

**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

1 THE COMMISSIONER: Good afternoon.
2
3 MR MUSTON: The first panel of witnesses we have today are
4 both from Advanced Pharmacy Australia.
5
6 A copy of the statement that they have prepared,
7 Commissioner, you will find behind tab L13, it is
8 exhibit L13.
9
10 THE COMMISSIONER: I have that, thanks.
11
12 MR MUSTON: Starting on your left is Jerry Yik, and next
13 to him is Jonathan Penm. I think Mr Yik will take an
14 affirmation and Mr Penm will take an oath.
15
16 <JERRY YIK, affirmed: [12.01pm]
17
18 <JONATHAN PENM, sworn:
19
20 MR MUSTON: Starting with you, Mr Yik, would you state
21 your full name for the record, please.
22
23 MR YIK: Yes, my name is Mr Jerry Yik.
24
25 MR MUSTON: You are the head of policy and advocacy at
26 Advanced Pharmacy Australia?
27
28 MR YIK: That's correct.
29
30 MR MUSTON: Mr Penm, could you state your full name for
31 the record, please.
32
33 DR PENM: Yes, I'm Jonathan Penm.
34
35 MR MUSTON: You are the vice chair of the New South Wales
36 branch committee of Advanced Pharmacy Australia?
37
38 DR PENM: Correct.
39
40 MR MUSTON: Also a member of the faculty pharmacy of the
41 University of Sydney.
42
43 THE COMMISSIONER: Is it Dr Penm?
44
45 DR PENM: Yes.
46
47 MR MUSTON: Dr Penm.

1
2 You have both prepared a statement dated 26 September
3 2024 to assist the Inquiry with its work. Do you have
4 a copy of that with you?

5
6 MR YIK: I do, yes.

7
8 DR PENM: Yes.

9
10 MR MUSTON: Have you each had an opportunity to review it
11 before giving your evidence today?

12
13 MR YIK: Yes.

14
15 DR PENM: We have.

16
17 MR MUSTON: Are you satisfied, to the best of your
18 knowledge, that its contents are true and correct?

19
20 MR YIK: Yes.

21
22 DR PENM: Yes.

23
24 MR MUSTON: That will form part of the tender in due
25 course.

26
27 THE COMMISSIONER: Yes.

28
29 MR MUSTON: Can I take you to page 4 of your statement
30 where you set out for us a number of key issues. In fact
31 before going to that, could I ask you for the benefit of we
32 laypeople just to explain the typical role of a hospital
33 pharmacist within a public hospital setting?

34
35 MR YIK: Yes, sure. Hospital pharmacists are very, very
36 important to the supply of medicines to patients in
37 hospitals, all the way from the - upon entry into hospital,
38 where we might be in the emergency department, all the way
39 through to your entire inpatient journey, upon discharge
40 from hospital, and then as well as any community care that
41 might be provided or any transitions of care services that
42 might be provided as well.

43
44 Now, supply of medicines is a core part of what
45 pharmacists do. As we all might be very familiar with, we
46 tend to see pharmacists as the people that give us our
47 medicines. That is very, very true and that is a very

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

5
6 MR MUSTON: Pausing there, to the extent that we might all
7 understand if you are an outpatient or an inpatient within
8 a hospital and a doctor prescribes a particular medication,
9 the hospital pharmacist will receive that prescription,
10 probably electronically these days, and collect and
11 administer - distribute whatever the product is?

12
13 MR YIK: Yes, that's right. What you have described there
14 is a fairly reactive model, so the pharmacist is at the
15 very end reviewing everything, and what - but in the acute
16 setting, what is best practice, as described in our
17 standards, is that you actually have pharmacists embedded
18 in the wards providing bedside medication management
19 services where you can actually review the medication
20 chart, make sure that the prescribing or charting of that
21 medicine is safe and appropriate for the patient before the
22 nurse then orders that medicine.

23
24 The pharmacist should be involved in that prescribing
25 and charting process alongside the doctor so that even
26 before it makes it down to the dispensary for the
27 pharmacist to supply it, it's already been deemed to be
28 a safe and appropriate prescription for that patient. So
29 that is probably the more clinical and cognitive service
30 that should be provided and what hospital pharmacists
31 should be able to provide, and which is, you know, an
32 extremely value-adding area.

33
34 MR MUSTON: Going back to the point of admission, we've
35 heard some evidence and heard some discussion on some of
36 our regional trips about medication reconciliation as
37 a role that pharmacists have within a hospital setting.
38 Could you just explain to us, say from the perspective of
39 a hypothetical patient who enters the hospital system, what
40 that involves?

41
42 MR YIK: Yes. I think yes, medication reconciliation is
43 an activity that requires pharmacists to undertake
44 a history of what medicines that patient is on prior to
45 entering hospital, so that when they are admitted, they can
46 have all their regular medicines from home being charted
47 and/or their reason for admission to hospital might be

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

11
12 So they might come into hospital and be taking the
13 wrong medicines and the pharmacist who does the medication
14 reconciliation can find that out. But even if there's
15 nothing wrong with the patient's medicines, there is still
16 a duty of the hospital to make sure the patient is taking
17 the medicines that they were on prior to home.

18
19 So if you're a patient that's using something to lower
20 your blood pressure, something to lower your cholesterol,
21 taking an anti-depressant, some pain medicines as well, you
22 should expect that in your five-day inpatient stay, that
23 you should have access to those medicines as well and
24 continue that therapy. You shouldn't have to stop taking
25 those medicines for five or six days while you are in
26 hospital. And to make sure that pharmacists and the
27 hospital can provide the right medicines, that's where that
28 medication reconciliation occurs, to make sure that we are
29 taking an accurate medication history, because if it's not
30 done, then the patient goes without medicines or, worse,
31 might be prescribed the wrong medicines.

32
33 MR MUSTON: When you say "prescribed the wrong medicines",
34 do you mean prescribed something which is inconsistent with
35 or reacts adversely with something that the patient is or
36 has been taking?

37
38 MR YIK: So it could be they are prescribed the wrong
39 medicine or the wrong dosage compared to what they were on
40 at home and, yes, it has potential to be one that they
41 might have an adverse reaction to. Why that might occur
42 sometimes is if you don't have a pharmacist doing the
43 medication reconciliation - and evidence proves and
44 suggests that pharmacists are the best clinicians to do
45 a medication history for medication reconciliation - where
46 you rely upon a doctor or a nurse who has a lot of other
47 things to do to take a really basic medication

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

6
7 So without a pharmacist doing a really comprehensive
8 and accurate medication reconciliation, that's what might
9 precipitate the issues that you have described.

10
11 MR MUSTON: You refer to a "comprehensive and accurate
12 reconciliation". What, in a practical sense, does that
13 involve beyond asking a patient to the extent that they are
14 capable of responding, "What are you taking"?

15
16 MR YIK: Many activities - and as you said, it's not just
17 asking the patient and as we know unfortunately patients,
18 certainly when they are in the acute environment, can be
19 poor historians. So we have to make sure we are checking
20 other sources. That could include the My Health Record;
21 could be calling up their usual community pharmacies as
22 well to look for dispensing records, and that might - and
23 some patients might have more than one pharmacy, which
24 makes it more complicated; contacting their prescribers as
25 well, so their GP or GP practice; any specialists as well
26 that they might have; carers as well. Yes, so there is
27 a variety of sources that we can use to get that accurate
28 medication history and often we do need to do that. But as
29 you can imagine, that's quite a significant amount of time
30 to do an accurate and comprehensive medication history that
31 you just would not expect a nurse or a doctor to do.

32
33 MR MUSTON: That would obviously require a sufficient
34 workforce within a pharmacy department to be performing
35 that task in relation to patients as they come in to the
36 facility.

37
38 MR YIK: Yes, absolutely. You require pharmacists to be
39 staffed on all those wards, especially in general medicine
40 wards, in emergency medicine where you are getting the high
41 flow of patients, to do that medication history.
42 Unfortunately, there are many, many, I would probably say
43 the vast majority of New South Wales hospital pharmacy
44 departments and their wards won't have a continual and
45 regular clinical pharmacist service at those wards.

46
47 MR MUSTON: In relation to that reconciliation process,

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

12
13 MR YIK: Yes, absolutely. I think we always obviously
14 apply risk assessments and we provide our services on
15 a risk-based approach, so looking at patient profiles, and
16 that could be age-related factors, can be their medical
17 history, can be the number of medicines that they are on.
18 It can be the types of medicines that they are on. There
19 are many patients who are taking 15, 20 medicines, and they
20 can be completely appropriate, but you might have patients
21 who are only taking five and they are all inappropriate or
22 can have the propensity to cause an adverse reaction.

23
24 So we aim to provide medication review to every single
25 patient. There is no way that is occurring in New South
26 Wales based on the funding issues that we've explored, and
27 even applying a risk-based approach and even trying to
28 ensure that we only review our high-risk patients, even
29 that service level is not able to be met in New South Wales
30 in many, many departments.

