in a hospital, they will often do four six-month rotations, so it's a two-year program, and those rotations will take them through the busiest parts of the hospital, so that they go on a really steep curve in developing and consolidating their skills.

I think it's six months in the dispensary, six months in the surgical ward, and six months in a general medicine ward because both of those wards have really high patient flows so you get exposed to a lot of different patients and develop your skills really, really quickly, and comprehensively.

Then your final rotation can be an area of your choice that will expose you to a specialist ward. So it could be your final rotation might be through the oncology ward, it might be through the psychiatry ward, it might be through the stroke ward, to get you exposed to an area that you might want to specialise in that also requires a pharmacist to be working in that ward as well.

DR PENM: I was going to say, what it provides different to a regular fully registered pharmacist is just structured training and mentorship. Because we have not had funding, or lack of funding, a lot of our departments just don't feel they can offer that training, and so they say, "Figure it out yourself. You're on your own." That's not helpful for from an investment point of view from our workforce retention.

So having these roles doesn't change the tasks they do, but it shows the support we have for them, that their career is important, that we value their service, and I feel that pharmacists in New South Wales don't always get that message and they don't have these programs, and other states do.

MR MUSTON: You tell us that there's potential benefit in providing funding to enable hospital pharmacy student placements within NSW Health facilities. What is the benefit to be gained there?

DR PENM: We see that a lot of students will - I'll step back. Your early years and experiences really do shape where your career goes and where you can see yourself, and because we don't have the capacity to even teach our own pharmacists in the hospital, we have even less capacity, sometimes, to take students. So I think within the report - and I'll have to figure out the page - but within New South Wales --

MR MUSTON: Page 14.

DR PENM: Page 14, thank you. We only offer about a month of exposure to the hospital environment for our students, versus, say, Victoria, has two to four months.

More exposure to hospital will help our students see themselves do that role, see that as a career path, help develop their mentorship, their identity. I think it will not only provide value to the students because they will now be more aware of what's happening in the hospital,

I think even those who go to community need to know what happens in the hospital, because that helps that transition of care thing we talked about earlier. Discharge becomes a problem when the community doesn't know what's happening, so they need to know what's happening for the hospital to get those benefits.

But I would also argue, as an educator, that having students in the hospital helps keep everyone performing better. When you're constantly teaching and you're constantly learning, that is a good environment for health care. That is a good environment for our patients. By taking students or limiting exposure to students, we fall into a scenario or culture where teaching is what you do when you have extra capacity, not - learning is not what you do every day, and I think teaching and learning should be things that happen every day, to have a system that is constantly trying to be better, constantly trying to keep our patients safe, and that's a good thing.

MR MUSTON: To the extent that it's suggested in your statement that more funding is required to enable that to occur, is that, in essence, a reference to the need to free up sufficient time within a workforce to enable that teaching to occur? It is not suggested that the placement students would be paid for their placements or anything

like that, is it?

MR YIK: Yes, look, I think there are, I guess, two prongs into that approach. One is - so funding for the clinical pharmacist educator is important, because if you have students going to your hospital, a lot of hospitals are being asked to do it out of the kindness of their own heart and because they have some moral responsibility to train the next generation of healthcare workers, and some hospitals do take that on, where they can, but as Dr Penm has said, they can't even train their own pharmacists, so a lot of hospitals don't.

So in other states, in other universities, they actually do pay for the position of the clinical pharmacist educator for the three or four weeks that they have their uni students in that hospital. I don't think that's occurring at all in New South Wales, and that's something that should be explored as well.

I think for the pharmacist - sorry, for the pharmacy student as well, historically, these placements were not paid, and - because placements weren't paid for, for a while. But what we are hearing from students nowadays is, "Yes, I want to do placements. It enhances my learning and it consolidates what I learn at university", but because of the cost of living crisis, because of placement poverty, students can't afford to do clinical placements full time if that means they can't work at their part-time job to pay for rent and pay for bills.

So I think again, that probably does need to be looked at again. We should be funding - we should be paying pharmacy students if they are undertaking a placement throughout their degree.

MR MUSTON: A pharmacy student undertaking a placement, are they able to actually make a meaningful contribution to the work of the pharmacy department or is it purely observation?

DR PENM: We did do that work earlier, at Sydney University, where we had students conduct best possible medication histories. They can provide value. I do hear your point that it's also - it takes time to teach and they might be learning, so why would you pay someone when they're learning? There are places that do use their

skills and provide value to the hospital. I think there are areas that they can provide value but you need to have the infrastructure, educators and supervisors to do that, and when they don't, it's very hard to utilise them to their full potential. I think in an environment like New South Wales, where we don't have a lot of staffing, it's very hard for them to see how to use pharmacy students at times, but we do have ways that you can if you have the right staffing.

MR MUSTON: The last question I want to ask you is about the pharmacists award and the proposition that it needs to be reformed. What is it about the pharmacists award that you think could be adjusted to solve some of these problems that you have identified?

MR YIK: Look, I think the award is really basic and doesn't meet the needs of pharmacists in New South Wales today. It doesn't recognise the ability or the need for pharmacists to specialise and advance their skills in different clinical areas. There's a fairly low ceiling that you can hit fairly quickly. It doesn't offer enough career progression at all. The pay scales aren't competitive in a state like New South Wales where you do have various clinical bodies such as the Clinical Excellence Commission, the Australian Commission on Safety and Quality in Health Care, the department, the Ministry of Health, and pharma companies in Ryde as well - there's a lot of areas in which pharmacists can move into in the state of New South Wales, which is really good.

That's really great for New South Wales pharmacy students and pharmacists. However, you need to make sure that your hospitals that are providing care to patients are also appropriately staffed and that you are attracting and retaining the best possible pharmacists that you can have, and the award does not support that at this point in time.

MR MUSTON: What is it about the award that means it lacks a career progression? What does the current career progression look like, at least through the lens of the award?

MR YIK: You have grade 1, 2 and 3 and you get the senior pharmacist. So at that senior pharmacist level, at that grade 3 level, in some hospitals you'll find grade 3 pharmacists who have been there for maybe five years, but

all of the extra pharmacists have been there for 40 years or 30 years, who are absolute experts in oncology or absolute experts in infectious diseases. The current award does not really make much of a distinction between those two groups of pharmacists. They are both excellent pharmacists, but perhaps that pharmacist who has been there for 30 years is just that bit better.

I think having that robustness and recognition of those advanced skills and consolidated skills needs to be reflected in the award, recognition through the Australian and New Zealand College of Advanced Pharmacy as well, where you are recognised as a resident, registrar or consultant in the 46 disciplines recognised by ANZCAP, allowances for if you have achieved higher education as well, so if you have done a masters, a grad dip or a PhD, that should be recognised through the award as well.

I think when you are also looking at the directorships and leadership and management positions as well, they should be strongly reviewed as well, because you have pharmacists reaching that grade 7, grade 6 level of the award, on a salary that is, I think, 150 to 170, depending on what hospital you are at, but your responsibility is so large - I don't know how else to describe it - you are managing a drug budget, an annual drug budget of over $200 million.

I think in any other type of healthcare area or supply chain department, where you're managing a budget that large, you're probably being paid a bit more than that, and so again - and when you're reaching that grade 5, 6, 7 level of the award, you're probably also a really good candidate to work in all these other opportunities in areas that New South Wales can offer as well. So again, does the award incentivise, attract and retain pharmacists to work in hospitals where they're delivering patient care? I think the answer is no. And I think that's probably what really needs to be reformed.

DR PENM: One thing I might just highlight, if you look at the award, grade 4 and above is really limited to directors and deputy directors. It is limited to management. What we've talked about today is a lot of the value we provide is a clinical service, so the award doesn't really value clinical expertise, clinical specialisation, in its current form. So we do have those people who are, as Mr Yik has

said, grade 3. They are very high clinicians, they want to keep pursuing that, they want to keep doing well there, but the award doesn't recognise if they do, and I think that can be very frustrating for our members.

MR YIK: I think the take-away from that is that you have pharmacists who love patient care. They are really, really dedicated to providing the best possible patient care to the patients in hospitals, but for them to further their career, they have to step away from patient care. I think this is what the award is telling them or the signals that the award and the landscape is sort of indicating - to advance their career, they have to go into positions that take them away from direct patient care.

MR MUSTON: Whilst not picked up in the award, in the sense that, as I understand your evidence, it doesn't result in you being paid more money or going up a grade, is the advanced training or recognition of advanced training qualifications used in any other way in a practical sense within the system at the moment? That is to say, does it change in any material way the way in which you might, in any particular facility, go about your work?

MR YIK: Formally through the recognition of awards, no, but it is something that we want to influence and change, and these obviously - the structure of these awards were, you know, done many decades ago, and so they haven't kept up to pace with how the healthcare landscape has changed, where we do have training colleges, you do have resident and registrar training programs for allied health and for pharmacists. So I think the short answer is no, but that's not because there isn't a need for it. There absolutely is a need for it and - yes. So that needs to be the discussion, whenever awards are being negotiated.

DR PENM: I might just add to that that it kind of shows where that recognition comes from, is that because pharmacists are not being recognised in the award, they want these other pathways to show off the skills they have. They would love for it to be recognised in the award, that would be amazing. But they have a skill, patients benefit, people need to know about it, and that's really where that's - why those programs exist and why those fellowships exist, to help make that obvious that, yes, it is a different level. It's just not recognised here.

MR YIK: I guess, yes, a lot of these programs that we've discussed today are industry led, led by our association, because there's an absolute need for it. Where the award is failing to recognise that, we've stepped in to provide that recognition program so that pharmacists can rightly feel proud and happy of what they're achieving and what they're providing to their patients and having - "Yes, I can say that, I am a consultant pharmacist in geriatric medicine because my college recognises me, even if my award doesn't."

MR MUSTON: Thank you. I have no further questions for these witnesses, Commissioner.

THE COMMISSIONER: Mr Chiu?

MR CHIU: Commissioner, I have no questions for these witnesses but there are a couple of matters that I wanted to raise with you. I can do that after the break, if you prefer.

THE COMMISSIONER: A couple of matters you want to raise with me in chambers?

MR CHIU: No, in open court, as it were.

THE COMMISSIONER: You can do that now, if you like.

MR CHIU: The first is something that fell from you earlier as to where the New South Wales Government or NSW Health's response is to the ramping inquiry --

THE COMMISSIONER: I was reading from --

MR CHIU: Yes. Just so you are aware, there was some evidence about that in an earlier statement of Ms Dominish in the earlier workforce block, if you wanted to have a look at that.

THE COMMISSIONER: Thank you.

MR CHIU: The second matter is that the issue of centralisation of intern recruitment for pharmacists, that wasn't previously raised, as I recall, with Ms Dominish. I would like to take some instructions from her and potentially put on a supplementary statement, if you would permit me.

THE COMMISSIONER: Yes, of course, yes.

MR CHIU: Thank you, Commissioner.

THE COMMISSIONER: Okay. We might adjourn until 2.15, given it is 1.20, so we will adjourn until 2.15.

MR MUSTON: We will excuse these two.

THE COMMISSIONER: I'm about to not only excuse them but thank them very much for their attendance.

We're very grateful for the time you have spent on this.

MR YIK: Thank you.

DR PENM: Thank you.

<THE WITNESS WITHDREW

LUNCHEON ADJOURNMENT

THE COMMISSIONER: Good afternoon.

MR MUSTON: Commissioner, this afternoon's panel, at least in person, from your left to your right is Michael Bonning, a general practitioner and former president of the AMA; Luke Sloane, the deputy secretary, rural and regional health, from the ministry; and Rebekah Hoffman, who is the chair of the New South Wales and ACT faculty of the Royal Australian College of General Practitioners.

On your screen is Georgina van de Water, the CEO of the Australian College of General Practitioners - you can work out which one she is, because the background tells you - and Dr Rachel Christmas, who we have heard some evidence from before, the president of the Rural Doctors' Association NSW.

THE COMMISSIONER: All right.

MR MUSTON: I think we probably need to work out which ones will take an affirmation and which ones will take an oath and we can probably do them quickly in two lots.

<GEORGINA SCOTT VAN DE WATER, sworn: [2.17pm]

<MICHAEL BONNING, affirmed:

<LUKE ANTHONY SLOANE, affirmed:

<RACHEL CHRISTMAS, affirmed

<REBEKAH HOFFMAN, affirmed:

MR MUSTON: Quickly, Dr Bonning, could you state your full name for the record, please.

DR BONNING: Dr Michael Bonning.

MR MUSTON: You are a general practitioner and a former president of the AMA?

DR BONNING: The AMA here in New South Wales, yes.

MR MUSTON: Thank you. And you've prepared a statement to assist the Inquiry with its work, dated 23 July 2024?

DR BONNING: Yes.

MR MUSTON: Do you have a copy of that statement with you?

DR BONNING: I do. Thank you.

MR MUSTON: Have you had a chance to review it before you give your evidence today?

DR BONNING: I wrote it, so yes.

MR MUSTON: You have reviewed it sufficiently recently to be able to tell us whether you are, as you sit there now, confident that its contents are, to the best of your knowledge, true and correct?

DR BONNING: Yes.

MR MUSTON: That can be found behind tab H7.9. I probably should have indicated, Commissioner, Mr Chapman appears for the AMA.

THE COMMISSIONER: Leave is granted, to the extent necessary, thank you.

MR MUSTON: I think it has been granted previously.

Mr Sloane, could you state your full name for the record, please.

MR SLOANE: Luke Anthony Sloane.