31
32 MR MUSTON: When you say it is not able to be met for
33 funding reasons, are you essentially telling us that there
34 are insufficient hospital pharmacists employed within
35 facilities to enable that process to be undertaken with
36 respect to the patients that, at least in the view of
37 pharmacists, it ought to be undertaken in relation to?

38
39 MR YIK: Yes, I am. So as we present in our evidence, the
40 number of hospital pharmacists in New South Wales is - you
41 know, comparatively speaking to Victoria and Queensland,
42 when you're looking at the number of hospital pharmacists
43 to the number of hospital beds that you have, New South
44 Wales is far, far behind.

45
46 So in that scenario, how do we - how do New South
47 Wales pharmacy departments apportion their pharmacists and

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

14
15 Best practice dictates that you detect these errors at
16 the very beginning, as other states are able to do because
17 they do have enough workforce, but in New South Wales, in
18 many areas, that error may only be detected at the very end
19 when the pharmacist is asked to supply that medicine, if at
20 all.

21
22 THE COMMISSIONER: The ratios that you have given in the
23 table on page 2 - any questions I ask, and also this
24 applies to Mr Muston, both of you should feel free to chip
25 in and answer if you want to - why is New South Wales so
26 much different to Victoria and Queensland? Funding might
27 be one issue, but are there any other reasons that you're
28 aware of?

29
30 MR YIK: Look, I think funding is a - it probably comes
31 down to funding, at the end of the day. I think there are
32 other areas around workforce investment as well, so there
33 is a workforce shortage across not just healthcare sectors
34 but every sector at the moment but historically, New South
35 Wales hospital pharmacy departments have been underfunded.
36 We aren't funding enough internships for pharmacy students
37 to come into the hospital setting. We know that hospital -
38 the hospital setting is the most desirable setting for
39 pharmacy students, but I think New South Wales currently
40 only offers 40-odd, according to our submission.

41
42 In Victoria, we've got over 100. So if you are only
43 getting 40 new interns each year and you want them to
44 continue, then you've got a fairly limited pool. So
45 I think funding is probably what it comes down to.
46 Recognition from the LHDs about what pharmacy departments
47 provide and the services that they provide and providing

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

5
6 THE COMMISSIONER: Sorry, what is not taken seriously?
7

8 MR YIK: A lot of our pharmacy departments are asked to do
9 a lot of extra activities to respond to the needs of the
10 state healthcare system. We're like, of course, we want to
11 do that, we want to make sure that we're providing the best
12 care possible but when we then say, "Well, we're going to
13 need this amount of pharmacy technicians, this amount of
14 pharmacists", the response from various levels within the
15 ministry or the LHD is that, "Well, sorry, we can't. We
16 can't fund that. You're just going to have to make that
17 happen", and so that's when it comes to, "Well, what can we
18 cut or what can we rearrange?" And I was speaking to
19 someone who was job was rearranged at some point during his
20 career due to these funding decisions.
21

22 DR PENM: I would just quickly add to it. We have lots of
23 people wanting to work in hospital. We just don't have
24 enough positions for them to have. And then those that are
25 in there, the pay structure doesn't reward them for their
26 contribution. When you're talking about the restructuring,
27 we often get those requests that say this hospital is
28 implementing a new service, implementing more emergency
29 department beds, implementing more wards. They will tell
30 us how amazing those new facilities are, the new doctors
31 they will hire for it, the new nurses they will hire for
32 it. But in the pharmacy, we go, "So, are we getting
33 anything?" "No". Pharmacy is generally not considered
34 when it comes to new services and we've just been taking
35 that load on and on and on and we've just got to this point
36 now that our ratios just seem vastly lower than other
37 states.
38

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

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

3

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

7

8 THE COMMISSIONER: On the ward.

9

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

18

19 THE COMMISSIONER: Potential error.

20

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

24

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

31

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

33

34 DR PENM: That's correct. So once the pharmacist does the
35 medication reconciliation, the pharmacist then charts those
36 medications, because they have the time and the ability to
37 do so, and they have done the medication reconciliation
38 because they have the staff to do so, and they show by
39 doing that they have now reduced that length of stay by
40 10 per cent, they have reduced the errors per patient by
41 62.4 per cent. That's a service that you can only do if
42 you have the staffing to do it.

43

44 THE COMMISSIONER: Sure.

45

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

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

5
6 The status of that is the Ministry of Health is
7 progressing this program and they have put out - we
8 understand that they have put out an EOI to various
9 hospitals and LHDs to ask, "Who wants to participate?"
10 There is lots of interest from many, many LHDs but what we
11 understand is they have also been told there won't be any
12 additional money to fund this service.

13
14 THE COMMISSIONER: So this is recommendation 8?

15
16 MR YIK: In the ramping inquiry?

17
18 THE COMMISSIONER: Yes.

19
20 MR YIK: Yes, that's right.

21
22 THE COMMISSIONER: We find that - do you have your whole
23 statement?

24
25 MR YIK: Yes, I do, yes.

26
27 THE COMMISSIONER: So this is the New South Wales
28 Government response to the ramping inquiry, just call it
29 that, page 5 --

30
31 MR YIK: So they've accepted that.

32
33 THE COMMISSIONER: -- that the New South Wales Government
34 will provide funding to increase the number of hospital
35 pharmacists so that their availability better matches
36 operating hours, et cetera. That's supported in principle.

37
38 MR YIK: Yes, and we are still waiting for that
39 investment. But the PPMC is just one of many different,
40 you know, additional requirements or initiatives that we
41 all want to do for the benefits of New South Wales
42 patients, but we keep being told continually that there is
43 no extra funding to provide that.

44
45 MR MUSTON: Just to pick up on something, Mr Yik, you said
46 a bit earlier, the position in many facilities is, if I've
47 understood you correctly, that the pharmacy workforce that

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

5
6 MR YIK: Yes. I would say so, that the core service of
7 a pharmacist is to supply medicines and, you know, their
8 role in the hospitals is to make sure that patients receive
9 medicines. That's a really, really important part of what
10 we do. But in an environment where we are meeting our own
11 professional standards, we are not just supplying
12 medicines, we are also making sure that the charting and
13 prescribing of those medicines is safe and appropriate
14 before it even reaches the pharmacy to dispense
15 a prescription.

16
17 So we should be detecting the errors or assessing it
18 for its appropriateness as early as possible, not at the
19 very end when we are in the basement, when we don't have
20 access to the nurse or the doctor to get things changed.

21
22 MR MUSTON: Just working through this hypothetical
23 patient, if we put to one side the workforce challenges and
24 assume the hypothetical patient appears at a hospital that
25 has a hypothetical workforce where pharmacists can provide
26 the best level of service you think they're able to
27 provide, it starts with a thorough reconciliation of their
28 existing medication. In relation to that, is that a task
29 that can usually be performed by a relatively junior
30 pharmacist, not wanting to downplay the importance of it,
31 but --

32
33 MR YIK: Yes, absolutely. These are, you know, key
34 competencies for pharmacists and certainly undertaking
35 medication reconciliation, medication histories, is
36 something that we train students and interns to do as well
37 so that once they are registered, they are more than
38 competent to do that independently.

39
40 I might throw to Dr Penm, who actually trains students
41 and interns who do these activities.

42
43 DR PENM: Yes, so we've got some data from
44 Sydney University showing that pharmacy students, pharmacy
45 interns, pharmacists, all of them are able to do it, and
46 they do in a way that is more accurate than doctors and
47 nurses. That's not to downplay their knowledge base; it

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

7
8 I will also just talk to your point about how do we
9 provide that value. When we're doing these tasks, it's
10 often obvious to us that if you solve the problem at the
11 beginning, it saves a lot of problems at the end.

12
13 So when we had that reactive model Mr Yik was talking
14 about earlier, we were just identifying that a lot of the
15 problems could have been sorted out much quicker, much
16 faster if a pharmacist was involved, which is why we have
17 become involved earlier, and that then speaks to the point
18 on page 9 that every dollar spent on pharmacy comes to \$23
19 of savings, because the kinds of things we're fixing are
20 actually easy to be fixed at the beginning versus trying to
21 fix them at the end.

22
23 MR MUSTON: So working through that process, obviously
24 money spent on a thorough reconciliation of someone's
25 medication has the potential to produce better or quicker
26 or at least less adverse outcomes, which has a financial
27 benefit attached to it. What is the next role for
28 a well-provisioned pharmacy department in terms of the
29 journey of this hypothetical patient who has been admitted?
30 You have completed your reconciliation of their medication,
31 they're receiving some medical treatment or a medical
32 assessment is being made of them by a doctor - what's the
33 pharmacist's role there?

34
35 MR YIK: I guess inpatients is probably the next, you
36 know, journey for that patient, and so as an inpatient,
37 depending on what you are diagnosed with, it could be - you
38 are likely to be prescribed some new medicines, they could
39 be - just say you have got an infection that is really
40 resistant to a lot of anti-microbials, so even choosing the
41 right anti-microbial, making sure that's at the right dose
42 for you, that any all your issues - that any adverse
43 affects are addressed and detected appropriately as well,
44 interpreting your cultures and sensitivity testings to
45 guide anti-microbial selection, looking at your renal and
46 hepatic function as well to inform the dosing of that
47 medicine, making sure that medicine is compounded correctly

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

5
6 So I guess there's a lot of - for that inpatient, it's
7 any changes to their medicines, be it a new medication
8 being charted, an old medicine being ceased or withdrawn
9 because that's causing harm or has the propensity to cause
10 harm, and any other additional medicines to treat side
11 effects, such as nausea, vomiting, pain - all these things
12 require a pharmacist to review daily and to inform the
13 charting and prescribing of those medicines as well.

14
15 MR MUSTON: And so that presumably is a role that would be
16 done collaboratively with the doctor who is treating the
17 patient?

18
19 MR YIK: That's right.

20
21 MR MUSTON: What is the extra that the pharmacist brings
22 to that collaboration that one might not ordinarily expect
23 of a doctor who is treating the patient?

24
25 MR YIK: So there is a lot of - because the patient's
26 health and their status in the acute setting is changing
27 continually, it does require extra focus on the medicines
28 to make sure that those medicines and the dosages are
29 appropriate for the patient, because the next day your
30 patient might be having acute renal failure and that would
31 require review of all the medicines to make sure that those
32 medicines aren't going to make that worse.

33
34 We also recognise that a lot of the prescribing and
35 charting in the hospital setting is done by junior doctors
36 who are less experienced with charting and prescribing of
37 medicines as well, and so having a pharmacist who is a bit
38 more experienced around the medicines can really improve
39 the quality and accuracy of prescribing as well.

40
41 Charting of medicines on a medication chart, it's not
42 just writing down the drug and the dose. There are also
43 other - that you're getting the mode of administration
44 right, any variable dosing issues as well, having to get
45 that right as well. Annotating, you know, making sure any
46 medication orders that might need to be withheld because
47 a patient has a procedure the next day or in the next two

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

7
8 DR PENM: I'll just add, there are at least two other main
9 things to focus on where pharmacists do provide value. One
10 is we do a lot more training on medications. Our knowledge
11 of medications is vaster because of that, but we have
12 a very generalist view. So, for instance, say
13 a cardiologist - cardiologists will know all their
14 cardiology medications very well, but they might not know
15 the psychiatric medicines as well. A pharmacist will be
16 aware that, "Actually, that has a lot of side effects, so
17 they need to be monitored; they interact." So it is
18 a really good partnership. Doctors will know what is best
19 to treat them in front of them, and we know whether it does
20 actually fit within the context of the patient, from that
21 broader perspective. That's often the types of issues that
22 we identify - drug interactions that we identify - earlier
23 on.

24
25 Another part of it is just that pharmacy sees things.
26 We really like the detail. We love about - the doses
27 matter to us. The formulations really, really matter,
28 getting the right dose for a patient with renal impairment,
29 that gets us excited. We want to make sure they get the
30 right dose, and that's often not the things that get
31 doctors excited. They have a lot of other things that get
32 them excited and they can do it, they're capable of doing
33 it, but they're just not high priority tasks and they get
34 skipped, they get missed.

35
36 That's where the errors happen because it is hard to
37 do tasks that you don't like to do. I know that's
38 a generalisation, but generally, pharmacy really enjoys
39 making medication safety a priority, we really like to do
40 that, we do it well because of that. So it's just a really
41 good partnership, and that is constantly seen when we ask
42 doctors, "Do you like having a pharmacist?" They go, "We
43 love it, they do the stuff I don't want to do and they do
44 it well." And pharmacy go, "And we love doing it". So to
45 just not have that combination, it seems like you're just
46 missing out.

47

1 MR YIK: And to make sure we are not putting our doctors
2 in disrepute, it is not that they don't like doing it --
3
4 THE COMMISSIONER: I didn't assume that.
5
6 MR YIK: But it's also they --
7
8 THE COMMISSIONER: The lack of excitement only means that
9 they're happy for you to do it.
10
11 MR YIK: They don't have the time to do it as well. They
12 also just don't have the time to do it as well. A lot of
13 junior doctors, certainly from other states, they have been
14 brought up in a system where they do have a pharmacist that
15 does a lot of these things for them and then they come to
16 New South Wales and go, "Where is the pharmacist?"
17
18 DR PENM: I think the PPMC model that we talked about
19 earlier highlights that, that all the medical profession
20 really enjoy us doing that task. They actually say "This
21 is great".
22
23 MR MUSTON: You tell us a little bit in your statement
24 about the advanced skills training for pharmacists in the
25 various different strands of advanced skills that
26 pharmacists can pursue. Presumably where a pharmacist has
27 obtained some advanced skill training and experience in a
28 particular area, whether it be, you know, chemotherapy
29 medication or any of the other wide array of advanced
30 skills that you have identified by reference to those nice
31 little icons in your statement, that pharmacist will be
32 able to bring a particular degree of skill and experience
33 to the table when dealing with issues like this, and
34 perhaps significantly more than a junior doctor, who is
35 just starting on their professional journey.
36
37 MR YIK: Yes, absolutely. I think what Dr Penm's talked
38 about, us being specialists but also generalists, is
39 a really good example, because say you're in a psychiatry
40 ward, you've got the psychiatry consultant and the
41 registrar, who might be really laser focused on the
42 psychiatry medicines, and rightly they should be, but the
43 pharmacist will also take that holistic view and look at,
44 well, how does it impact their medicines for their
45 cholesterol, how does it impact their medicines for their
46 blood pressure?
47

1 These are all important factors for us to all
2 consider, so the pharmacist will take that viewpoint in
3 there. I think you are right about the need for advanced
4 skills and specialisation as well. What we do know with
5 health care is that patients are coming into hospital more
6 unwell, more advanced in their disease state and so that
7 also then requires your practitioners, including your
8 pharmacists, to make sure that they have the right skills
9 to provide care for these patients. So we do try to
10 specialise pharmacists where we can. If you've got an
11 oncology ward in New South Wales or a psychiatry ward in
12 New South Wales, you don't just put every pharmacist -
13 sorry, any pharmacist in that ward; you want to make sure
14 that the pharmacist you're putting into that ward already
15 has the skills in oncology, in psychiatry, so that they're
16 providing the best and safest and highest quality health
17 care to that patient wherever possible. That's not being
18 done at the moment in many parts of New South Wales, but
19 it's certainly what patients should be expecting from us.
20

21 MR MUSTON: So in terms of those forms of advanced
22 training, in smaller regional and rural facilities which
23 offer a general array of services to their patients,
24 obviously whilst a pharmacist might choose to pursue some
25 advanced training, the real skill that they bring to bear
26 in that setting is going to be that slightly more general
27 skill set; would that be right?
28

29 MR YIK: Yes, that's right. I think there are some -
30 you'll have general pharmacists and general medicine
31 pharmacists in all hospitals, whether it be rural, regional
32 or metropolitan areas, but I think that there is going to
33 be more and more demands from patients to have specialist
34 services outside of metropolitan areas.
35

36 Around the country, there is a need for this as well.
37 We are ready, our workforce, to provide the services
38 through different models of care. So be that outreach or
39 telehealth or remote services, these can be provided and
40 these will only proliferate even more in the coming years.
41

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

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

5
6 MR YIK: Look, that is progressing and that has been
7 rolled out, certainly in WA for a telehealth chemotherapy
8 service. In New South Wales there is the Virtual Clinical
9 Pharmacy Service, or VCPS, that has actually won a few
10 awards, where they are providing pharmacy services to
11 patients electronically and via telehealth.

12
13 At the outset, it is important for us to state that
14 in-person services are of the highest quality, but because
15 of the workforce shortage, a lot of hospitals have been
16 forced to look at providing services digitally and via
17 telehealth means, and that has bridged a massive access gap
18 in access to pharmacists, pharmacist services, the Med Rec
19 counselling by a pharmacist, where it otherwise would
20 simply just not have been provided at all due to funding or
21 due to not having a pharmacist living in the area. So
22 these means have now bridged that gap and some of these
23 cancer services, you now can actually have an oncology
24 pharmacist speak to a cancer patient, look at the
25 medication chart, making sure that that oncology medicine
26 is charted appropriately, it's the right dose, it's
27 calculated appropriately, before it's then compounded and
28 administered to the patient.

29
30 MR MUSTON: Continuing to walk through this hypothetical
31 patient's journey, decisions around prescribing are dealt
32 with collaboratively in an ideal situation, charting is
33 then done by a pharmacist in the ideal situation. Pausing
34 there, I'm assuming that having regard to the competing
35 pressures on doctors' times, that, to be blunt, having
36 a pharmacist deal with things like the charting is a more
37 cost effective way of dealing with that problem from the
38 system's point of view, than having the doctor do that?
39 Would that be a fair assumption?

40
41 DR PENM: It's not just cost effective; it's more accurate
42 and safer.