MR MUSTON: You are the deputy secretary of rural and regional health within the NSW Ministry of Health?

MR SLOANE: That's correct.

MR MUSTON: You've prepared two statements to assist the Inquiry with its work, the first dated 9 April 2024?

MR SLOANE: Yes.

MR MUSTON: And another one, more recent statement, dated 3 October 2024?

MR SLOANE: Yes.

MR MUSTON: You have copies of both of them with you?

MR SLOANE: I do.

MR MUSTON: You, too, have had an opportunity to review them before giving your evidence today?

MR SLOANE: Yes, I have.

MR MUSTON: Are you satisfied that their contents are true and correct?

MR SLOANE: Yes, I am.

MR MUSTON: They are behind tabs D6 and L3, Commissioner.

THE COMMISSIONER: Yes.

MR MUSTON: Dr Hoffman, could you state your full name for the record, please.

DR HOFFMAN: Dr Rebekah Hoffman.

MR MUSTON: You're the chair of the New South Wales and

ACT faculty of the Royal Australian College of General Practitioners?

DR HOFFMAN: Correct?

MR MUSTON: How long have you held that role?

DR HOFFMAN: Twelve months this week.

MR MUSTON: When you're not dealing with the work that you do within that role, you're a general practitioner practising in the southern suburbs of Sydney?

DR HOFFMAN: Correct.

MR MUSTON: Ms van de Water, could you state your full name for the record, please.

MS VAN DE WATER: Georgina Scott van de Water.

MR MUSTON: You are the CEO of the Royal Australian College of General Practitioners?

MS VAN DE WATER: That's correct.

MR MUSTON: How long have you been in that role?

MS VAN DE WATER: I've been in this role for six months, I've been with the RACGP for two and a half years.

MR MUSTON: Thank you.

Finally, Dr Christmas, could you state your full name for the record again, please.

DR CHRISTMAS: Dr Rachel Christmas.

MR MUSTON: You are the president of the Rural Doctors Association of New South Wales?

DR CHRISTMAS: I am.

MR MUSTON: When you are not dealing with the work associated with that office, you are a GP VMO practising in, if my memory serves me correctly, Temora.

DR CHRISTMAS: Correct, yes.

MR MUSTON: With advanced skills training in obstetrics?

DR CHRISTMAS: That's right.

MR MUSTON: Age hasn't taken away all of my faculties quite yet.

In terms of the process and the way in which we go about the evidence this afternoon, I'm going to ask a series of questions working through a range of issues that are of interest to the Inquiry.

Equally, I would invite any of you who have issues which you think are adjacent to areas on which questions might be asked, to tell us and chime in. Don't feel that you are confined in any strict sense to the questions I'm asking, but equally, don't feel that you are prevented from asking one another questions, if you think that would be a useful way of trying to get to the bottom of some of these issues.

What we are hoping to do, having identified through our regional hearings and some early workforce hearings, what we see as some of the key challenges particularly within the workforce area in this, for the purposes of this particular session, within the area of primary care, we're looking to try and tease out some potential solutions based on the wealth of experience that you all have coming from different perspectives. It may well be that the questions that you're able to ask one another through that process are of greater utility than any questions I will be able to ask you. So please don't feel constrained in any way from doing so if you think that would be helpful.

But can I start just by making sure our baseline, in terms of the challenges, accords with what each of you see as being the key challenges within this area. The first is that within the medical workforce, there is a generational shift away from general practice at the moment. Would you all generally agree that that's a key challenge in the area of primary health?

DR BONNING: Yes.

MR SLOANE: Yes.

DR CHRISTMAS: Yes.

MR MUSTON: That has, as one of the immediate consequences, a challenge which is it makes accessing good primary care very difficult for many people within New South Wales.

DR BONNING: I think that the challenge in splitting that out is that Australia's workforce planning around primary care, general practice, as opposed to where we get our general practitioners from, includes a significant number, and I think slightly more than half of the practising GPs in Australia originally did their medical training in other countries. So that becomes how we have managed the workforce over an extended period of time. That's both through Australia's recruitment kind of pathways and visa schemes as well as, I think, international doctors seeing our system and wanting to move here, Australia is a great place to work. So, you know, there is a number of pushes and - sorry, pulls and pushes that are sending people to be part of our primary care system.

MR MUSTON: So the drift away from primary care as a career path, at least on the part of domestically trained doctors, is a contributing factor to challenges that are faced by the community in accessing good primary care?

DR BONNING: Yes.

MR MUSTON: But to an extent, that challenge is being addressed, at least in some part, by the introduction of a substantial body of internationally trained general practitioners into the workforce?

DR BONNING: Yes.

MR SLOANE: I would probably just make one other comment. When we're defining primary care, we talk about specifically the general practice portion of it, because there is the rest of the multidisciplinary team that make up good primary care, but I'd say the influences that you have spoken about also have impacted nursing, allied health, practice management, and all the other aspects of work with general practice in the primary care setting.

On top of that generational move away from general practice, I think there's the other compelling issue of

quite a substantial change in workforce expectations, not only in primary care but in a lot of areas around what would previously have been quite a significant workload that was 24/7, to post COVID era, of a new balance of work/life, whereas one full-time equivalent might have done the work, you know - and again, backing this up with evidence across the shortages and FTE or otherwise - that might be two, 2.5FTE doing the same amount of work now, because people don't want to do the overtime and they want that life/work balance, and it's across all aspects of workforce, I think.

MR MUSTON: For those of you who are working in the general practice and primary health setting, is that generally - does that accord with your experience?

DR HOFFMAN: Absolutely. So there's definitely a trend in the upcoming generation, both of males and females are more inclined to work part time rather than full time, on average, with many GPs only wanting to do three to four days a week.

DR CHRISTMAS: And I also would add that in rural areas where GPs work more than full time, that's a disincentive to people wanting to go rural because they see a workload that is unsustainable.

DR BONNING: I think when you think about - obviously Dr Christmas has just made that comment, but on top of that, when you think about your workforce strategies for communities where there is a need for an extended version of general practice - I have to be really clear, I work in the city and therefore I see patients in very kind of office hours, but, you know, you need to have a workforce approach that thinks about a community needing four or five or six doctors, maybe, to replace only two who are leaving, because the idea that you're willing to do, you know, one in two on call is less and less likely. Also, you know, what we used to consider reasonable, now we would consider quite unsafe as well. So there's a shifting understanding of what is both good for the community, but also good for the practitioners. We can talk at other times about the fact that there are many issues with people working too long and too hard, so a normalisation of how the workforce should be used is important, too.

MR MUSTON: Dr Christmas, can I just test that quickly

with you. In terms of a practitioner in a rural or regional setting, we've heard a lot of evidence in the course of our travels about the changing work patterns of new graduates and that generation of doctors that are coming through, but is it your experience that the need to replace, say, one FTE with two or three FTEs is not just that the two or three who are coming along are not willing to work to the one FTE that was once there, but, rather, the individual they are replacing might, in fact, have been doing two or three FTE of work themselves.

DR CHRISTMAS: Absolutely, and I think we see that in our registrars coming along, who work very hard and they're very good at what they do, but they are not prepared to work the hours that existing GPs like me are working. And that's not because I want to work those hours; that's because the work just has to be done.

It may not be because I see excessive amounts of patients during the day, but the load on the administrative and my hospital load as well and my on-call requirement means that there are just so many hours in the day.

If I were to balance my day, including hospital work and general practice work, into a reasonable, say, 10-hour working day, I would see half the number of people that I see in general practice, because I just - there is no time to do the necessaries, the admin, the follow-up, the extra reading, the extra things that you need to do to take care of your patients within work hours.

MS VAN DE WATER: That's absolutely something we are hearing from our members as well, that the increase in the administrative load on GPs is absolutely impacting on their available patient hours.

MR MUSTON: So whilst it sounds as though the causes are multifactorial, a challenge that is presented is accessing good primary care not just through GPs but through all of the other medical professionals and clinicians who form part of that team that is, a good general practice is increasingly growing very challenging for people within New South Wales?

DR BONNING: Yes.

MR SLOANE: I would be commenting for rural and regional

New South Wales, yes, I think that's what we're seeing.

MR MUSTON: I suppose, just drawing on the experience of all of you in the panel, is that problem particularly acute, do you think, in the rural and regional settings - that is, difficulty in accessing good primary care is particularly challenging for people who are currently living in rural and regional settings; not all of them, but some?

MR SLOANE: Yes, look, I would say it's varied and very contextual. Some towns have a very - sorry for the sort of colloquialism - but a very sweet spot around their access to primary care, you know, we've only got to use cases from travelling to go Braidwood and Crookwell and Goulburn this week where two years ago they were in a position to have - especially Braidwood is a good example, the GP practice was being sold and they didn't see a very near future for that to be stood up or continued on, whereas now, two years on, they have very much got a successful GP, it's running very well there, it's co-located with the hospital, they've got visiting rights, it is working very well. They've attracted another GP to come in who is also going to be a VMO at the hospital, and they're expecting a third. So they're very able to manage, I think, a population of 3,000 and it has restored access to general practice in that primary care setting outside of the hospital quite impressively. Similar with Junee. I could go through all the towns where it's working very well.

However, the alternative is really real as well. Perhaps towns, depending on their liveability as perceived by those people moving there, or deciding not to, you know, some of them are really struggling with even getting a nurse-led model up or attracting health professionals in to sustain not only primary care but health care.

I think you would have heard through evidence to date, from what I have seen and read, that that challenge presents itself in quite a variety of regional towns in New South Wales.

MR MUSTON: Dr Christmas, I saw you nodding. Did you want to add anything to that?

DR CHRISTMAS: No. I think Luke has summarised that really well. It does vary depending on the town. But

overall, I would say the statistics are in favour of primary health services being under threat or actually dying in a lot of rural and regional areas.

DR HOFFMAN: I would add to that by saying that we have spoken before, saying one rural town is one rural town, and some are absolutely having a phenomenal GP workforce and thriving. Wagga has an incredible GP workforce of mostly overseas trained doctors. They have a wonderful culture there. They have attracted and are attracting new doctors there, whereas I'm off to Dubbo and Wellington tomorrow and they don't.

MR MUSTON: So variable from town to town or place to place?

DR BONNING: If you were to think about it, you know, directionally over time, and this is very much my comment, there's maybe a hollowing out of rural and regional practice. So there are some centres and they end up becoming hubs for the other local communities, but if you were to go back in time, 20 or 30 years, you would have known those communities to have their own GPs and potentially other allied health professionals who were there, and that has - that model has, you know, not been sustainable, both for the workforce reasons and also for financial reasons.

THE COMMISSIONER: When we talk about access to general practice, though, there's a variety of circumstances - there are the towns where the GP market has just failed, there is no-one left and there has had to be interventions of one form or another, whatever they ever been.

Then there are the towns where they are still probably not making huge amounts of money but have what I'll call very full, busy GP practices, but access is problematic to people that are either new to the town or aren't on the books because the books might be closed, or it might take between two or six weeks to get an appointment for what I'll call a routine GP visit, which might be in the category of a town or a place or a region that is not providing what we would hope for in terms of reasonable access to GPs if you are having to wait that long. So there are all those variations as well. You would agree with that, I imagine?

DR BONNING: I would agree with that, Commissioner, yes.

MR SLOANE: I would agree with that, and then I would say that's also reflected in emergency presentation data in those towns where we have a hospital facility with emergency access.

MR MUSTON: If I could unpack something you said a moment ago, Dr Bonning, about the hollowing out, it's one thing to say a small satellite town adjacent to a centre like, say, Dubbo or Wagga, no longer having a GP where it once was, might result in people having to drive from that small satellite town or village into a centre to access their primary care, which may be acceptable, may not be acceptable, depending on the time of the drive, but once they get into that central town, there needs to be a sufficient GP workforce to meet the needs of that wider population that they are serving, and it may vary from town to town, but often for each GP that retires in a little satellite village, you're not getting an extra one practising in a central town.

DR BONNING: That would be very true. You know, you need to then coalesce more in a central location. I think a number of us are GPs, GP VMOs on this panel, but I like to think of myself as a Swiss army knife when it comes to solving lots of problems in medicine, but I'm not very much without the allied health team and the nursing team that makes up what we do in primary care. There's lots of things we can do on our own, and that is, I think, as difficult for my patients, if not far more difficult, because there is at least a very strong floor underneath me. I can bulk bill people, which I do a lot of the time, and thinking about my day at work, you know, you will bulk bill a lot of people because you know that they need it, they need the access.

Then, you know, you're talking to some exercise physiologists, and I'm lucky enough to have access to certain things in the public system near me, but $300 a week for some people to access some services, you know, if you were trying to get someone on to a program to forestall their diabetes or to make it so that they don't need a knee replacement because we helped them to lose weight, those things are challenging.

Seeing me for $82, I bulk bill under the system,

great, but they don't then have the money to take on the next step. I see them for half an hour, wonderful, but for the other 160-odd hours of the week, there's not much that - they need other supports as well in the system because general practice and GPs are only one part of it.

MR MUSTON: That's a challenge in the metro.

Can I ask you, Dr Christmas, at least in your part of regional New South Wales, do you find that there is an inability to access that constellation of allied health and other professionals which contribute to the delivery of good primary care?

DR CHRISTMAS: Absolutely, because I know in my town, in many towns like it, we just don't even have the health professionals available, let alone being able to afford them. So we have a system that's reliant on people rather than processes and systems. If we have a physiotherapist, they take maternity leave, we're without a physiotherapist.