43
44 MR MUSTON: Better in almost every respect?

45
46 DR PENM: Best practice.

47

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

11
12 MR MUSTON: In this hypothetical well-resourced facility
13 where the patient is discharged, what's the pharmacist's
14 role at the point of discharge if they have one?

15
16 DR PENM: Yes, so we know discharge and transitions of
17 care is a high-risk scenario. A lot of medication-related
18 harm happens at transitions of care, and some of these
19 patients come back to hospital. That happens for a variety
20 of reasons: one, it's not just the clinical decisions that
21 are being made, what's best for them, but there's a lot of
22 coordination to make sure that the primary care, both
23 physician and community pharmacy, are aware of what's
24 happening and that those medicines are actually available
25 outside and they can do it in a timely manner.

26
27 Within New South Wales, we're not part of the
28 pharmaceutical benefits reform and so we don't have access
29 to the Pharmaceutical Benefits Scheme medication quantities
30 that all the other states in Australia do, so we generally
31 discharge patients with about five to seven days' worth,
32 and that means that they've got to see their GP in that
33 short amount of time to get more medicines, otherwise they
34 just go without until they do. That's part of it.

35
36 We've got the clinical decisions, that the right
37 medicines are prescribed, the labs have all been monitored,
38 they're not getting side effects from those, they're
39 getting the right response.

40
41 Then we've got to coordinate that everyone knows what
42 they should be on, including the patient. That often -
43 well, not often but can sometimes be missed, and then that
44 comes with patient education, counselling, producing
45 patient medication lists, so it's also written down,
46 because we know, no matter how much I tell you, you're not
47 going to remember everything, and that applies to all of

1 us.

2

3

4

5

6

7

8

9

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

11

12 THE COMMISSIONER: Sorry, the Australian Commission is?

13

14

15

16

17

18

19

20

21

22

23

24

25

26

27

28

29

30

31

32

33

34

35

36

37

38

39

40

41

42

43

44

45

46

47

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.

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

6
7 MR YIK: Very important.

8
9 MR MUSTON: -- follow-up care, primary care givers are
10 able to see a patient, assess their needs, understand and
11 make inquiries about the medication, changes in medication
12 and new medications that might have been introduced, is
13 important.

14
15 MR YIK: Yes, absolutely. After an acute admission, you
16 would have had quite a - you know, often for patients, it
17 is a major life event to go into hospital because you have
18 had a heart attack, you have had a stroke, and so those
19 first few days back at home you are recovering, you're
20 getting all your life administration all sorted. The last
21 thing you want to have to think about is, "I'm running out
22 of medicines in three or five days. Where do I get more?"

23
24 This issue is even more pronounced in areas where
25 there are GP shortages. It's impossible to see a GP within
26 seven days, so having the ability to have a month's worth
27 of medicines just gives you that extra time to settle back
28 at home, take the medicines that you need to have and not
29 miss any days, because if you are only being given seven
30 days and you can't see your GP within those seven days,
31 well, what's going to happen? I think we all know this is
32 occurring, but this is the reality that we live in.

33
34 MR MUSTON: So in terms of that reality, you ask the
35 rhetorical question, what's going to happen? There would
36 seem to be two possible answers to that: one is you don't
37 take the medication that you need to be taking, which has
38 potentially adverse consequences for the patient?

39
40 MR YIK: Absolutely, yes. So you can have a readmission
41 if you're not taking the right medicine.

42
43 A really good example of this, where a patient missed
44 out on medicine at the transitions of care - so this isn't
45 really related too much to the pharmaceutical reform
46 agreement but again it goes to the broader issue around
47 transitions of care and why you need pharmacists - four

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

15
16 So it's these types of issues that are - we know that
17 they're going to occur before they even occur, because we
18 know this is what's going to occur. If someone has just
19 had a stroke, they've been put on these new medicines to
20 prevent them from having another stroke, it is so important
21 that they have access to these medicines. But without
22 a pharmacist at the discharge, at the transitions of care,
23 no-one is thinking about that. It is no fault against the
24 nurse or the doctor, but you need a pharmacist whose sole
25 focus is on those medicines to be the advocate for the
26 patient so that they have a safe transitions of care.

27
28 That issue, you know, without requisite investment
29 into the pharmacy workforce, it's going to happen again.
30 I don't know how else to say that, but it's going to happen
31 again.

32
33 In the last four years since that report, where that
34 inquiry originated from a medicine-related issue, still not
35 much has really been done to support the funding of
36 pharmacy departments to make sure that we do have
37 pharmacists on discharge, at transitions of care, providing
38 that cognitive and clinical pharmacy service.

39
40 MR MUSTON: Not taking the medication that they need is
41 one possible answer to your rhetorical question. The other
42 one is, if you can't get into your GP, you will re-present
43 at the hospital, presumably through emergency, to say,
44 "I haven't been able to get my medicine. Could you please
45 give me a script for a little bit more while I wait to see
46 the GP?"

47

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

8
9 MR MUSTON: So coming to some of the solutions, I think we
10 understand the importance of pharmacists within the
11 hospital setting and the potential challenges that you
12 identify if there are not sufficient of them from
13 a pathway - a pipeline point of view, but equally within
14 the workforce. The first is an increase - you propose an
15 increase in the number of pharmacy intern positions.

16
17 MR YIK: Yes.

18
19 MR MUSTON: Perhaps, Dr Penm, you are best placed to
20 answer this, but could you just explain what is the
21 intern - what role does an internship play in the career
22 progression and education of a pharmacist, and what do you
23 think increasing hospital pharmacy intern positions would
24 do from a workforce point of view within New South Wales?

25
26 DR PENM: Yes. So once a pharmacy student completes their
27 degree and has a registerable degree, every one of them
28 needs to complete a one-year internship before they can
29 practise independently. That comes with both supervised
30 hours and an exam at the end. So that's every pharmacy
31 student who has to do that.

32
33 At my own university, the University of Sydney, we
34 have around 350 students coming out every year. As you can
35 see, we only have 40 hospital internships, which is very
36 small for the amount that's applying, that's that top
37 10 per cent, and we have data that 80 per cent of students
38 want to go to a hospital.

39
40 If people don't get that initial entry level into the
41 hospital - they apply, they don't get it - it definitely
42 turns them off wanting to come in, but those who do get it
43 they can see their skills in practice, they get mentorship,
44 which we know is extremely important in the early years of
45 development for a healthcare professional, and if you have
46 a very positive experience early on, that will keep people
47 for a long time. That's the retention strategy.

1
2 But we're finding they're very attracted to hospital
3 because that's where their medication knowledge will be
4 used the most, in the most complex patients environment,
5 but if we don't look after them, then they're going to
6 leave. So increasing the number will definitely attract
7 more people to see the joys of hospital, to see - for
8 patients to get those benefits that we've talked about,
9 which is really good, and I think we have interns or
10 students wanting those positions. But we also want to make
11 sure we look after them once they're in.

12
13 MR MUSTON: Looking after them once they're in requires
14 sufficient workforce to enable mentorship and support to be
15 provided to the interns, presumably.

16
17 DR PENM: Yes. Looking after them is having those
18 resident training programs afterwards to then facilitate
19 the specialised skills that they need if they want to
20 progress their career. It needs to be rewarding them for
21 those skills and to recognise the value they have - that
22 comes from the healthcare awards, so that also needs to be
23 looked at, and then having the educators and mentorship
24 that we've talked about.

25
26 MR MUSTON: Just before we come to the educators and
27 mentorship again, can I ask, in your statement on page 6
28 you refer to the situation in Victoria where intern
29 positions are 60 per cent funded by the state government.
30 Could I just ask you to expand, does that mean that they
31 are 40 per cent funded from somewhere else, or they are
32 not - you only get 60 per cent of an income if you're an
33 intern?

34
35 MR YIK: It is certainly not that we get only 60 per cent
36 of the wage. In Victoria they have a fairly centralised
37 recruitment and funding model for hospital pharmacy interns
38 in Victorian hospitals. That government does take the
39 entry pipeline into workforce fairly seriously and so the
40 Victorian government provides 60 per cent of the intern
41 pharmacist's salary to the hospital and health service, and
42 so the hospital only has to pay - find 40 per cent of the
43 intern's wage from their own budget.

44
45 In New South Wales, the way that it works is without
46 that funding, without dedicated funding from the
47 government, they have to find 100 per cent of the wage, and

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

8
9 DR PENM: One example of that is that one of the largest
10 hospitals in New South Wales doesn't take any interns.
11 Even though it's a teaching hospital, it's one of the
12 largest, in some sense probably needs it the most, they
13 don't, because it comes 100 per cent out of their budget
14 and they say, "Well, we're struggling to deliver the
15 service as it is, we're just going to hire four
16 pharmacists." The consequence is you're filling in holes
17 and you're going to cause more problems for yourself in the
18 future.

19
20 MR YIK: In Victoria your major teaching hospitals take
21 anywhere between 7 to 10 interns each year. I think in
22 New South Wales it would range from zero to four.