We don't have an exercise physiologist in our town, we have one who visits, but then people need to be able to afford it, and even with EPC, so enhanced primary care, item numbers, it's still not affordable. We don't have public access to exercise physiologists.

We have one physio in our public system who is overworked dealing with hospital and outreach centres and being in our town. We have one other physio - or two other physios in town, one on maternity leave, one part time. So, yes, we just don't even have the access, let alone making - you know, understanding that the role of allied health is really important in primary care, just accessing people is difficult, and that can fall over if someone leaves.

MR MUSTON: Coming back to the definitional issue I think that you raised, Mr Sloane, when we're talking about primary health and primary care, we should not be just seeing it as an ability to go and have your appointment with a GP within a relatively timely fashion; there are all of those other services that sit around the GP which are also, am I right, critically important to the delivery of good primary care?

MR SLOANE: Yes, I think so. Primarily it's access, and

the anecdotes we hear from talking to communities are that, you know, they want to be able to see a face-to-face doctor and there's a lot of faith and admiration of general practice located in all of the regional towns, where it is located. But, yes, it is a multidisciplinary approach, but it relies on that initial consult and referral.

But we're looking at models now that are, you know, in necessity and out of necessity from the workforce challenges that we talk about, that might be nurse practitioner led or otherwise. But again, it's as part of a multidisciplinary team, and not every patient's going to need to be referred for physio, but it's awfully helpful if we can have a full multidisciplinary team wrapped around every single patient that needs it that comes into a service.

Again, we've seen again, probably more so from anecdote more than anything, that there will be physios, allied health or otherwise, leaving, and over the last couple of years, to NDIS or into private practice, leaving the public health service. That is not necessarily, I think, seen terribly our numbers but it is definitely felt by communities.

I only yesterday saw the first social worker that has returned to NSW Health from working in the NDIS and it's the first time I've actually heard the opposite story in a long while. We're seeing that in a lot of smaller towns, where they've moved away from - in order to take up, you know, smaller work hours or lower work hours because of maternity leave or family obligations or that life/work balance.

So there is a conscious choice, and I think I put it in my statement around how we can then attract and/or retain staff in a work environment, like Michael said, that's very positive and good for them, which is a very healthy move for health professionals into the future, but ultimately they're making choices that will suit them and their lifestyle and especially in regional areas.

MR MUSTON: Does anyone want to comment on the way in which I have sought to define primary care?

DR CHRISTMAS: I just had a comment on a part of what Luke said about accessing primary care - allied health care.

One of the things with the way things work at the moment is often patients still need to come and see a doctor first, before they can access the primary care through our enhanced primary care models and so on, so that actually doesn't reduce the demand on my services. They still have to see me for a care plan, they still have to see me for follow-up, and so it's not actually taking people out of my system. So my books are still full. So even though we know that allied health is really important for certain things like dietetics and physio and exercise physiology, it still requires me to sign off on things to enable people to access that if they're going to use public funding to do so.

MR SLOANE: I would say similarly - sorry, thanks, Rachel, that has just triggered - we heard yesterday in Canberra about a piece of work around referrals and referral pathways to specialist care. I think we do hear that a lot, of the need or necessity, and it comes from a little bit of social prescribing as well, to go and see a GP to go and see a specialist yearly, and it's part of continuity of care, but it is one of those things that - the referral process, whether it is necessary or unnecessary to go to other specialist care or allied health care or other parts of the multidisciplinary team that I'm sure also takes a fair bit of general practice's time up as well.

MR MUSTON: I would be interested, having raised that, to explore with the other panel members, Dr Hoffman, the value in having a process whereby someone who is receiving specialist care or sub-specialist care is required to get a referral from a general practitioner. What are the pros and cons from the perspective of someone who is dealing with that?

DR HOFFMAN: I think that the initial referral is absolutely essential. Patients, in the nicest way, are fairly terrible at self-diagnosing and identifying the most streamlined cost-effective way to get a diagnosis and treatment. They often want everything that's available, which is incredibly expensive, rather than the one thing they need, and often that one thing they need may not be what they think they need or what they want the answer to be.

GPs are very good at saying, "You don't need 50,000 different tests. Let's take your history. Let's do an

examination. Let's do the one thing that you need" - rather than the 50 things that often, online has told them to do - "and streamline that process."

Where I think it can be improved is the ongoing annual reviews. We probably don't need, if they are stable and they are seeing their rheumatologist, to continue to refer them back. When we do need to see them is if something has changed. So if, in the meantime, they have had a heart attack or they've had a stroke or they've had a really significant event, then absolutely, we need to update that specialist and send them back.

Does that need to be done by a face-to-face visit and a letter? Probably not. We can definitely communicate, and collaborate more effectively than we currently do, and in rural and regional areas, that doesn't need the patient coming in to see a GP to be able to do that.

MR MUSTON: Without wanting to hypothetically burden your books with unnecessary visits, is there still value in that even if it is just an annual visit to get your referral updated because it gives you that opportunity to deliver some opportunistic care?

DR BONNING: I'm trying to think of the last time I saw someone just for a referral, because you use that opportunity, especially for someone who's otherwise relatively well - you know, I have a great patient, he's in his early 40s, he has had problematic hypertension since his 30s, and that is common for some people. He has no other health problems - fit, runs, works, everything else going fine.

But the opportunity at his age to think about other interventions for lifestyle, for bending the curve of his likelihood for other comorbidities and diseases across his life course, is actually really useful on at least a once annually basis.

We also know there is a differential in presentations. I would like to see more of the men who are on my books a little more frequently, and that's one of the things where we do miss those people. You only have to look at cardiovascular disease as a whole group, it is about 2.8 million - there was a piece of study work that came out a couple of weeks ago - maybe 2.8 million who are at

higher risk of cardiovascular disease. When you break down what we actually do for them through the health system, there is at least a few hundred thousand of them, maybe pushing up towards 750,000, who are not seen regularly enough to try and manage these conditions.

So, you know, we have this ticking kind of time bomb out in the community of hundreds of thousands of people who, if only we could intervene on some of their risk factors, we would likely at least delay a major cardiovascular event, a heart attack, a stroke, something like that, and that has big impacts on both - because we've also got to remember that benefits of good health don't necessarily accrue to the health system. The best patient is the one that the public health system will never see.

Good general practice is invisible because we look after people on a regular basis and they never darken the doorstep of an emergency department or specialist rooms or anything else, and in that moment, the benefits accrue to every other part of society.

THE COMMISSIONER: They remain economically active.

DR BONNING: But they also remain socially engaged. They remain part of a carer pool for grandchildren or parents or whoever. They remain people who, yes, contribute to the economy both through their work but also through their engagement with it in other ways. We always see that as a bit of missing part of this. I can keep people really well but no-one else sees it.

It's very hard to identify where those benefits are, even though what we're seeing from other countries is looking more at, you know, risk adjustment, looking at whole cohorts. Do cohorts under certain styles of management perform better? The answer is there are differences. We can stratify for how we should be intervening, where we should be putting funding, because we also know that primary care is incredibly efficient, and it is cost-effective as well, because we run it through small businesses but also because we're not treating something very simple in a palace of health care that costs hundreds of millions of dollars - that's not a great fit between capital use and the operational needs of the patient, whereas my rooms are. You know, if I need to see you for something, it is relatively simple, I will see you there.

MR MUSTON: Does anyone want to add to that or have anything they want to say?

DR CHRISTMAS: Yes, I do. Thank you. I think what Dr Bonning has said is correct. We do so much here that is unseen and that the primary care is really important and the danger in becoming a referral person who just shoots off a referral annually to the cardiologist, (a) it devalues entirely what I do, I become a post office doctor and that's not what I am.

I think the danger is that the population sees me purely as an administrative person and that is absolutely not the case, and that you do lose that opportunity for those opportunistic primary care things, the family history that you need to work on, the screening tests, the immunisations, all of those things, lifestyle and lifetime - where you're at in your life and what's important at that time - longitudinally that we do so well in general practice.

So there are benefits certainly to seeing people regularly and also, when am I going to do the referrals? That would be in my own time, if I don't see them, and I don't have time for that. So that time would have to come out from seeing patients. We have to remember that every time you ask a GP to do something, such as a referral without seeing the patient, that's unpaid work that happens some other time, and in my case, that would be 10 o'clock at night.

MS VAN DE WATER: I might add to that. I think the relationship the GP has with their patient, the understanding of their patient's history and the role in preventative care is just invaluable. It's invaluable to the system, it's invaluable to the individual, and certainly has a huge impact on the quality of life of individuals, and I think that's from a non-clinician perspective and certainly an observation, listening to the reflections there from Michael and Rachel.

DR HOFFMAN: There is economic work led by Dr Michael Wright out the University of Technology Sydney - he is a GP as well and heavily involved with the college of GPs - which looks at the value of continuity, so the idea of what Georgina van de Water just covered, which was this idea of

there is invisible value in not having to repeat the story all over again, not having - you know, the understanding that comes from a long-term relationship of remembering that something happened or that you had an allergy, we know that you had an allergy to something 10, 15 years ago, which you may forget as well. The systems in general practice are actually incredibly good at doing that, but it relies upon continuity, so patients remaining within at least the same practice, if not the same practitioner.

MR MUSTON: We touched on some of the challenges insofar as they apply in rural and regional settings, and the sort of patchy nature of that, there are patches where there is good access to primary care, there are areas where there is not. What about within metro areas in, say, metro Sydney, Dr Hoffman?

DR HOFFMAN: Yes, so in metro Sydney, we actually have less GP FTEs than we do in some of the modified Monash three to four areas. There are definitely pockets of Sydney where it's very difficult to find a GP, particularly at short notice. We've released our "Health of the Nation" survey last year which looks at 3,000 GPs, admittedly it is across Australia, not just New South Wales and ACT.

We are starting to see a turn, a shift in this, and so patients, about 54 per cent, say that they can access their GP within 24 hours if they need to for an urgent reason, and for a non-urgent reason, 90 per cent can access them within two weeks. So we are starting to see that there is a shift, there is an improvement. That's a big jump from where we were at 12 months ago. But yes, we do have a long way to go, but we're hopeful that we're starting to see an improvement.

THE COMMISSIONER: What's that improvement? Do you have any sense of what has caused that improvement?

DR HOFFMAN: Look, I'm going to step in and speak for Georgina, but I'm really - RACGP has taken back over training 18 months ago and 2017 was the last time that we filled all of our registrar places. Next year, we've filled them again for the first time, and not only have we filled them, we have also been allowed to back-fill last year's places as well. So although, yes, at the beginning we said there's less people wanting to be a GP, we're again seeing that improve. We're again seeing that change.

We've got more people wanting to be a GP next year than we have places to train them. So we're actually now going back to the federal government going, "Let's train more. Let's not actually turn any junior doctors away that want to be a GP." Because why would you? We need to train them, we need bums on seats. We have the supervisors ready to train them. We have places that are unfilled for registrars. Let's actually use them and put them there.

So yes, although access is a problem, and it doesn't take overnight to train a GP, it is still three, two years, if you have got previous training, to get to be a specialist GP at the end of the day; we're actually starting to see some improvement in some numbers.

MR MUSTON: Just so I can understand the system, you said a moment ago that you have filled the training places and you have been allowed to back-fill the training from last year. Could you just unpack that a little bit? You've got a number of places which are available --

DR HOFFMAN: I will pass to Georgina.

MR MUSTON: -- which is, I gather from what you are telling me, a lower number than the potential empty chairs in practices that could be occupied by trainees; is that right?

MS VAN DE WATER: Yes, absolutely. Just as an example, for this current term we had over 1,400 available training places within training practices. General practice is an apprenticeship model for training, and so our practices that are accredited to supervise registrars in their practices told us they could host a cumulative total of 1,423. Now, in that, we only had, in full time equivalent, around about - well, just under 1,000 places, registrars available. That's in New South Wales.

MR MUSTON: Just pause there. What's the limiting factor? What caps you at the thousand? It's funding of some description I assume.

MS VAN DE WATER: The number of registrars that have joined the training program over the past number of years. As Rebekah said, we were undersubscribed since 2017. The RACGP is funded by the Department of Health for 1,350 registrars a year across Australia, and those places, for

the first time, in 2025, will be filled and are, in fact, oversubscribed by eligible and suitable doctors that are interested in general practice, including our rural generalist program, which is also oversubscribed.

So it's the cumulative effect of undersubscription over multiple years that has resulted in our inability to meet the supply and demand - well, the supply and demand modelling tells us that there is greater capacity for us to train if there were more doctors in the system to train.

Now, more doctors in the training system means greater distribution, it means greater access to care for communities, and particularly those communities not only in our rural and remote areas but also our outer metro. That's something that we are growing more and more concerned about, is with the urban sprawl, the growth of population, the ability to access care in outer metro communities.

MR MUSTON: Again just so I understand it, the funding that you receive, or that is received from the Commonwealth Government for the training of these registrars, how is it channelled from the Commonwealth into the hands of the person who receives it? If you could just talk me through that funding stream as it applies to a particular registrar, hypothetical registrar.

MS VAN DE WATER: The RACGP has a grant agreement with the Department of Health to deliver the Australian General Practice Training Program. So we are funded to support the registrar training, which includes a range of activities as well as placements into communities. So that money is funded to the RACGP to deliver the education and training program.

There are incentives for individuals. For instance, in New South Wales, there are 239 GP catchment areas. We are incentivising at least 40 of those catchments to ensure that registrars have access to funding to support them relocating, to support them accessing technology and infrastructure that will help them when they relocate to a location in one of these targeted areas.