23
24 DR PENM: Zero to two. You don't see four very often
25 these days.

26
27 THE COMMISSIONER: What is the hospital you are referring
28 to in New South Wales?

29
30 DR PENM: That would be Westmead Hospital.

31
32 MR MUSTON: So do you see value in the centralised
33 recruitment process which is operated through Victoria?
34 Putting to one side the way the funding works, of the
35 salaries, what do you see is the value of that centralised
36 recruitment process, say starting from the perspective of
37 the student?

38
39 DR PENM: Centralised recruitment would mean that the job
40 applications are centralised, the whole process of
41 interviews and putting in your preferences. That comes
42 with two main benefits. One is it means you can prioritise
43 all your efforts on making one application good, as opposed
44 to putting in 40 applications that often have mistakes,
45 which is very, very exhausting for students.

46
47 I see, once they go into a job interview, there will

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

11
12 The other part is they have to really prioritise that,
13 so they can't really say, "I just want this for the
14 leverage"; it's, "Which hospitals are worth my time?" For
15 a lot of people based in the general metro region they will
16 generally go to a large hospital but that means our smaller
17 regional hospitals suffer for that.

18
19 We have people who are probably happy to work there
20 but they just don't have the capacity to apply for it, they
21 have to prioritise their time. So we do see in some places
22 people who will apply to a regional/rural hospital, or they
23 might want to, but because they are waiting out for the
24 larger hospital to do their advertisement, they're just not
25 going to apply until that does. So there are just multiple
26 add-on effects around distribution and equity of positions
27 in New South Wales by not having it centralised.

28
29 MR MUSTON: Something you said a moment ago about waiting
30 for a larger hospital to advertise, is it also the case at
31 the moment in New South Wales that pharmacy positions are
32 advertised as and when they are required, including intern
33 positions; there's not a season where everyone who wants
34 a pharmacist this year puts out an ad and says, "We want
35 a pharmacist"?

36
37 DR PENM: I think they all try to, but the priorities mean
38 that everyone will start to advertise in the second half of
39 the year, but that can range -it can be a difference of one
40 to four months, and every HR group seems to have
41 a different timeline, you know, how they advertise it. So
42 we do know we need them for next year, but it's not like
43 this month they all happen; it can happen in a four- to
44 six-month period.

45
46 MR MUSTON: Do I gather from what you've told us that at
47 least your view is from the perspective of students, if not

1 the system, a centralised recruitment process for
2 pharmacists entering into at least into their intern year
3 would be a sensible idea?
4

5 DR PENM: I think students would love it, would be very
6 positive towards it.
7

8 MR MUSTON: No doubt pharmacists within facilities who are
9 having to review multiple applications and interview
10 candidates who they are not going to give the job to would
11 probably also appreciate it. Mr Yik, as someone who
12 practices in a hospital perhaps not doing that work, do you
13 have a comment on that?
14

15 MR YIK: I think what Dr Penm has described is very
16 accurate. It's not just good, as you've described, for the
17 students but also for the hospital, where they're not
18 sifting through, you know, more applications than they need
19 to. So through that central applicant process you can give
20 your top, you know, three preferences and then you get
21 matched according to that, so then everyone has less work
22 to do but it's much more targeted and appropriate and more
23 efficient for everyone.
24

25 MR MUSTON: Increasing the number of intern positions by
26 100 FTE would have two benefits, presumably: the first is
27 it would increase the pharmacy workforce at the junior end
28 who is able to do some of that junior work, like
29 reconciliation, easy dispensing and the like --
30

31 MR YIK: Mmm.
32

33 DR PENM: Mmm.
34

35 MR MUSTON: -- which would relieve the pressure on
36 existing pharmacy workforce - yes?
37

38 MR YIK: Yes, absolutely. So obviously intern pharmacists
39 still need to be supervised by pharmacists during their
40 intern year, but they are able to undertake a lot of those
41 activities under the supervision of pharmacists that can
42 contribute to making sure that patients get medication
43 reconciliation, they get some medication chart review, they
44 get counselling by a pharmacy professional as well.
45

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

1 be increasing the workforce or the realistic workforce -
2 that is to say, more work could be done by increasing the
3 number of interns? It's not just that they would be
4 watching, adding more strain on the resources of existing
5 pharmacy workforce?
6

7 MR YIK: Yes. It certainly does increase the output, the
8 clinical output that a pharmacy department can provide. It
9 certainly makes the care more comprehensive and safer and
10 higher quality as well.
11

12 MR MUSTON: From a pipeline point of view, it would seem
13 logical that increasing the number of intern positions
14 would improve the strength of the pipeline of pharmacists
15 coming into hospitals, but is that assumption sound?
16

17 MR YIK: Look, it is sound to an extent, because you are
18 increasing the knowledge base of pharmacy professionals in
19 New South Wales that are appropriate and trained in the
20 hospital setting. As we've presented in our evidence,
21 I think up to - some hospitals are reporting up to
22 90 per cent of their applicants for hospital pharmacy jobs
23 are just inappropriate or not suitable or not suitably
24 qualified for the job, because all of their experience has
25 been in the community pharmacy setting.
26

27 That's transferrable to the hospital setting to an
28 extent. There's still significant retraining and training
29 requirements for the hospital setting, and where you are
30 already a short-staffed workplace, it's a lot to take on,
31 and so we just end up in this cycle where we end up not
32 recruiting anyone.
33

34 So increasing the number of intern placements can
35 probably - well, will likely increase the available
36 workforce pool that is appropriate to work in the hospital
37 pharmacy setting without significant retraining required,
38 but I think we also want to keep them in that hospital
39 setting at the end of their intern year.
40

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

1 going to have to let you go back out into the community."
2 The hospitals rightly train students from all healthcare
3 disciplines and have a duty to do so, but why are we not
4 keeping them in the system at the end?
5

6 MR MUSTON: In terms of that training and the way in which
7 it's delivered, you've talked about educators in your
8 statement and the importance of having a workforce of
9 educators who actually assist in guiding that training both
10 at an intern level but also through advanced skills
11 training. Do you see value in that process being
12 centralised within the ministry - that is to say, the
13 training workforce to potentially be a part of, say,
14 a central pillar of the ministry that's also involved in
15 recruiting the interns?
16

17 MR YIK: Yes, look, I think we're certainly very open to
18 that. I think at this point we would take any attention or
19 funding from the ministry that looks at the education and
20 training of pharmacy professionals beyond internship.
21 I think as we've described in our evidence, in Australia
22 there are resident pharmacist and registrar pharmacist
23 training programs that are convened by AdPha. So far,
24 we've got over 800 pharmacists who have either undertaken
25 or have completed a training program, yet only 50 of them -
26 sorry, less than 50 of them are from New South Wales, and
27 that is because there is no capacity and no funding to fund
28 those positions for residents or registrar pharmacists.
29 Even for hospitals that do want to provide these training
30 programs and think, "Well, I've got an oncology ward and
31 I need an oncology pharmacist, I want to train a pharmacist
32 in the area", again, the lack of educators can often be
33 a barrier as well.
34

35 So even when we want to try and hire education
36 pharmacists within our hospitals, that can be really
37 difficult to get approval and clearance from the LHD.
38

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

1
2 MR MUSTON: That education workforce - you've mentioned
3 the value, obviously, of face-to-face pharmacy when dealing
4 with patients as potentially being better than remotely
5 delivered pharmacy, but remotely is better than nothing.
6 What about education? Is there scope for remotely
7 delivered education through pharmacist educators who are
8 not necessarily on the ground, particularly in smaller
9 facilities in rural and regional areas?

10
11 MR YIK: Yes. I think there absolutely is a capacity for
12 that and it's something that we would be very, very happy
13 to explore. As we've talked about, these resident
14 pharmacists and registrar pharmacist training programs, we
15 want to deliver them in rural and regional healthcare
16 settings but, of course, you may not have the education
17 pharmacists there on site because they don't happen to
18 live there, but that should not be the
19 rate-limiting step as to why a young pharmacy professional
20 can't undertake those training programs.

21
22 So we are very open to having mentors or education
23 pharmacists delivering the services remotely or via, you
24 know - we all have Zoom and Teams nowadays, and every time
25 that we accredit those sites to undertake and deliver those
26 training programs, as long as you can demonstrate that you
27 can provide that service, then that should be fine. So if
28 that is to be delivered electronically or via telehealth -
29 via Zoom or Teams - we would facilitate that and accredit
30 that program.

31
32 MR MUSTON: The ability to know where it's needed and
33 where that outreach or remote teaching might best be
34 delivered requires some level of centralised control or
35 coordination over the process, though, presumably?

36
37 MR YIK: It would and it would require the attention and
38 knowledge of what pharmacy educators provide and the
39 importance to ensuring the quality of clinical placements
40 for pharmacy students and for interns and for developing
41 your current pharmacist workforce as well.