One area is Armidale. The New England area of New South Wales we know is incredibly under-serviced with GPs. Moree is certainly an area that we are supporting

additional funding to those registrars and practices in those regions.

It's a funding grant agreement from the Department of Health to the RACGP. We then look at innovative approaches that are relevant and locally defined to ensure that we're doing - applying approaches to make placements attractive in the areas of greatest need.

MR MUSTON: At a time when, I gather from the evidence that we've heard already, there is a shortage of GPs or a void in particular as a forward projection, a void that needs to be filled, is there a dialogue between the college and the Commonwealth about what can be done to avoid turning candidates away?

MS VAN DE WATER: Frequently.

MR MUSTON: How does that dialogue go?

MS VAN DE WATER: Well, you know, it is an approach to the department and supported by Minister Butler thankfully this year, which was our approach that we have a number of doctors who will be turned away if we're not able to be flexible in our approach to distribution, in our approach to offers that are made.

We have taken up, for instance, an arrangement where we have a composite pathway. So registrars entering the program may train for part of their training in an outer metro area, but undertake a rotation into regions like New England, Western New South Wales and the Murrumbidgee, for instance.

What we're finding is that a large number of those doctors, once they undertake a six-month placement in those towns, are more likely to stay for longer. So if we can develop an interest, enable a rotation into an area of greater need, we know there is an increased likelihood that those registrars will stay for longer and often after their training as well. Those are the conversations.

MR MUSTON: Can I ask you quickly, at the time of the last intake and as a result of the discussions that the college had with the Commonwealth ministry, were there any interested candidates who had to be knocked back or was an arrangement able to be reached whereby all interested and

suitable candidates were offered a position?

MS VAN DE WATER: So we're on the second intake at the moment. There will be a handful that will be knocked back and that's purely - a range of reasons behind that. When I'm talking "a handful", I'm talking about 20 at the end of the day. We are looking at innovative approaches and oversupply.

What that means is that there will be some that won't get training places in the areas that they absolutely are committed to training in and are not willing to look at alternative arrangements to training, and in those instances, we will have to - they won't accept an offer. They will be made an offer but they may not accept that offer.

MR MUSTON: So just to put a practical example around that, someone might be made an offer in, say, Wagga Wagga, and come to the view that they don't really want to move or work in Wagga Wagga and so they will knock back that offer because they would prefer to do something in a metro area, for example?

MS VAN DE WATER: That's possible. We find people are more flexible than that in most instances but there are the odd occasions where individuals don't want to train outside of the city.

DR BONNING: I think part of your original question was around metro areas as well. If we dive back into that, while I can't provide figures to you, I'm sure we could find them, about the socioeconomic determinants of communities and therefore their access to general practice as well. My general understanding of that area is that areas of higher sociodemographic kind of standing, so higher SEIFA indexes, have more access to general practice.

The problem is that conversely those areas of lower SEIFA index are also the ones the chronic disease, more issues of social determinants of health where we probably need more access per capita to general practice as well, and we need that access to be affordable.

There's a little bit of a mismatch. So even when we talk about outer metro, inner metro, we've got to remember that the populations that we serve aren't just a ring

around 15 kilometres from Sydney or from the CBD, we do very much need to think about what those local regions need and what they look like. The Hills district is very different to - I trained down in Airds near Campbelltown and that community is very different. It has very different needs but it also really suffers from some of the negative socioeconomic factors of the community also then meaning that most - that many doctors won't or don't end up practising there.

MR MUSTON: So a double whammy of social determinants of health are not favouring them and the same drivers which lead to the social determinants of health not favouring people in a particular community will often discourage general practitioners from wanting to practise in that area perhaps of the greatest need.

DR BONNING: That's entirely correct, an excellent kind of summation of that, and we can see that around the world. So the general view, and it's well backed-up internationally, is that when you have a cohort of medical practitioners - that's not just GPs, that's cardiologists and nephrologists and surgeons and what-not - the overall health of your community gets better the more generalists you have.

The more the focus becomes on a sub-specialty and a hyper sub-specialty or sub-sub-specialty, the more likely you are to have significantly increased costs with overall health outcomes that are, for the community, worse.

The reason we know that is because generalists and generalism is often about looking after the whole person, and when you do that, you find a lot of the things that lead to lots of the reasons why you might have the need for a sub-sub-specialist. None of us are just our left ventricle plus our right foot plus one of the vessels in our brain; we are a whole person. The thing I need you to do is exercise and eat better, and those things will have significant benefits for your right foot, your left ventricle, and the vessel in your brain.

Again, the evidence is there to talk about that. The Commonwealth funds put out their kind of league table of 10 relatively comparable nations. It includes Australia, UK, Canada, Germany, the Netherlands, New Zealand, amongst others, and still rates Australia as the best performing

system in the world. Part of that is because of access to general practice, but general practice being a useful coordinator and central player in the delivery of services, because of that need to recognise that the person who walks in, the one we always love in practice - the person who walks in with fatigue is more complicated than most people think. It is not, "Oh, I'm tired", because tiredness can come from probably 15 different systems and have significant impacts, and that actually needs to be worked out in the context of the individual through a conversation and understanding, rather than, "Oh, well, we just need to do this procedure", or, "We just need to start this drug."

I think that's just a ringing endorsement, at an international level, of how Australia performs both because we sit in the middle of the pack of OECD when it comes to spending on health care, but we actually sit at the top of that particular tree, from the Commonwealth fund, in terms of health outcomes. But there's inequity in the system.

MR MUSTON: In terms of the challenges that we've been talking about, maldistribution sounds like it's part of the problem, but is it not just maldistribution, it is also not enough GPs system-wide to meet the primary care needs of the population of New South Wales as it currently stands? Would that be a fair assessment or are there enough GPs but they're just not in the right place?

DR HOFFMAN: I would also just add to that, it is not just GPs; it is across the whole primary care workforce. There's not enough nurses, there's not enough allied health, there's not enough pharmacists, there is not enough of one individual specialty to serve the entire population of New South Wales.

DR BONNING: So your comparator - you might think about New Zealand. New Zealand is about four and a half, five million people, so it's a bit smaller than us. They've done actually really well in developing their general practice workforce. They've paid much higher rates to get general practice, and they've hit a different problem.

MR MUSTON: Just pausing there. New Zealand, I think, is a capitated model. Is my understanding correct?

DR BONNING: It is a different system, but the problem

that I want to recognise in all of this is if you focus on what is a very complex system - if you focus on just one part of it, often forgetting the other bits, we end up with these patients who are too sick for general practice, so they're too complex for us to manage, they take up a huge amount of time, they are not sick enough or acutely unwell enough for the emergency department, and they can't afford a private specialist and there is no access to public sub-specialty medicine.

So getting in to see the public nephrologist, you might as well wait, you know, six months. That then becomes, well, it's the same as almost not having someone, because I need someone within three weeks for a patient somewhere. Then you end up with, as Mr Sloane was talking about, this scenario where people come via the emergency department, when they have acutely deteriorated, for something that was otherwise manageable with a little bit of input.

One of the things that's in my witness statement is about some different programs that exist out there to try and intervene, whether it's in paediatrics, whether it's the SUSTAIN program, which is useful, but lots of the ability to get advice, to get support is also what augments general practice to actually do its job really well.

Two minutes on the phone with a psychiatrist on Monday gave me a plan for someone who is at the point in their depression where they are becoming apathetic, they can't work, they are unable to get out of bed. Rather than see the public psychiatrist, who wouldn't be able to see them for months, being able to talk to the public psychiatrist for two minutes, here's a plan, I can initiate that management plan, I can follow up every week with this person or, you know, on the phone tomorrow, as I'm going to.

That has meant that he will not end up in a situation where he is an emergency presentation, maybe with a very serious outcome, hopefully, because we'll keep close tabs on him. We have, you know, a good relationship with him, but also we've used the psychiatrist for the top end of their spectrum of knowledge. They know this patient, they've met them before and they are then able to say, "Here are some things that might work. Work your way through those. Talk to us in two or three months. If you

need us sooner, here is the number to call."

THE COMMISSIONER: The patient you just gave an example of, absent the kind of interventions you just talked about, is that an example of someone who is in that gap between what you said was too sick for general practice but not sick enough for acute care?

DR BONNING: Yes, he is --

THE COMMISSIONER: And what more should I understand by that concept?

DR BONNING: As I am sitting at a wooden table, it's very useful. He will hopefully not present to an emergency department. He does not have the kind of features of his melancholic depression that predispose him to suicidality. However, he can't work, he can't do anything else. He's living with his mother at the moment, so it's making - you know, it is a real drain on her ability to work. There are some complicated things here.

He is someone who would show up to an emergency department not because they were, you know, in extremis, but because they just can't function anymore and they just need access to a practitioner. They just need someone really smart in psychiatry, and that's what we borrow in general practice all the time. We borrow the minds of others to help us with a complex person who has lots of needs.

That is always - I think that is always one of our greatest skills as well, is working out when - I've known this gentleman for years. This is probably the second time I've called the psychiatrist in five years, and all I needed was two minutes. He's doing something, you know, in the consulting room, I'm speaking to the psychiatrist. We move on. We are efficient.

He has hope now because I've spoken to someone else. We're not magicians, but certainly our patients need to know and feel like we're throwing everything we can at helping them at a time that's really dark for them, and even knowing that we can call and speak to the psychiatrist, he's more hopeful now about where his life's going to go, and that's a big deal in that kind of illness.

MR MUSTON: Just in that example, your ability to speak to the psychiatrist, was that because there is a pre-existing networked system or arrangement whereby you could do that or is it because you happen to have attended university or something with that person or some other connection which is ad hoc and serendipitous?

DR BONNING: This is a great psychiatrist who will provide his mobile number to GPs. Recognising that, again, I've called him twice in five years, he would much prefer that than seeing one of his patients, who he does care - you know, or seeing someone who could have been prevented from needing to see him in an emergency department. So I spoke to him, and it was a public day for him so he was available to take the call. But most of that is very patchy and it is not systematised. We know that when we do systematise these things, it gives someone like me, who is fairly gregarious and able to get people's phone numbers - it's helpful for me. But there are many GPs for whom those networks aren't as easy to access, and I'm lucky, he's lucky that we had that in the moment, but there are plenty of patients for whom I don't have that either.

MR MUSTON: Dr Christmas, you have raised your hand. Do you have a rural perspective on the way these networks work in your practice?

DR CHRISTMAS: I do. I agree wholeheartedly with what Dr Bonning has said about that slipping through the gaps - the patients who are sick, not sick enough to go to an emergency department, can't afford a private specialist. That is my whole population here, really. We have no public clinics, or minimal public clinics, in our hospitals in Wagga and Griffith, which are my nearest centres. There are a few, but they're sparse and oversubscribed, and, you know, to get someone into a renal physician in the next three months would be heaven. It is two years to get into our neurologist. I can't manage someone with progressive neurological things. As good as I might be as a GP, I'm not that clever. We do need these specialists, and their hands are tied because they are doing their best as well.

So access and looking after patients who are on that fringe of how sick are they and when do we escalate their care to the hospital system is a really delicate area. I think GPs get very good skills and rurally we have to get more proficient at dealing with sicker patients, because

we're looking after the heart failures who can't get into the cardiologist; we're looking at the respiratory patients, working them up, doing as much as we can. I think there is little systemic support for accessing specialist care but we use our network a lot.

One of the advantages of being rural is that we build those networks with our specialist colleagues. I have my favourite specialists that I speak to on speed dial, just about. They know me, and whether they roll their eyes when I'm calling or not - they never seem to when I speak to them, so that's nice.

But, you know, you call in a favour. "Mr So-and-so that you saw three months ago, can your secretary get the notes? This, this, this is going on." I can say that my specialty colleagues are really very helpful, most of the time, because they understand that if we do our job well, we support them better, and they know they're sending the patients back to being looked after well in general practice, which is reducing their re-presentation to hospital and so on.

So that primary/secondary care, non-GP specialist/ GP specialist interrelationship, is incredibly important in looking after our patients, especially as general practice gets more complex.

This is my second point. I think the nature of general practice is changing. We have increasing complexity around management. If we look at diabetes and the number of drugs that we now have for diabetes and the considerations around renal disease, around heart disease and heart failure and diabetes and the medications used to manage that, the comorbidities that occur with these illnesses.

So what used to be someone just went along 40 years ago until they had their heart attack and then you put them on a statin, that's not what happens these days. It's all about identifying people early, treating them early with lots of different ways of treatment.

So general practice is becoming incredibly complex. So we need to be getting better and better at dealing with more and more in more detail. I think the corollary of that is that a lot of people are removing themselves -

anecdotally, I don't have the data on this - from the coalface of general practice and the actual general general practice that we see and sub-specialising. So you'll see a lot of GPs getting into, "I do women's health general practice", "I do menopausal general practice", "I do drug and alcohol general practice", or, "I sub-specialise in mental health." That's not to say that those aren't valuable areas to work in but it removes GPs from doing general practice.

It's sometimes a very thankless job and not particularly sexy. If you're going to look at what people want to do, managing someone's chronic ulcers when they've got heart failure may not be the nicest job but it is actually really important.

So I think we are diluting the number of GPs that we have doing the general practice because it's actually really hard work and you need to know a lot and you're trying to work with many different systems with a lot of shortfalls.

MR MUSTON: Dr Hoffman, is the anecdotal experience of the sub-specialisation of general practice consistent with your observation?

DR HOFFMAN: I have a few points, apologies. Not only is that happening, but there's also really good evidence that that is good for general practice. There is good evidence out of Adelaide that diversification and sub-specialisation of general practice means that GPs are more likely to stay in the workforce for longer. The GPs who do have their special interest or their thing that they get really, really good at - and that might be children's health, that might be writing novels, that might be educating the public, that might be professional general practice and the business of general practice - actually are more likely to stay in the workforce for longer.

Your point previously for Dr Bonning in regards to, "Was it a friend that you called or was it the hospital advice line", with psychiatry, there actually are some really good systems that you don't have to call a friend. There is a GP advice line where GPs can directly call a psychiatrist to get advice, but it's only in that specialty. That's something, if that was replicated out to other specialties, would be enormously beneficial to GPs.

If we could call and not get put through to the intern, the most junior on the renal team, and actually speak to a renal physician, then that would be fabulous. So, yes, that exists for some specialties but not all specialties.

If I dare take his example a little bit further - and I do see a lot of mental health patients - yes, it's probably going to be Michael who calls up tomorrow to check that the patient is okay and he will probably call them once a week ongoing until they are past this acute crisis, but I would actually argue, does it need to be Michael calling tomorrow? Does it need to be him next week and the week after and the week after that? Realistically, Medicare says yes, because otherwise there's no patient rebate, and unless he, Michael, physically calls him, no-one's getting paid for that time. But ideally, it's not.

We work in a multidisciplinary team. I would far rather it was my practice nurse who made that phone call, or someone who was trained in mental health, to be able to go, "Are you okay? How did you sleep last night? Do you need an appointment with your doctor this week? Can I call you again tomorrow and check in?" That doesn't need to be me, and it probably shouldn't be me. It shouldn't be me, and that's why I will stay at work until 10 o'clock at night to make sure I've ticked all those boxes and made sure everyone's okay, but I would much rather we did that as a team-based approach.

MR MUSTON: I see general nodding from all of the clinicians on the panel on that one. I take that as a yes.

MR SLOANE: Sorry, Mr Muston, can I bring you back to your original question?

MR MUSTON: Please do.

MR SLOANE: I haven't referenced it in my witness statement, but the distribution question, it's probably good just to have it on record, there is a paper - and I would have to dig it out to find it - on a very affluent suburb, it is related to MBS funding and where it's spread, so a very affluent suburb of Sydney. In this particular study it showed that the MBS spend per person was $900, whereas in rural, regional and remote areas it was somewhere in the realm of $300 to $350 per person.

There can be assumptions drawn, and there were from this paper, around that distribution and access, more than anything - perhaps workforce shortages or otherwise. I don't think it's any narrative at all on general practice, because I think some of the things that have been said, at the moment - I did jot down a note - I think it really needs to be mentioned that there is a dramatic under-appreciation of what general practice does, especially in the defined rural, regional and remote areas, because, as you've heard here, you know, in the city, they are very much that, similarly, integrated sort of anchor for care for all patients that are actually seen, but in the rural, regional and remote areas, they're quite often not only doing that but also then putting on their other superhero suit and doing the same thing at the hospital.

Everything I've learned from the interface between NSW Health and general practice in rural, regional and remote areas - not just in the work that they do in the New South Wales public health system but also in that private practice setting - is actually phenomenal. So I want that to be heard.

I think there are three points, just following up from that. I can't remember whether Dr Bonning or Dr Hoffman said this, but those incentives - and I'm sure you've talked about incentives a fair bit during the hearings - there is that other side of, and I think Dr Hoffman has touched on it a little bit, around those other incentives around that sub-specialisation, and I know Dr Christmas said so too - that is that change in workforce that we talked about at the start of today's proceedings around what is that attraction or the pull for people to come to? It is not just that 100 per cent hands-on work anymore, it is a blend of teaching, research, university appointments, some virtual care, and we've seen that and we've heard about models like the vRGS, because I know you've seen that at Dubbo. But that blended model of that and hands on or that and the sub-specialisation for GPs is what is keeping them in some of these communities.

I will just note there is no funding mechanism at the moment, when we talk about those referrals to psychiatrists, specialists, the cardiologists and the neurologists, to leave the hospital to come and work with the GPs on the ground or take those phone calls. It is

very relational.

DR BONNING: I was about to say, there's something in my statement about some models that are already up and running, but we will talk about them.

MR SLOANE: There have been some really successful pilots that we have seen, whether it be diabetic endocrinology consultants going out and working with general practice to lower HBA1C, diabetes risk levels, down for whole communities and whole suburbs, whether it be city or regional. But there's no real mechanism for that to happen under the current MBS scheduling, and reiterating around, you know, Commonwealth responsibility around primary care where really, in regional, rural and remote areas, the blur of the line between that and our reliance on it from a NSW Health perspective is absolutely pivotal.

I just wanted to touch on virtual models around connecting. There is a bit of a reliance to do that, and that's becoming a more accepted model for regional patients to be able to link in with general practice, to team up and do a virtual consult, but there is always the need for that hands-on or that face-to-face consult in the first instance for specialty care, but that is far more becoming the workaround, and the specialists are just not available in regional areas.

MR MUSTON: Just pausing there, I will maybe invite the clinicians to accept or reject this proposition, but whether it's fly-in/fly-out or something that's delivered virtually, there is an important difference, isn't there, between a metro-based specialist who flies in to save the day on the one hand, as opposed to a metro-based specialist who contributes their time, either in person or virtually, to form part of a proper multidisciplinary team, including a general practitioner, including potentially practice nurses, who will be delivering all-round care to the patient such that each of them is delivering care at the top of their scope and of the type that is needed?

DR BONNING: This comes not from my general practice role, it comes from my previous role with the Australian Medical Association here in New South Wales, but it is the understanding of the practitioner, so a sub-specialty practitioner, who contributes to care is part of it, and understanding what the resources and capacity is in the

community as well to maintain or to put and execute on the management plan that is in place. You know, as Dr Christmas was saying, do we have an exercise physiologist, do we have a dietician, do we have a diabetes educator, you know, those kinds of things that, for one of our most common conditions, diabetes, all of those things are very, very important. So if you've got someone who has a transactional relationship with a community, that's tricky, because all of those things sound good in principle but they can't be enacted, and so the person's care doesn't go anywhere. Whereas if you get, you know, models of care, and I'm both referring to one that's in my witness statement around SUSTAIN, which is a pilot but very good, it's around paediatric care, it's around having two general paediatricians available across a heap of practices for co-consultation, we write to them with some notes and say, you know, "What do we do next?"; we get help. We do teaching and education with them. It's running this year, it's very useful, and I believe the Commission has received a separate stand-alone submission regarding that program from another practitioner who is involved.

But there is also a really interesting virtual program that runs from Austin Hospital in Melbourne, so outside of our jurisdiction obviously. It's around cardiac care, it's about getting people home, it's about using not just the virtual consultation model but remote monitoring.

There is a product called Biobeat, which you can stick to the skin, it drops off after about seven days, it gives intermittent monitoring. Someone who would otherwise be in a hospital bed, which is very expensive, and also a long way from home, can be at home, can be supported by their GP with virtual long-term relationships with the cardiologists and cardiothoracics teams that are involved, and we know that that is both good for the health system down there, financially it's very good; it's good for the patients because they get home sooner; and it doesn't seem to have, at this point, had any adverse outcomes, so people get home soon and they do well.

We know that through other models, Hospital in the Home, virtual care models - all of those are pathways that we try and use but in a consistent fashion, because just having someone come out is not the same as having - so that is a person-based response, and Dr Christmas was talking about that earlier. Rather than having it about a person,

it needs to be about a system that supports care and that recognises and understands what local capacity is so that you're using whatever exists on the ground, which could be GPs, it could be nurses, it could be allied health professionals, to the best of their ability, wherever you happen to be, whether that's metro or regional.

MR MUSTON: We've touched on --

THE COMMISSIONER: Before we move on, can I just make sure I have understood something Mr Sloane said a moment ago.

You were talking about one of the pilots for diabetes, bringing down diabetes risk levels and there being no mechanism for that to happen under the MBS, you then said:

There's no real mechanism for that to happen under the current MBS scheduling, and reiterating around, you know, Commonwealth responsibility around primary care where really, in regional, rural and remote areas, the blur of the line between that and our reliance on it from a NSW Health perspective is absolutely pivotal.

Tell me if I'm wrong, do I understand that to be in the circumstances where, particularly in regional, rural and remote areas, NSW Health is actually doing things or funding things that you would call primary care, as distinct from the Commonwealth, or were you making a different point?

MR SLOANE: No, I would say that that is exactly the point I'm making. Not only that --

THE COMMISSIONER: I thought it was. That's why I nodded when you were talking, but I thought I had better double-check.

MR SLOANE: Perhaps without remuneration from the Commonwealth in order to do so, yes. I can elaborate on that if you want me to.

THE COMMISSIONER: Please do if you want to.

MR SLOANE: I think we have worked through keen

collaboration with the Commonwealth across a couple of different initiatives with regards to remuneration for exercises like that. We have 185 facilities across regional New South Wales, some bigger than others, including the likes of Dubbo, Wagga, et cetera, but there are many that are much smaller than that. We've got I think 66, I want to say, multi-purpose services where we absolutely are relying on. There's no specialist doctor that's a specialist in MPS doctoring, we absolutely rely on general practice, from the town, and quite often they're split between private practice and providing a GP VMO model.

In many of those instances, we are working with the GPs in town and the MPS to seek section 19(2) Insurance Act exemption under the Act in order to allow that doctor to be able to perform those activities and their own private practice billings but then also bill under the MBS scheme and then enable a reinvestment, so we can reinvest in locum employment if that doctor needs to go on annual leave, God forbid.

Those are successful schemes. We do that in a lot of places, but there are places where, unless the local health district is providing a salaried model - and you would have heard about the 4Ts model when you went to another version of a single employer model - unless they are providing that and providing that stability and salaried model for that general practitioner, it would be very difficult to attract someone there.

It's the balance between - let's not forget, as has been mentioned today, in 90 per cent of these, they are very small businesses in rural and regional areas, general practices, and they've got to be a successful and fiscally viable private businesses. Sometimes the volume - you talk about the books being closed at 1,000, 2,000 patients in some areas, there's a lot of areas where that's not the case and the volume from an MBS billing point of view doesn't make it a viable scenario. I'm not sure if Dr Hoffman or Dr Bonning would back me up, but it does not make that a viable way.

I mentioned it in my witness statement around salaried medical positions. You know, currently as the NHRA itself is being negotiated, we are embarking on some pilots where there is a pool of funding from the Commonwealth at the

moment to perhaps provide some innovative pilots with regards to block or salary funded primary care general practice roles or nurse practitioner led models in certain towns where there's thin or failing markets or totally failed markets that we need to build back up.

I think there are, from a NSW Health perspective, a lot of areas where they have, either on contract through the Royal Flying Doctor Service or through other private general practice arrangements, salaried or become the single employer for a GP to ensure that that community or communities have access to general practice.

Whilst we still access the 19(2) exemptions to be able to remunerate that and that billing gets reinvested through that, the primary care model in the town, it's not exactly optimal.

THE COMMISSIONER: It's still a cost to New South Wales.

MR SLOANE: Yes. I don't think - I'm happy to be corrected on the record into the future but I don't think the primary healthcare networks necessarily have the fiscal levers to do that at all from their commissioning model, specifically with regards to salarying GPs. I don't necessarily see it working like that, but NSW Health, because we rely on those doctors, responsibility falls with us as well to provide a GP VMO and someone to see at hospital when they present to emergency, so that does happen.

DR BONNING: Describing failing markets out there, and there are some, I think it's important to recognise it's much cheaper to intervene - Mr Sloane does this a lot more than I do - before it becomes a failed market, like building something up from where there's nothing anymore is incredibly expensive. We say about cost to the health system or to NSW Health, and what they need to spend to support or do some of those things or have GP VMOs in their hospitals, but on the flip side, if the primary care model fails, then the flow-through to the hospitals is probably many times more expensive. So, you know, I think we've got to be intervening earlier or sooner otherwise the model really, if it does fail, then it's very expensive to rebuild.

MR MUSTON: We will come back to the intervention in just

a moment.

MR SLOANE: Sorry, can I make one more comment?

MR MUSTON: Please do.

MR SLOANE: Just off the back of that as well, there are many towns - this is a fine line, I think this is where I talk about the rubbing up against that line of need. There are quite a few towns where - and rightly so because of the workforce model change or the life/work balance of the general practitioner being preserved - they no longer provide a visiting medical officer service to the hospital. We still have an obligation from a NSW Health perspective to have a doctor on site.

We could talk about some of the casual medical workforce that we access to do that, which again, coming back to Dr Bonning's point, can sometimes be very expensive, but we're also quite cautious in that scenario that if we do that and have a medical officer in the facility, that sometimes can affect the private practice in the town. It's a very fine line to walk between the balance of making sure we're preserving that general practice's business as a small business, as that resource to the town, purely from the primary care point of view.

I think their personal choice not to attend or visit the hospital is absolutely warranted, they can always make that, I don't think there's anyone around that would question that or think that there was any sort of obligation to do that. However, we have to be very aware that if we do employ someone via the Rural Doctors' Settlement Package to the hospital, purely as a VMO without private practice, that can and might affect the primary care business in town.

We've seen that happen in many towns where a new or large conglomerate general practice might roll into town and set up business and the effects that that has had on perhaps a longstanding smaller private practice in regional New South Wales.

It's very much worth mentioning, because they are some of the collateral damages from us needing to provide that locum service through the public health system at the hospital, and being quite cognisant of current bulk billing

policy and bulk billing arrangements, its impact on where people present to and the impacts then on that private practice again causing what could be that private practice to fail because people are presenting to the emergency before going to the primary care practice.