42
43 MR MUSTON: In terms of those pharmacists who have
44 obtained those advanced skills training, you tell us in the
45 statement - I assume I've understood it correctly - that to
46 the extent that there are benefits associated with
47 pharmacists being involved in the delivery of care in terms

1 of reducing errors, enhancing outcomes, those benefits are
2 enhanced even further where a pharmacist with some advanced
3 skills training is operating within an area of that
4 particular - where they have that skill?
5

6 MR YIK: Yes. Absolutely, and we have developed these
7 programs so that patients are receiving services from the
8 most appropriately trained pharmacists.
9

10 Going back to, you know, two decades ago, if you were
11 walking into an infectious diseases ward or an oncology
12 ward, the pharmacist that was being put into that ward may
13 have just been a general pharmacist who may not have
14 received training, but because there were just no
15 formalised training programs at all, there was an
16 expectation, or it was a standard, really, that you would
17 just learn on the job.
18

19 So you did that model for a number of years, for
20 decades, because there was no other model to ensure that
21 pharmacists were ready, educated and prepared, before they
22 stepped into that ward. And this is what this program aims
23 to provide, because it's just much safer and more
24 appropriate for the patient.
25

26 MR MUSTON: Given the relatively small number of people in
27 New South Wales who are passing through this program, do
28 I infer from what you said a moment ago that, at least in
29 New South Wales, as distinct, perhaps, from other states,
30 we're still doing things the same way as we were doing them
31 decades ago?
32

33 MR YIK: If at all, and I guess we go back to our very
34 early evidence, that there are still many wards that don't
35 have pharmacists on them at all. But I guess as you've
36 suggested, even when you do have a pharmacist on that ward
37 in New South Wales, they may not be the most appropriately
38 trained or - sorry, they may not have sufficient training
39 compared to practitioners and their peers in other states.
40

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

1
2 MR YIK: A resident pharmacist position is aimed at
3 pharmacists who are entering at the start of their career,
4 it is to consolidate and expand the skills that they have
5 obtained in the intern year. For a resident pharmacist in
6 a hospital, they will often do four six-month rotations, so
7 it's a two-year program, and those rotations will take them
8 through the busiest parts of the hospital, so that they go
9 on a really steep curve in developing and consolidating
10 their skills.

11
12 I think it's six months in the dispensary, six months
13 in the surgical ward, and six months in a general medicine
14 ward because both of those wards have really high patient
15 flows so you get exposed to a lot of different patients and
16 develop your skills really, really quickly, and
17 comprehensively.

18
19 Then your final rotation can be an area of your choice
20 that will expose you to a specialist ward. So it could be
21 your final rotation might be through the oncology ward, it
22 might be through the psychiatry ward, it might be through
23 the stroke ward, to get you exposed to an area that you
24 might want to specialise in that also requires a pharmacist
25 to be working in that ward as well.

26
27 DR PENM: I was going to say, what it provides different
28 to a regular fully registered pharmacist is just structured
29 training and mentorship. Because we have not had funding,
30 or lack of funding, a lot of our departments just don't
31 feel they can offer that training, and so they say, "Figure
32 it out yourself. You're on your own." That's not helpful
33 for from an investment point of view from our workforce
34 retention.

35
36 So having these roles doesn't change the tasks they
37 do, but it shows the support we have for them, that their
38 career is important, that we value their service, and
39 I feel that pharmacists in New South Wales don't always get
40 that message and they don't have these programs, and other
41 states do.

42
43 MR MUSTON: You tell us that there's potential benefit in
44 providing funding to enable hospital pharmacy student
45 placements within NSW Health facilities. What is the
46 benefit to be gained there?
47

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

9
10 MR MUSTON: Page 14.

11
12 DR PENM: Page 14, thank you. We only offer about a month
13 of exposure to the hospital environment for our students,
14 versus, say, Victoria, has two to four months.

15
16 More exposure to hospital will help our students see
17 themselves do that role, see that as a career path, help
18 develop their mentorship, their identity. I think it will
19 not only provide value to the students because they will
20 now be more aware of what's happening in the hospital,

21
22 I think even those who go to community need to know
23 what happens in the hospital, because that helps that
24 transition of care thing we talked about earlier.
25 Discharge becomes a problem when the community doesn't know
26 what's happening, so they need to know what's happening for
27 the hospital to get those benefits.

28
29 But I would also argue, as an educator, that having
30 students in the hospital helps keep everyone performing
31 better. When you're constantly teaching and you're
32 constantly learning, that is a good environment for health
33 care. That is a good environment for our patients. By
34 taking students or limiting exposure to students, we fall
35 into a scenario or culture where teaching is what you do
36 when you have extra capacity, not - learning is not what
37 you do every day, and I think teaching and learning should
38 be things that happen every day, to have a system that is
39 constantly trying to be better, constantly trying to keep
40 our patients safe, and that's a good thing.

41
42 MR MUSTON: To the extent that it's suggested in your
43 statement that more funding is required to enable that to
44 occur, is that, in essence, a reference to the need to free
45 up sufficient time within a workforce to enable that
46 teaching to occur? It is not suggested that the placement
47 students would be paid for their placements or anything

1 like that, is it?

2

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

13

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

20

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

31

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

36

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

41

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

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

10
11 MR MUSTON: The last question I want to ask you is about
12 the pharmacists award and the proposition that it needs to
13 be reformed. What is it about the pharmacists award that
14 you think could be adjusted to solve some of these problems
15 that you have identified?
16

17 MR YIK: Look, I think the award is really basic and
18 doesn't meet the needs of pharmacists in New South Wales
19 today. It doesn't recognise the ability or the need for
20 pharmacists to specialise and advance their skills in
21 different clinical areas. There's a fairly low ceiling
22 that you can hit fairly quickly. It doesn't offer enough
23 career progression at all. The pay scales aren't
24 competitive in a state like New South Wales where you do
25 have various clinical bodies such as the Clinical
26 Excellence Commission, the Australian Commission on Safety
27 and Quality in Health Care, the department, the Ministry of
28 Health, and pharma companies in Ryde as well - there's
29 a lot of areas in which pharmacists can move into in the
30 state of New South Wales, which is really good.
31

32 That's really great for New South Wales pharmacy
33 students and pharmacists. However, you need to make sure
34 that your hospitals that are providing care to patients are
35 also appropriately staffed and that you are attracting and
36 retaining the best possible pharmacists that you can have,
37 and the award does not support that at this point in time.
38

39 MR MUSTON: What is it about the award that means it lacks
40 a career progression? What does the current career
41 progression look like, at least through the lens of the
42 award?
43

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

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

8
9 I think having that robustness and recognition of
10 those advanced skills and consolidated skills needs to be
11 reflected in the award, recognition through the Australian
12 and New Zealand College of Advanced Pharmacy as well, where
13 you are recognised as a resident, registrar or consultant
14 in the 46 disciplines recognised by ANZCAP, allowances for
15 if you have achieved higher education as well, so if you
16 have done a masters, a grad dip or a PhD, that should be
17 recognised through the award as well.

18
19 I think when you are also looking at the directorships
20 and leadership and management positions as well, they
21 should be strongly reviewed as well, because you have
22 pharmacists reaching that grade 7, grade 6 level of the
23 award, on a salary that is, I think, 150 to 170, depending
24 on what hospital you are at, but your responsibility is so
25 large - I don't know how else to describe it - you are
26 managing a drug budget, an annual drug budget of over
27 \$200 million.

28
29 I think in any other type of healthcare area or supply
30 chain department, where you're managing a budget that
31 large, you're probably being paid a bit more than that, and
32 so again - and when you're reaching that grade 5, 6, 7
33 level of the award, you're probably also a really good
34 candidate to work in all these other opportunities in areas
35 that New South Wales can offer as well. So again, does the
36 award incentivise, attract and retain pharmacists to work
37 in hospitals where they're delivering patient care?
38 I think the answer is no. And I think that's probably what
39 really needs to be reformed.

40
41 DR PENM: One thing I might just highlight, if you look at
42 the award, grade 4 and above is really limited to directors
43 and deputy directors. It is limited to management. What
44 we've talked about today is a lot of the value we provide
45 is a clinical service, so the award doesn't really value
46 clinical expertise, clinical specialisation, in its current
47 form. So we do have those people who are, as Mr Yik has

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

5
6 MR YIK: I think the take-away from that is that you have
7 pharmacists who love patient care. They are really, really
8 dedicated to providing the best possible patient care to
9 the patients in hospitals, but for them to further their
10 career, they have to step away from patient care. I think
11 this is what the award is telling them or the signals that
12 the award and the landscape is sort of indicating - to
13 advance their career, they have to go into positions that
14 take them away from direct patient care.

15
16 MR MUSTON: Whilst not picked up in the award, in the
17 sense that, as I understand your evidence, it doesn't
18 result in you being paid more money or going up a grade, is
19 the advanced training or recognition of advanced training
20 qualifications used in any other way in a practical sense
21 within the system at the moment? That is to say, does it
22 change in any material way the way in which you might, in
23 any particular facility, go about your work?

24
25 MR YIK: Formally through the recognition of awards, no,
26 but it is something that we want to influence and change,
27 and these obviously - the structure of these awards were,
28 you know, done many decades ago, and so they haven't kept
29 up to pace with how the healthcare landscape has changed,
30 where we do have training colleges, you do have resident
31 and registrar training programs for allied health and for
32 pharmacists. So I think the short answer is no, but that's
33 not because there isn't a need for it. There absolutely is
34 a need for it and - yes. So that needs to be the
35 discussion, whenever awards are being negotiated.

36
37 DR PENM: I might just add to that that it kind of shows
38 where that recognition comes from, is that because
39 pharmacists are not being recognised in the award, they
40 want these other pathways to show off the skills they have.
41 They would love for it to be recognised in the award, that
42 would be amazing. But they have a skill, patients benefit,
43 people need to know about it, and that's really where
44 that's - why those programs exist and why those fellowships
45 exist, to help make that obvious that, yes, it is
46 a different level. It's just not recognised here.

47

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

11

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

14

15 THE COMMISSIONER: Mr Chiu?

16

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

21

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

24

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

26

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

28

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

32

33 THE COMMISSIONER: I was reading from --

34

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

39

40 THE COMMISSIONER: Thank you.

41

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

1
2 THE COMMISSIONER: Yes, of course, yes.
3
4 MR CHIU: Thank you, Commissioner.
5
6 THE COMMISSIONER: Okay. We might adjourn until 2.15,
7 given it is 1.20, so we will adjourn until 2.15.
8
9 MR MUSTON: We will excuse these two.
10
11 THE COMMISSIONER: I'm about to not only excuse them but
12 thank them very much for their attendance.
13
14 We're very grateful for the time you have spent on
15 this.
16
17 MR YIK: Thank you.
18
19 DR PENM: Thank you.
20
21 <THE WITNESS WITHDREW
22
23 **LUNCHEON ADJOURNMENT**
24
25 THE COMMISSIONER: Good afternoon.
26
27 MR MUSTON: Commissioner, this afternoon's panel, at least
28 in person, from your left to your right is Michael Bonning,
29 a general practitioner and former president of the AMA;
30 Luke Sloane, the deputy secretary, rural and regional
31 health, from the ministry; and Rebekah Hoffman, who is the
32 chair of the New South Wales and ACT faculty of the Royal
33 Australian College of General Practitioners.
34
35 On your screen is Georgina van de Water, the CEO of
36 the Australian College of General Practitioners - you can
37 work out which one she is, because the background tells
38 you - and Dr Rachel Christmas, who we have heard some
39 evidence from before, the president of the Rural Doctors'
40 Association NSW.
41
42 THE COMMISSIONER: All right.
43
44 MR MUSTON: I think we probably need to work out which
45 ones will take an affirmation and which ones will take an
46 oath and we can probably do them quickly in two lots.
47

1 <GEORGINA SCOTT VAN DE WATER, sworn: [2.17pm]
2
3 <MICHAEL BONNING, affirmed:
4
5 <LUKE ANTHONY SLOANE, affirmed:
6
7 <RACHEL CHRISTMAS, affirmed
8
9 <REBEKAH HOFFMAN, affirmed:
10
11 MR MUSTON: Quickly, Dr Bonning, could you state your full
12 name for the record, please.
13
14 DR BONNING: Dr Michael Bonning.
15
16 MR MUSTON: You are a general practitioner and a former
17 president of the AMA?
18
19 DR BONNING: The AMA here in New South Wales, yes.
20
21 MR MUSTON: Thank you. And you've prepared a statement to
22 assist the Inquiry with its work, dated 23 July 2024?
23
24 DR BONNING: Yes.
25
26 MR MUSTON: Do you have a copy of that statement with you?
27
28 DR BONNING: I do. Thank you.
29
30 MR MUSTON: Have you had a chance to review it before you
31 give your evidence today?
32
33 DR BONNING: I wrote it, so yes.
34
35 MR MUSTON: You have reviewed it sufficiently recently to
36 be able to tell us whether you are, as you sit there now,
37 confident that its contents are, to the best of your
38 knowledge, true and correct?
39
40 DR BONNING: Yes.
41
42 MR MUSTON: That can be found behind tab H7.9. I probably
43 should have indicated, Commissioner, Mr Chapman appears for
44 the AMA.
45
46 THE COMMISSIONER: Leave is granted, to the extent
47 necessary, thank you.

1
2 MR MUSTON: I think it has been granted previously.
3
4 Mr Sloane, could you state your full name for the
5 record, please.
6
7 MR SLOANE: Luke Anthony Sloane.
8
9 MR MUSTON: You are the deputy secretary of rural and
10 regional health within the NSW Ministry of Health?
11
12 MR SLOANE: That's correct.
13
14 MR MUSTON: You've prepared two statements to assist the
15 Inquiry with its work, the first dated 9 April 2024?
16
17 MR SLOANE: Yes.
18
19 MR MUSTON: And another one, more recent statement, dated
20 3 October 2024?
21
22 MR SLOANE: Yes.
23
24 MR MUSTON: You have copies of both of them with you?
25
26 MR SLOANE: I do.
27
28 MR MUSTON: You, too, have had an opportunity to review
29 them before giving your evidence today?
30
31 MR SLOANE: Yes, I have.
32
33 MR MUSTON: Are you satisfied that their contents are true
34 and correct?
35
36 MR SLOANE: Yes, I am.
37
38 MR MUSTON: They are behind tabs D6 and L3, Commissioner.
39
40 THE COMMISSIONER: Yes.
41
42 MR MUSTON: Dr Hoffman, could you state your full name for
43 the record, please.
44
45 DR HOFFMAN: Dr Rebekah Hoffman.
46
47 MR MUSTON: You're the chair of the New South Wales and

1 ACT faculty of the Royal Australian College of General
2 Practitioners?
3
4 DR HOFFMAN: Correct?
5
6 MR MUSTON: How long have you held that role?
7
8 DR HOFFMAN: Twelve months this week.
9
10 MR MUSTON: When you're not dealing with the work that you
11 do within that role, you're a general practitioner
12 practising in the southern suburbs of Sydney?
13
14 DR HOFFMAN: Correct.
15
16 MR MUSTON: Ms van de Water, could you state your full
17 name for the record, please.
18
19 MS VAN DE WATER: Georgina Scott van de Water.
20
21 MR MUSTON: You are the CEO of the Royal Australian
22 College of General Practitioners?
23
24 MS VAN DE WATER: That's correct.
25
26 MR MUSTON: How long have you been in that role?
27
28 MS VAN DE WATER: I've been in this role for six months,
29 I've been with the RACGP for two and a half years.
30
31 MR MUSTON: Thank you.
32
33 Finally, Dr Christmas, could you state your full name
34 for the record again, please.
35
36 DR CHRISTMAS: Dr Rachel Christmas.
37
38 MR MUSTON: You are the president of the Rural Doctors
39 Association of New South Wales?
40
41 DR CHRISTMAS: I am.
42
43 MR MUSTON: When you are not dealing with the work
44 associated with that office, you are a GP VMO practising
45 in, if my memory serves me correctly, Temora.
46
47 DR CHRISTMAS: Correct, yes.

1
2 MR MUSTON: With advanced skills training in obstetrics?

3
4 DR CHRISTMAS: That's right.

5
6 MR MUSTON: Age hasn't taken away all of my faculties
7 quite yet.

8
9 In terms of the process and the way in which we go
10 about the evidence this afternoon, I'm going to ask
11 a series of questions working through a range of issues
12 that are of interest to the Inquiry.

13
14 Equally, I would invite any of you who have issues
15 which you think are adjacent to areas on which questions
16 might be asked, to tell us and chime in. Don't feel that
17 you are confined in any strict sense to the questions I'm
18 asking, but equally, don't feel that you are prevented from
19 asking one another questions, if you think that would be
20 a useful way of trying to get to the bottom of some of
21 these issues.

22
23 What we are hoping to do, having identified through
24 our regional hearings and some early workforce hearings,
25 what we see as some of the key challenges particularly
26 within the workforce area in this, for the purposes of this
27 particular session, within the area of primary care, we're
28 looking to try and tease out some potential solutions based
29 on the wealth of experience that you all have coming from
30 different perspectives. It may well be that the questions
31 that you're able to ask one another through that process
32 are of greater utility than any questions I will be able to
33 ask you. So please don't feel constrained in any way from
34 doing so if you think that would be helpful.

35
36 But can I start just by making sure our baseline, in
37 terms of the challenges, accords with what each of you see
38 as being the key challenges within this area. The first is
39 that within the medical workforce, there is a generational
40 shift away from general practice at the moment. Would you
41 all generally agree that that's a key challenge in the area
42 of primary health?

43
44 DR BONNING: Yes.

45
46 MR SLOANE: Yes.