THE COMMISSIONER: Is an example of what you were talking about before, where you might get access - New South Wales might - NSW Health or the practitioner engaged by NSW Health might get access to the MBS but there is still a primary care cost to NSW Health - Bowraville, I think, was a place we visited where there's a net cost to New South Wales for providing the GP and other primary care services at that care facility where the GP has retired?

MR SLOANE: Yes, exactly. And then the 19(2) exemption only allows us to reinvest that in the primary care practice - I think I outlined that in my first statement in April - to certain items with regards to the primary care practice, which is great because it does then allow us to invest that in the locum setting so the general practice can take leave or otherwise, and we've had quite successful reinvestment in some areas where the community has done that. But again, it's limited as to what it can be reinvested in or subsidised salary for that doctor.

I think just on that, and I know I bang on a lot about the single employer model and the rural generalist single employer, our main focus in New South Wales was to really maintain that focus on general practice and private practice in these smaller towns. Sure, salaried benefiting the hospital, of course, but we're extremely cognisant of this model and setting it up and making sure that we're investing in primary care and private practice for general practice rather than a hospitalist model.

MR MUSTON: I will come to you in a moment, Dr Christmas, I can see your hand is up.

Could I just ask a quick question about Bowraville while we touch on it. My memory of the evidence, and I will be corrected very quickly if it's wrong, is that the shortfall to the state is something in the order of $400,000 a year.

THE COMMISSIONER: I thought it was $300,000, but it was given in evidence.

MR MUSTON: Ballpark.

MR SLOANE: I'm not aware of the exact figure of the shortfall but I think if we look at any of the small sites for New South Wales public health across the system with regards to aged care, and I guess some of the community service obligation and this economies of scale, there's a significant gap between the funding that is provided for the Commonwealth in order to continue day rates in aged care as well as provide what, in a lot of small towns, is the equivalent of primary care function for the patients that work in to the - and I might use inverted commas, "emergency departments", where we're seeing the profile of primary care patients presenting for less than nominal, you know, injury or illness.

MR MUSTON: It's less economically efficient to be treating those patients in an emergency setting than it would be in a good primary care GP clinic type setting.

MR SLOANE: Absolutely, and I think it's probably worth mentioning at the moment that there is a small town in the Hunter New England, just near to Narrabri, where the GP practice is doing a swimmingly good job looking after the community there. There is significant pressure for the local health district. You would have heard about Wee Waa already. There is significant pressure to the local health district to re-open the hospital to its former glory, sorry to use colloquialisms.

In order to do so, we would have to be paying a significant amount, as requested by the general practitioner that was being negotiated with, in order to do that, which is out of lockstep with fiscal strategy at the moment for NSW Health, and we're talking about a hospital that has less than three presentations per day, that are low and very low acuity and has an occupancy - well, now they're only working in the daylight hours, but when they were open, had an occupancy of less than three people per 24-hour period.

MR MUSTON: Good primary care service delivered in that town would reduce those presentations.

MR SLOANE: That GP is doing a phenomenal job.

THE COMMISSIONER: That's Dr Bonning's point about the benefits of having a GP practice in a regional town taking the pressure off public hospital EDs. I suppose that cost to New South Wales of $300,000 or $400,000, you would need an economist to work it out for you, but there would be a saving from avoidable hospital presentations and maybe also just general population health benefits.

MR MUSTON: And that assumes we walk into the trap that Dr Bonning urges us to avoid, which is viewing this economically --

THE COMMISSIONER: Exactly.

MR MUSTON: -- trying to compare savings in the health system with expense in the health system. If one says a good primary clinic in, say, Bowraville, reduces presentations in the emergency department, there is an actual hard saving in the health system, which might even eclipse $300,000 - you'd have to do the numbers. If you add to that the potential benefits of someone who is able to remain in the workforce because their elderly parent can continue to care for a child, for example, it's small beans, the $300,000 to $400,000.

DR BONNING: While I note Dr Christmas has her hand up, just to finish that thought, as we hear, there are certain small communities where, you know, we probably had a hospital there for historical reasons and only for historical reasons. There are probably, you know, certain economies of scale you need to reach before deciding whether running a hospital in a community, versus someone needing to go 20 kilometres up the road, you know, is viable. I would imagine that that's the kind of financial calculus that the health department needs to do to work those things out.

MR MUSTON: It's a financial calculus that would comfortably be managed if you were making a decision about whether or not to build a new very small hospital in a relatively small town, but where you have one already there, one has to overlay a political calculus which changes the dynamics somewhat; is that right Mr Sloane?

MR SLOANE: I think there are many aspects to add to that. If you do build a hospital and set up a service there, it's the volume from a safety and quality point of view to the

practitioners - and I'm not just talking medical, for everyone working there. We've seen that play out in Wee Waa where the volume is low, it has been low since before 2013. We have seen nurses move to other hospitals, the doctors are less inclined to take postings up there because the volume there to not only maintain practice, maintain a fellowship and maintain their skill levels, outside of rotating into other areas in order to do so, is just not there. It's probably not interesting work, I could imagine, and that's definitely the feedback that we've had from clinicians that have moved 25 kilometres up the road. So it's very, very tricky, but then it becomes quite a discussion around equity of access and shift of risk, I think, yes.

MR MUSTON: Dr Christmas, you've had your hand up for a while. I know you put it up to comment in relation to the discussion around providing primary care through a public facility in a town and the impact on private business, but I know you also have something, based on your earlier evidence, to tell us about the risk of taking services out of hospitals and the deskilling effect that that can have on GP VMOs.

DR CHRISTMAS: Yes, that's right. But I guess my point - it has moved on somewhat in the conversation since I first thought of this - is slightly tangential. I think one of the things we need to be aware of is that, in our rural areas, a lot of the GPs in small towns are overseas trained and a lot of them have not worked in the Australian hospital system.

What that means is that they are not credentialled to work within our emergency departments in these small towns. So one of the things that is a barrier is actually getting them into the hospital system to allow them to train up in our system, so then they can actually provide services, be credentialled to be VMOs in small country hospitals.

That's something that is an area for potential growth, and I think there is a program somewhere in New South Wales where that has happened, where they've trained up some - it's just in the back of my mind at the moment, I can't think of the exact details, but where we allow GPs from overseas to spend time in our hospitals to learn that system so then when they do go out into our communities in rural areas, they actually are able to work as GP VMOs,

which is often what they want to do because they have skills from other countries that they can then apply.

MR MUSTON: One thing, turning to the solutions to some of these problems, and in particular a solution which seems to commonly be offered up to deal with the increase in presentations in emergency departments, is the urgent care clinic or the concept of an urgent care clinic. Could I perhaps invite whichever of you wants to go first to fire away to express a view on --

DR HOFFMAN: I'm very happy to go first. They are both looking towards me.

MR MUSTON: -- whether an urgent care clinic is a solution to the real problem or whether it;s dealing with a symptom of the real problem?

DR HOFFMAN: I think urgent care clinics are incredibly costly. They are clinics that see also very low numbers, not low numbers compared to ED, but most urgent care centres around Australia are seeing less than 30 patients a day, and at a cost of somewhere $200 and $250 per service, so they are very expensive services and very low volume.

Where we have seen places where they don't have urgent care centres and they have actually ingrained that back into general practice, so the north coast - and Wagga's about to start one similarly - we actually see patients that are seen by their usual practice. GPs absolutely can do urgent care. We're trained in urgent care. And the ability to not silo urgent care to a separate location but to do it with their practice who knows them, who knows their social history, their financial history, knows so much more about them than someone who has never met them before, isn't only a cost saving, it is also often the preferred option for the patient.

DR BONNING: The document I might direct you to is - in Western Sydney they spent two or three years working out a model of urgent care services. I use that term specifically rather than "urgent care centres". Because their idea was, there is a single front door, which Dr Amith Shetty and others have talked about, Dr Walid Jamal, Dr Kean-Seng Lim, all of whom are very across this, have talked about, which is the idea that someone finds

their way into the system and then there is a way to, you know, appropriately direct them but also - and that comes to a number of resources that exist, whether it is Healthdirect, whether it's nursing triage lines, whether it's other services, but it uses the capacity that exists in a community and also recognises that, you know, I, as someone - I served for quite a while in the Royal Australian Navy, deployed overseas, I'm pretty comfortable with stuff that happens, but that's my style of practice, you know. There are others who would be less comfortable with that and so you use the resources you have. Fractures, great, I'm happy to see that in practice, but someone else may not be.

If we think about New South Wales, we've got about 3,000 general practices, at best we're maybe going to have 100 urgent care clinics. So it's much more - and I recognise this because of where some of the funding comes from - if you look at it from an emergency department presentation, where a non-admitted emergency patient costs about $600, $700, a $200 urgent care rather than showing up to the hospital is good investment because otherwise it's costly somewhere else, but compared to an $82 bulk billed appointment in general practice, you know, 20 to 40 minutes with me, plus or minus the nurse and others in our practice, the economies look very different depending on which perspective you have.

The challenge is also that you need to then have - because if you use a service-based approach, you have a capacity in a community or in a region, as opposed to "I have stood up X number of clinicians, practitioners, who will sit at a site and see as many people who come through the door." So that, you know, by definition is somewhat inefficient, whereas your ability to use what exists out there - and also, hopefully, to connect people back to their regular GP. We function in our practice that if you call, we will work out a way for you to be seen, because the nurse will talk to you, and our nurse, who probably knows you better than we do, because she's there every day of the week and I'm not, will work out a way in which you can be seen by someone who knows you.

That is far more useful most of the time than many other things. A patient of ours who has a portacath for their chemotherapy had something left in that portacath, so in-dwelling in this portacath. A portacath is beneath the

skin's surface. It's not really supposed to have things communicating with it from the outside. It's a high risk then for infection. I also didn't know how to use this thing, but, you know, our nurses do. That's someone who otherwise would have presented back to an emergency department who can very easily be seen in general practice. It took us five minutes. We literally just had to work out what was the contraption sticking into the portacath and how to get it out. Otherwise they would have sat as a category five triage patient in an emergency department for a few hours until someone got around to dealing with it.

MR MUSTON: Do you have a view on urgent care clinics/centres, Mr Sloane?

THE COMMISSIONER: Sorry, when we're talking about "urgent care clinics/centres", urgent care clinics, we're talking about the Commonwealth funded urgent care clinics. We're not talking about urgent care services - what are they called, services --

MR MUSTON: There's a subtle distinction

THE COMMISSIONER: -- or are we talking about both?

MR MUSTON: I think we're talking about both. In the sense that whoever might be funding them for present purposes, my question relates to the concept of, in effect, a category 4, category 5 doctor who you can see in circumstances where you're unable to get into see your GP and it would be preferable that you not present to emergency. What role do you see those centres, whoever might be funding them, as playing in the system?

MR SLOANE: First of all, my emergency nurse is going to come out in me a little bit. Many emergency department clinicians would argue that 4s and 5s, if they have presented to the emergency department, probably need to be there. A lot of 4s and 5s get referred from general practice when it's outside of the scope - the incredible scope - that general practitioners have. Some of the 4s and 5s that present to emergency departments, while they are not critically unwell when they present, may well be very undifferentiated, very complex patients that absolutely do need to be in emergency departments.

So I think it is quite dangerous for us to talk specifically about, you know, Australasian triage categories, because that actually applies to when someone arrives to emergency.

Speaking about it from a rural, regional and remote perspective, because that's where I probably would come at it, being involved in some of the urgent care services' placements and topography, it's very difficult at the moment because of that perhaps workforce shortage or access to primary care to justify an urgent care service over - and when I talk about "urgent care service", I'm encompassing both Commonwealth centres and/or concept services and models of care that have been installed from the state point of view. In rural, regional and remote areas, it's very difficult to justify that because we're quite often putting it in a place that if we had a few more general practices and some very healthy primary care practices, perhaps we wouldn't necessarily need it. I think it's a --

THE COMMISSIONER: I also assume, but I don't know, the locations that are selected for these clinics - I assume they're not selected in locations where there's a risk of them cannibalising general practice business?

MR SLOANE: Yes, correct, and I think through the decision-making process around that, that was a massive consideration - thus NSW Health looking at expansion of current services that are able to do the primary care services that are already in place, that are able to then either expand or adjust their service proper to encompass that, what we would call an urgent care service application --

THE COMMISSIONER: They are not advertised to be a substitute for primary care, are they? They are advertised, I think, to take pressure off EDs.

MR SLOANE: No, and I'm definitely not saying they were advertised to be a substitute. What I'm saying is when we've looked at locations in regional areas where that might be a consideration, we would be installing something in order to boost up primary care where there is no primary care, so it's a moot point. With the application of, yes, good general practice in primary care in some of those locations in regional areas, perhaps there would not be

a need for that.

As we've discussed through the process, I think the increase in presentations to emergency, even though we know in regional areas there's quite - per, you know, 100,000 people there's far more emergency presentations where there is a facility than there is in metro areas, where there is primary care and good primary care services and general practice in that location, we see a lower presentation rate because they are being looked after, yes.

MR MUSTON: Dr Christmas?

DR CHRISTMAS: Thank you. I think in a lot of rural areas we are urgent care centres, so general practice already is automatically an urgent care centre because we are the hospital and we are general practice. What we see in our general practice we might deal with as much as we can in general practice and then up to the hospital, if need be, but it's not uncommon to be giving fluids or to be giving iron infusions, to be dealing with fractures, to be dealing with pneumonias and working them up and making sure they're safe to be managed from home and so on.

I think the barrier to using general practice as a more urgent care service is time - so remuneration and skill set. Often in the model of care that we have for managing illness, we're paid on a fee for service time-based approach. Dealing with someone who is very unwell can actually take a lot of time and may not be very financially viable. I have heard anecdotally of, you know, situations where someone would say "Why are you looking after that in general practice? Just send them to the hospital", and yet it is something that we should be able to manage in general practice, even if it is a little bit more time consuming.

I guess the other concern is urgent care centres require a lot of funding, so it's an acknowledgment that to do the job well, you require funding to do it, especially to bulk bill, however, there is a push for general practice to bulk bill, to service our communities and to bulk bill, and where is the acknowledgment that that needs to be funded, because fundamentally a lot of this urgent care stuff is general practice.

There is a discrepancy there. "Oh, yeah, provide an

urgent care service and we'll fund to you do it", but we won't fund general practice to do the job that it does. I think that discrepancy has been expressed by people that you speak to around, you know, providing general practice care and urgent care.

MR SLOANE: I totally agree with Rachel. I guess that's what I'm alluding to from the spots that it's happened in New South Wales, from NSW Health, it has been leveraging and doing that for general practices that are already in existence, with co-located services or otherwise.

DR BONNING: Also, generally what we see in these urgent care clinics are GPs, so they were working somewhere and now they're working here. We haven't increased the net number of GPs available to the system.

One of the reasons why it can sometimes be hard to manage urgent presentations in general practice is because my books are - you know, I'm back to back for most of the day. When I talk about how our nurse will fit things in, it will be because we'll finish early and we'll have a bit of time and I can call a patient or we'll get them in while someone's lunch break is on. This is the flexibility of the system, but also the willingness of - we would prefer to see our own patients.

I love my patients, I love my job, but, as Dr Christmas says, there are limits to being able to do that, otherwise we would still be there, and we often are there, at 10 o'clock at night. But we know that often the best outcomes for things that are within our scope of practice are achieved by us having the nuanced understanding of our patients, their lives, their capacity, even, you know, what is it going to be like to go home, you know, if this issue is happening, if this is a pneumonia that's safe to manage at home? Actually, it turns out the person who is at home with you isn't just your wife or husband or whatever, it's the person you actually are already caring for, you're the carer, so that's not a safe place to go home to for someone who is of diminished capacity. All of those kinds of things are, I think, things we inherently understand better for our own patients and, you know, personally it is what I would prefer to do as a practitioner.

MR MUSTON: I gather from that that none of you would

suggest that the care that is able to be delivered in an episodic way through an urgent care centre or clinic is any real substitute for primary care in the sense that we've been describing it and discussing this afternoon?

DR CHRISTMAS: I think there is a role, there can be a role for that after-hours care. People get unwell after hours and that's again a capacity in general practice thing. If you have a lot of GPs, they may be able to stagger their work hours so you have some GPs who work until 8pm and start at 10am or something, rather than 8 until 6 or whatever you are doing. So there is a capacity to provide - well, it would be nice to have more capacity to provide after-hours care through general practice, if you have enough people to do that, where it's not just adding increased workload to the GPs existing already - anything to keep people out of the fragmented hospital system which often over investigates and spends a lot of money doing all of those things they do.

MR MUSTON: Can I ask a question about the drift away from general practice that we've talked about. What could be done to turn that around? In a way it sounds like some success is being found in the training which is now being managed and delivered through the college, but are there other things that could be done to try and reverse that trend?

MS VAN DE WATER: I might just lead off with adding on to some of the previous discussion as well. I think all of the doctors on the panel here today have spoken about the cost in a patient turning up at the hospital and the urgent care centres compared to that of general practice. We released data last week that the average cost to the government for a patient to visit an emergency department is $692. Now, that's for a patient who is not admitted to the hospital. Whereas the patient spending 20 to 40 minutes with their GP is a cost of $83. So managing the funding and the distribution of that funding and the way in which that funding can be accessed by a general practice through the team provision of service to patients is absolutely something that will support improved access, but no doubt maximising the service that's provided by each of the clinicians and team members within each of the primary care settings.

DR BONNING: So given the question now is about what does

our future look like, you can project ahead. I'm trying to remember where it is, where the data is. I think the Australian Bureau of Statistics and the Institute of Health and Welfare project that forward for New South Wales and they say our number of general practitioners won't start really to rise in total on projections until about 2034, something like that. We had a number of people stay in the workforce because of the pandemic, they felt - or they returned on the sub-register, so we actually had an influx and that number has dropped away. To replace that but actually to grow our workforce is taking some time. That's important from a population who we see, over time, needs, because they are ageing, because it is growing, more general practice services. So that is kind of - that's the call to arms, why do we need it.

MR MUSTON: How do we do it is the question.

DR BONNING: What you achieve in all of this, though, is - the last time, and Georgina, please correct me if I'm wrong, I seem to remember that the commitment to go from 800 or 900 GP training places to 1,300 to 1,400 was by Minister Roxon back in 2008 or 2009, so it's been quite a while.

It used to be that about 40 per cent of the graduates out of medical school went into general practice. Now we know that number, depending on which year you pick, for Australian medical graduates, is somewhere between 12 and 15 per cent. So your target, given that we are now in a position where the college is delivering a program that is being fully subscribed, is to grow the subscription limit, and I think that's a clear recommendation.

The second is that every - you know, the college of GPs, the College of Rural and Remote Medicine, the rural doctors agencies, lots of others, we've all been saying, you know, "How great is general practice", we're talking about it here, Mr Sloane's been complimentary about it. It would be lovely to see that the rest of the public knows that, because otherwise it does become, "Why am I the clerical staff" you know, the number of times I've been asked in my career about, "Oh, Did you choose to be specialise in anything?" I'm like, "Yeah, I'm really good at this job, thanks very much" is quite challenging. It's changing the public's mentality about what their GP is there for.

Overall it is creating a future which requires public education around the role of general practice, especially if we want to keep healthcare costs under control. It would be encouraging people to have a regular, consistent relationship with their GPs and funding us into the system, both by the Commonwealth and the state, to be able to do those things that cross over between the two. So regular general practice that is funded through Medicare but also shared programs with hospital systems, so bridging that divide and that gap so that our patients who are complex - you know, we see programs and models of - they are called, GPwSIs, GPs with special interests, who work across hospital systems - it's more prominent in Queensland than here, but we see it here as well. One of the great things about that, I always say, is the ability of the GP to know when to discharge the patient from the outpatient service, or even the inpatient service, is often very good because they know what's happening in the community. It's about using those resources better.

The overall funding for unreferred medical services, which is general practice, is about 6.5 per cent of the total healthcare spend. What's his name again? He's from Ochre Health. Hamish Meldrum did a survey of the public. The public thinks that general practice services are funded to somewhere between 20 and 40 per cent of the total health care spend. So the public expects a lot of us, they think there's a lot of money that goes there. There isn't that much, or as much as they anticipate. So bringing more people in the front door, giving people options, as was talked about, with regards to keeping them in practice, so they are interested in something, ways in which we take that interest and make them excellent and as part of the team, whether it's, you know, they want to be really good at cardiology, they deliver great women's health services in the community, you know, like me, I do lots of doctors' health, so health care for other doctors - all of those kinds of things we really double down into that.

I think lastly, we work with the federal government on how to make general practice more viable, but also more viable to do the things we've just talked about, to provide care, more care out of hours, to be more able to fit in, manage, support those people who need our care when they need it, to make sure that there are systems in place rather than just great people, so systems like we would

have in the hospital system to support a community - all of those things are what are going to mean that, over the long run, you actually end up spending far less because your population is healthy.

MR MUSTON: Dr Hoffman, from the college's perspective, are there things that you think we could be doing to turn the tide in terms of the drift away from general practice?

DR HOFFMAN: Absolutely. There are probably three populations that I want to speak to. The first one is the retiring GP or the GP that plans to retire in the next five years. The second is the cohort of GPs who have obtained their medical degree in another country and the third is the cohort of Australian-trained doctors choosing to be GPs.

Apologies, my PhD is on burnout in general practice, so I will try to concise this down to a few minutes rather than 40,000 words. Retiring GPs, we actually asked this in our survey most recently a month ago - and there is a big cohort of GPs who did come back during COVID that now plan to retire in the next five years. When we asked them, "What will keep you in the workforce? What will keep you working for longer?" It's red tape and it's costs. So being able to pay or incentivise pay more and reduce the red tape, reduce the doctors sitting at their desks until 10pm at night, will absolutely increase the workforce.

The second one is our overseas trained doctors, our doctors who are specialist GPs in other countries. As of next Monday, will have an expedited pathway, if you trained in the UK, in Ireland or New Zealand, to come to Australia and work here. They will still have a moratorium, they will still be required to work in Modified Monash areas 2 through 7, but there will be a significantly faster way for them to come to Australia and work here.

We need to make sure that not only when they come here, they are embraced, they understand the GPs and the Australian hospital system, that they've got good reliable networks and that they are safe. It's not yet clear from the Ahpra and from the AMC, exactly how that's going to work. I'm happy to stop at any point.

THE COMMISSIONER: Can I ask you a question so I understand just in relation to the point you were making

about retiring GPs and what are their frustrations. One you said was red tape. I'm not a clinician. That could mean anything. Can you tell me what you mean by red tape?

DR HOFFMAN: What I mean by red tape is paperwork. So it really comes down - it's the patients asking for their Centrelink certificate to be updated because it's been three months since the last one was done or their WorkCover certificate to be done because it's been 28 days since their last one, and nothing has changed in that 28 days but that's the time frame that's required for me to sign a new piece of paper. The GP can't make the decision to extend that out and say "They've broken their leg, it's going to be six weeks" or "it's going to be three months." This piece of paperwork should be able to be modified to be three months. It's that, no, I've got to do this every 28 days, that we're not actually given permission to be flexible with that.

If there was a little bit more flexibility around some of that, it would be great. There's NDIS paperwork that we don't have funding as GPs to be able to complete. So we either charge the patient or we do it for free. The red tape is the paperwork.

THE COMMISSIONER: Got it, thanks. Now, I interrupted you. You were still talking maybe about overseas trained doctors but heading to locals.

DR HOFFMAN: No, I was moving on to junior doctors. I was moving on to probably my favourite topic, which is junior doctors and medical students. We rightfully say there used to be about 40 per cent of medical students, when they left medical school, that went, "Yes, let's be a GP", and that's dropped right back to 11 per cent. So what we would really like to see are targets at a university level to pick that back up, and the target needs to be at about 50 per cent, that 50 per cent of medical students, when they leave, go "Yes, general practice is for me."

Then there is this dive, when they're junior doctors and they come in and they're interns and they're residents and they never experience general practice again except when they're sick or when they're in crisis. This is the cohort that most commonly decide not to be a GP. So re-engaging them back in general practice, and that could be through what we previously had done about a decade ago,

the PGPPP, so that's where they do community rotations through general practice for one of their standard terms, one of their 10- to 12-week terms, that might be through a single employer model. There are a number of ways that --

THE COMMISSIONER: I have asked someone previously what that acronym stood for. I'm going to ask you again. What did it stand for?

DR HOFFMAN: It's the postgraduate primary --

DR BONNING: Prevocational general practice placements program.

DR HOFFMAN: Thank you.

THE COMMISSIONER: The person that I asked to describe the acronym also said it was a terrific scheme, but no-one could tell me why it was abandoned, other than it coincided with a particular election.

DR HOFFMAN: I've spoken to HETI about this only yesterday, and they've actually said it was too successful, which I'm not sure if that's entirely true.

THE COMMISSIONER: Now we're in Utopia.

DR HOFFMAN: They needed the workforce in the hospital.

DR BONNING: It's expensive. It was always expensive for hospitals. Just to comment, I think, on that, even prior to that, so before general practice became as formalised as it is now, many of the senior consultants you were seeing in hospital used to moonlight in general practice, so this is before 1996. They would be doing their registrar training but then they would come and work for someone on the weekends.

The reason I say - none of them went into general practice, but they had an appreciation of what we did and what was difficult about it, and many of them will say, "I love what I do because I do the same thing. It's a nice niche bubble. I hate what you do. I couldn't do what you do" - because it's a fracture, followed by a complex mental health, followed by a heart failure, followed by a child, followed by someone with Alzheimer's. That's a pretty

common day. That appreciation - so coming back to who are we talking to when we think about the future, we're talking to the public about understanding what a GP does and how great it can be. The funding models also drive then what kind of GPs we produce, so if the focus is on getting through lots of patients, then the easiest pathway is to write a referral, to say, "Please do this", and send them somewhere else so that someone else does the work.

But also it is about our rest of our colleagues, and that's why PGPPP and other programs have been great, because they reintroduced a whole generation of hospital-based specialists to the idea of, "Oh, wow, the patients I see in the hospital have often been kept incredibly well for a very long time", and it promotes a much more respectful discourse within our professions, and that's important, too.

MR MUSTON: Dr Christmas, you wanted to add something?

DR CHRISTMAS: Yes, thank you. One of the things we know about general practice, and especially in rural areas, is that if you have exposure during the junior doctor years, you are more likely to choose that as a specialty, whether that be in the country or the city, especially, though, in the country, because general practice in the country is different to in the city because we do that public/private thing where we're in the hospitals as well, and often general practice suffers from that it's not as lucrative financially, it's not a sexy profession, you don't go to someone and say, "Hi, I'm a GP, pay me some kudos".

There's this whole idea, which is perpetuated through medical school and through the hospital system, that general practice really is the pour cousin, which we all know in primary care is not the case; it is actually incredibly important.

We know that if junior doctors are exposed to general practice, we get them in that gap that you were talking about - your name just suddenly has gone out of my head, I'm so sorry - talking about getting people, at that time in junior doctor years, before they get snaffled by the consultant in cardiology or in surgery, that they also have a great time with mentors in general practice.

The trick about this is in rural hospitals, we've got

called what's called the "John Flynn" rural general practice - anyway, it's got another acronym - where there is funding for junior doctors to go into places like where I work, where they work part of the time in the hospital under supervision and part of the time in general practice, so they really get an idea of what this whole idea of rural general practice is all about.

The trouble with this is it is becoming a thing that they will do if they can afford to part with their interns or residents from the base hospital. So what we see is these positions are not being prioritised and they're not being filled because they want them back in the base hospital to fill their night shift or to fill their emergency or their whatever, medical rotation.

If there are KPIs around that, if there's, "Actually we need to fill these positions, these are a priority", because we realise that (a) it's a good support for someone like me doing the job, because I am my own resident, my own intern, my own registrar, consultant, I can actually really do with that help and that would help ease the load on me so I can do my job better, but it gives junior doctors from metro and rural areas excellent experience and exposure so they actually understand the breadth of general practice. So even if they don't choose - as Dr Bonning was saying, even if they don't choose general practice as a specialty, they go into their specialties understanding more about it and saying, "Oh, yeah, I've seen this kind of patient. This is what I'm sending them home to and this is how I need to communicate with the GP." Because if one more junior doctor says, "And, GP, kindly chase results" - they don't understand that, from a general practice point of view, that doesn't --

THE COMMISSIONER: Had you finished what you wanted to say, Dr Hoffman, when I interrupted you about the acronym?

DR HOFFMAN: No. I think what you're hearing from the three doctors on the panel is that general practice is the best career that is available of any of the medical options, and if the junior doctors experience a quality general practice, then we would have more numbers of doctors wanting to be GPs. RACGP has the capacity to train these junior doctors who want to be GPs, and again it's not overnight, but it isn't a 15- till 2032-year solution but it might be a three- to five-year solution, and that

absolutely will change health care in rural, regional and outer metro New South Wales.

MR MUSTON: Mr Sloane, do you have any insights into the state's position or views on this, what might have been an excessive successful scheme?

MR SLOANE: Look, I think again, what became very obvious early on in my original post as coordinator general, and then it still continues, is that models like the Murrumbidgee model - you know, we've all heard a lot about that and now we've expanded that across the state around the rural generalist single employer model.

What we heard through the previous rural and remote access to health care and hospital inquiry, from a lot of doctors who were in the early stages of training, was when they do go to specialise and are thinking about going into general practice, one of the big barriers for them, at that point in time, was the loss of their entitlements. When they leave the public New South Wales health system, they loose their maternity leave option and their annual leave, any other entitlements that they have accrued during that time, and it was a pretty big decision.

It became very obvious to us quickly, off the back of the successes of the Murrumbidgee model, that if we could somehow play our part from a NSW Health point of view in providing a single employer model that works very closely with the colleges with regards to the training and be able to do so that, you know, as I said earlier in the day, very much works to preserve private practice.

For me, I'm very biased, I want private primary health care to stay in regions, because that's the reliance. Doctors like Rachel work tirelessly out there and we needed to do anything that we possibly could to play in that space and play our part with regards to it. So we did seek exemption from the Commonwealth in order to do so, in order to make that both a hospital and private practice viable model.

Early days, we only started last year, but we've already increased the single employer model places across the state from five in Murrumbidgee. I think we're starting 29 at the start of next year and I might make it very clear that this is advanced skill training positions

that are doing registrar training.

We know economically, not that I want to harp on about that a lot, that that's far more cost effective than paying some exorbitant prices for temporary medical officers, even though they're a very valuable asset, for things like leave or otherwise. So we know employing a registrar into a salaried position, we still get an incredibly equipped doctor and then we afford them the option to be able to train and be exposed to primary care and private practice.

It's not smooth sailing, like we've had to work through a couple of the rough edges of the model with regards to the cost to the district. The remuneration is not necessarily there from the Commonwealth. We have to create some pretty significant engagement and trust and assurance with the private practices that we're working with, and so we've had to appoint a small team in order to do that and travel around and actually have those discussions with, whether it be the AMA, RACGP or ACRRM, HETI, and most importantly all the private practice providers, who are essentially donating their training skills and ability in order to get this model off the ground.

We've had amazing feedback from all of the candidates involved so far. There has been a bit of interesting sort of misinformation about how successful the Murrumbidgee model has been, but of the five candidates they've had through their program, three of them have been fellowed and been retained in the district or in regional areas. A lovely couple has sort of springboarded off that to stay and be retained in Deniliquin and provide a very well-loved service as general practitioners in that town.

So again it's not going to be one of those things - it will piggyback off the stuff that Dr Hoffman and her team are doing from the college point of view, and ACRRM as well, but it's one of those things where, from a state health point of view, we've had to recognise our responsibility and play right up to that line of where the Commonwealth responsibility starts and stops.

The sort of contribution has been not fiscal from the Commonwealth whatsoever; it's been in the form of 19(2) exemptions, again, so it is another rerouted way of, I guess, applying funding through a different mechanism or

otherwise. With all intents and purposes, we hope it continues to be successful and grow as we go forward, with a view that we will retain doctors in the regions with that exposure, and we will hopefully ease the burden on and work closely with primary practice in regional areas as well.

MR MUSTON: What are the tools that you've got available when you're dealing, in a place-based way, with the thin, failing or failed GP market? You referred to some success in Braidwood. What worked there, just as a starter?

MR SLOANE: This is one of those tricky things because it is from a state health point of view, ear to the ground. It's close relationships between local health districts and primary health networks. It's use of other non-government organisations like the Rural Doctors Network to try and understand - I am of the understanding that Department of Health and Ageing have some form of tool, I believe it's very manual, to track and have an overview of thin and failing markets, but we do rely on negotiation between our very well-organised local health districts, their local communities and the GPs that are working in those towns.

Eden is a very good example of where again, the doctor, a very small, very hard to keep viable business because of low volumes or otherwise, and I think the - again, I might be misquoting here but the GP there was finding it very hard to go on leave, had been working continuously for quite some time. If he was to hire a locum in order to go on leave, he would have been - I'm not talking about the locum pricing but that whole concept itself would have been very hard for him to do that and keep the business viable.

So it was escalated through me, just through good relationships and knowledge, that that might be a consideration and that would put that small community in a bit of a spot, and so we worked very closely with RDN, and then up through the Commonwealth, to go, "Right what's happening from a thin markets' point of view to help this person?" And RDN were able to successfully help him get a cost-effective option in order to take that leave.

Again that rolls into some of that succession planning that Dr Bonning talked about, and Dr Hoffman, with regards to how can we put some other systems around that and stop it from happening. For that instance, it's very difficult

for NSW Health to go, "Right, we're going to help you out by moving a staff member", because there is absolutely no remuneration for us to do that. But we are very cognisant of the impact that not having that GP, or that GP service for that community, will then have flow-on effects to not only the community proper, which is the most important thing, but where do we then accept them into state health care.

MR MUSTON: I might ask any of you to comment on this, but in the context of a market which we might describe as a failed market, so not jeopardising a thin or existing GP market in a particular centre and no realistic prospect of attracting a GP or GPs into a particular area to provide primary care to that community, is a salaried model something which is of interest or you think would be of interest to the state and, Dr Hoffman, from your perspective, something which you think would be of value to the college from a training perspective but also as an attractor to someone who might prefer to work in that type of commercial environment?

DR HOFFMAN: Again I think one town is one town is one town. What is attractive in one town would be very different to another town. In Sydney we have Kurnell, on the outskirts of Sydney, and it's a failed market. It hasn't had a GP for two years and it's in Sydney. So putting a salaried doctor there probably won't put a GP there. There's complex reasons as to why they can't attract and find a GP to stay there.

I might pass to Georgina, because we've had enormous successes in Tasmania from the single employer model and filling the Tasmanian market from offering similar.

MS VAN DE WATER: Our experience is there that, as you say with each town, similarly for each doctor, and the single employer models across Australia have had varied interest and different levels of success. I think absolutely I agree with what was said about the Murrumbidgee model, and the retention of that is really going to be the proof in the pudding, I think, of the success of that model and the team down there have done a tremendous job.

From our perspective, we have implemented opportunities for remote supervision for registrars, so where there isn't a GP in a town, understanding from our

local teams on the ground, working with the local LHDs, working with the PHNs and others to identify those areas where there is a service gap and look at how we can leverage safe and quality supervision through a remote supervision arrangement that we've implemented in the last 12 months.

For instance, towns like Broken Hill have been able to achieve that, as well as some other towns across New South Wales - sorry, Bourke, not Broken Hill, where we've been able to achieve registrars delivering service through flexible funds that have been applied specifically for relocation costs and support of return visits, and then additionally with remote supervision.

I think absolutely we need to ensure that we are creating opportunities for exposure for doctors within those junior medical officer years, the prevocational years, to experience quality general practice. At the same time we need to make sure that we're setting expectations around our Australian universities to create rotations and opportunities for med student placements in general practice in our rural and remote communities.

The other aspect that I think is really important as we move forward is making sure that our international medical graduates who take up placements in practices in rural and remote communities are well supported to apply their skills but also adapt their skills to the Australian context. Part of that is helping the community to understand the role that these doctors have and the ability that those doctors bring through their own experience as well.

It's a wrap-around comprehensive approach to making sure that we're feeding in to the service capacity and making sure that between the local health district, the training programs in the region, as well as our other agencies, that we're truly working collectively to make sure we're supporting those doctors that are in situ to be able to stay there.

MR SLOANE: Yes, I agree with all of what has been said. I think the other thing we're doing from a NSW Health perspective is we have, over the last 12 months, been in consultation with the Department of Health and Ageing around specific funding to trial that.

I one hundred per cent agree with Dr Hoffman's comments. Planning for any sort of model needs to be place based and contextualised. You can take any model on scale but the success relies on the contextualisation to that.

We're currently looking, and have put out an EOI recently, for access to a pool of funding - and I outline this in my witness statement - that lies outside of the current regulatory levers and funding mechanisms from the Commonwealth. It's a small amount of funding, but to be applied to test pilot sites - we often hear about pilots, but if we don't try stuff, test it and evaluate it, we can't really check - across a couple of different areas.

We're looking at Canowindra, first and foremost, in western New South Wales. We'll be looking at a salaried model there, very similar to HealthOne at Bowraville. I will just point out there's other economic benefit to Bowraville around cultural safety for the community there that's probably very invisible, from the Aboriginal people that are accessing health care there and the work they have done.

We're looking at a cross-jurisdictional cross-PHN trial with the Victorian town of Swan Hill and between the Murrumbidgee PHN and the Murray PHN around almost a 4Ts-esque style model of salaried medical officer or multidisciplinary team led model down there to cover off four or five different communities that lie along the inter-jurisdictional border there as well.

The other one is consideration for Balranald. We haven't worked through all the details in that at the moment, but we can see that again that low volume, non-viable MBS billing funding which could hardly prop up a viable small practice there and that's why it has been very tricky for them to get a medical practitioner in that town and I know it's very important to that town. We're looking at how we could put perhaps a salaried model there. It might not necessarily be medical led, but some form of salaried model from a primary care perspective and in collaboration with Far West Local Health District.

MR MUSTON: I note the time, Commissioner. I think we've occupied half an hour longer of these witnesses' time than I was going to. I could ask a lot more questions but

I probably don't need to.

THE COMMISSIONER: Fair enough. I don't know whether it is relevant or not but maybe it is just curiosity, why can't Kurnell - what are the complex reasons or some of them for not being able to attract a GP?

DR HOFFMAN: Good question. It's a very high load of mental health and complex mental health, with an expectation to be bulk billed and with the incentive rates for an MM1 --

THE COMMISSIONER: You can't run a successful business there under the MBS rates as they stand.

DR HOFFMAN: No.

DR BONNING: As you get closer to any of the boundaries of other DPAs - so priority allocations, so where we can place internationally trained doctors - so when you're on the close side of the line, very hard to place there. When you are on the close side of MMM1 going into MMM2, also very difficult to place there.

THE COMMISSIONER: So Kurnell isn't necessarily an isolated example of that problem where there's socioeconomic disadvantage, so the expectation from the patients is, "Well, I can't pay you, it has to be bulk billed", but the needs are so complex and the time taken for the consult makes it economically unviable for the GP's business.

DR BONNING: Areas around Newcastle have some really similar experiences. Hunter New England has lots of challenges for those exact same reasons, because it's - if it is a fee for service model, the amount of time you need to spend, it does become unviable.

THE COMMISSIONER: Yes, because mental health is not a six-minute consult.

DR BONNING: No.

THE COMMISSIONER: Mr Cheney, do you have any - or Mr Chiu, I'm not sure which one to ask at the moment.

MR CHIU: We have no questions.

THE COMMISSIONER: Great, thank you.

To all five of you, thank you very much for your time. We are very grateful. I apologise for going slightly longer, but it was worthwhile from our perspective. So thank you again. You are excused.

<THE WITNESSES WITHDREW

THE COMMISSIONER: We will adjourn until 10 o'clock tomorrow.

AT 4.36PM THE SPECIAL COMMISSION OF INQUIRY WAS ADJOURNED TO THURSDAY, 17 OCTOBER 2024 AT 10AM

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