47

1 DR CHRISTMAS: Yes.

2

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

7

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

22

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

27

28 DR BONNING: Yes.

29

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

34

35 DR BONNING: Yes.

36

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

45

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

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

12

13 MR MUSTON: For those of you who are working in the
14 general practice and primary health setting, is that
15 generally - does that accord with your experience?
16

17

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

23

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

28

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

47

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

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

11
12 DR CHRISTMAS: Absolutely, and I think we see that in our
13 registrars coming along, who work very hard and they're
14 very good at what they do, but they are not prepared to
15 work the hours that existing GPs like me are working. And
16 that's not because I want to work those hours; that's
17 because the work just has to be done.

18
19 It may not be because I see excessive amounts of
20 patients during the day, but the load on the administrative
21 and my hospital load as well and my on-call requirement
22 means that there are just so many hours in the day.

23
24 If I were to balance my day, including hospital work
25 and general practice work, into a reasonable, say, 10-hour
26 working day, I would see half the number of people that
27 I see in general practice, because I just - there is no
28 time to do the necessities, the admin, the follow-up, the
29 extra reading, the extra things that you need to do to take
30 care of your patients within work hours.

31
32 MS VAN DE WATER: That's absolutely something we are
33 hearing from our members as well, that the increase in the
34 administrative load on GPs is absolutely impacting on their
35 available patient hours.

36
37 MR MUSTON: So whilst it sounds as though the causes are
38 multifactorial, a challenge that is presented is accessing
39 good primary care not just through GPs but through all of
40 the other medical professionals and clinicians who form
41 part of that team that is, a good general practice is
42 increasingly growing very challenging for people within
43 New South Wales?

44
45 DR BONNING: Yes.

46
47 MR SLOANE: I would be commenting for rural and regional

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

2

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

10

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

30

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

37

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

42

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

45

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

1 overall, I would say the statistics are in favour of
2 primary health services being under threat or actually
3 dying in a lot of rural and regional areas.
4

5 DR HOFFMAN: I would add to that by saying that we have
6 spoken before, saying one rural town is one rural town, and
7 some are absolutely having a phenomenal GP workforce and
8 thriving. Wagga has an incredible GP workforce of mostly
9 overseas trained doctors. They have a wonderful culture
10 there. They have attracted and are attracting new doctors
11 there, whereas I'm off to Dubbo and Wellington tomorrow and
12 they don't.
13

14 MR MUSTON: So variable from town to town or place to
15 place?
16

17 DR BONNING: If you were to think about it, you know,
18 directionally over time, and this is very much my comment,
19 there's maybe a hollowing out of rural and regional
20 practice. So there are some centres and they end up
21 becoming hubs for the other local communities, but if you
22 were to go back in time, 20 or 30 years, you would have
23 known those communities to have their own GPs and
24 potentially other allied health professionals who were
25 there, and that has - that model has, you know, not been
26 sustainable, both for the workforce reasons and also for
27 financial reasons.
28

29 THE COMMISSIONER: When we talk about access to general
30 practice, though, there's a variety of circumstances -
31 there are the towns where the GP market has just failed,
32 there is no-one left and there has had to be interventions
33 of one form or another, whatever they ever been.
34

35 Then there are the towns where they are still probably
36 not making huge amounts of money but have what I'll call
37 very full, busy GP practices, but access is problematic to
38 people that are either new to the town or aren't on the
39 books because the books might be closed, or it might take
40 between two or six weeks to get an appointment for what
41 I'll call a routine GP visit, which might be in the
42 category of a town or a place or a region that is not
43 providing what we would hope for in terms of reasonable
44 access to GPs if you are having to wait that long. So
45 there are all those variations as well. You would agree
46 with that, I imagine?
47

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

2

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

7

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

22

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

37

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

46

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

1 great, but they don't then have the money to take on the
2 next step. I see them for half an hour, wonderful, but for
3 the other 160-odd hours of the week, there's not much
4 that - they need other supports as well in the system
5 because general practice and GPs are only one part of it.
6

7 MR MUSTON: That's a challenge in the metro.
8

9 Can I ask you, Dr Christmas, at least in your part of
10 regional New South Wales, do you find that there is an
11 inability to access that constellation of allied health and
12 other professionals which contribute to the delivery of
13 good primary care?
14

15 DR CHRISTMAS: Absolutely, because I know in my town, in
16 many towns like it, we just don't even have the health
17 professionals available, let alone being able to afford
18 them. So we have a system that's reliant on people rather
19 than processes and systems. If we have a physiotherapist,
20 they take maternity leave, we're without a physiotherapist.
21

22 We don't have an exercise physiologist in our town, we
23 have one who visits, but then people need to be able to
24 afford it, and even with EPC, so enhanced primary care,
25 item numbers, it's still not affordable. We don't have
26 public access to exercise physiologists.
27

28 We have one physio in our public system who is
29 overworked dealing with hospital and outreach centres and
30 being in our town. We have one other physio - or two other
31 physios in town, one on maternity leave, one part time.
32 So, yes, we just don't even have the access, let alone
33 making - you know, understanding that the role of allied
34 health is really important in primary care, just accessing
35 people is difficult, and that can fall over if someone
36 leaves.
37

38 MR MUSTON: Coming back to the definitional issue I think
39 that you raised, Mr Sloane, when we're talking about
40 primary health and primary care, we should not be just
41 seeing it as an ability to go and have your appointment
42 with a GP within a relatively timely fashion; there are all
43 of those other services that sit around the GP which are
44 also, am I right, critically important to the delivery of
45 good primary care?
46

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

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

7
8 But we're looking at models now that are, you know, in
9 necessity and out of necessity from the workforce
10 challenges that we talk about, that might be nurse
11 practitioner led or otherwise. But again, it's as part of
12 a multidisciplinary team, and not every patient's going to
13 need to be referred for physio, but it's awfully helpful if
14 we can have a full multidisciplinary team wrapped around
15 every single patient that needs it that comes into
16 a service.

17
18 Again, we've seen again, probably more so from
19 anecdote more than anything, that there will be physios,
20 allied health or otherwise, leaving, and over the last
21 couple of years, to NDIS or into private practice, leaving
22 the public health service. That is not necessarily,
23 I think, seen terribly our numbers but it is definitely
24 felt by communities.

25
26 I only yesterday saw the first social worker that has
27 returned to NSW Health from working in the NDIS and it's
28 the first time I've actually heard the opposite story in a
29 long while. We're seeing that in a lot of smaller towns,
30 where they've moved away from - in order to take up, you
31 know, smaller work hours or lower work hours because of
32 maternity leave or family obligations or that life/work
33 balance.

34
35 So there is a conscious choice, and I think I put it
36 in my statement around how we can then attract and/or
37 retain staff in a work environment, like Michael said,
38 that's very positive and good for them, which is a very
39 healthy move for health professionals into the future, but
40 ultimately they're making choices that will suit them and
41 their lifestyle and especially in regional areas.

42
43 MR MUSTON: Does anyone want to comment on the way in
44 which I have sought to define primary care?

45
46 DR CHRISTMAS: I just had a comment on a part of what Luke
47 said about accessing primary care - allied health care.

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

14
15 MR SLOANE: I would say similarly - sorry, thanks, Rachel,
16 that has just triggered - we heard yesterday in Canberra
17 about a piece of work around referrals and referral
18 pathways to specialist care. I think we do hear that
19 a lot, of the need or necessity, and it comes from a little
20 bit of social prescribing as well, to go and see a GP to go
21 and see a specialist yearly, and it's part of continuity of
22 care, but it is one of those things that - the referral
23 process, whether it is necessary or unnecessary to go to
24 other specialist care or allied health care or other parts
25 of the multidisciplinary team that I'm sure also takes
26 a fair bit of general practice's time up as well.

27
28 MR MUSTON: I would be interested, having raised that, to
29 explore with the other panel members, Dr Hoffman, the value
30 in having a process whereby someone who is receiving
31 specialist care or sub-specialist care is required to get
32 a referral from a general practitioner. What are the pros
33 and cons from the perspective of someone who is dealing
34 with that?

35
36 DR HOFFMAN: I think that the initial referral is
37 absolutely essential. Patients, in the nicest way, are
38 fairly terrible at self-diagnosing and identifying the most
39 streamlined cost-effective way to get a diagnosis and
40 treatment. They often want everything that's available,
41 which is incredibly expensive, rather than the one thing
42 they need, and often that one thing they need may not be
43 what they think they need or what they want the answer to
44 be.

45
46 GPs are very good at saying, "You don't need 50,000
47 different tests. Let's take your history. Let's do an

1 examination. Let's do the one thing that you need" -
2 rather than the 50 things that often, online has told them
3 to do - "and streamline that process."
4

5 Where I think it can be improved is the ongoing annual
6 reviews. We probably don't need, if they are stable and
7 they are seeing their rheumatologist, to continue to refer
8 them back. When we do need to see them is if something has
9 changed. So if, in the meantime, they have had a heart
10 attack or they've had a stroke or they've had a really
11 significant event, then absolutely, we need to update that
12 specialist and send them back.
13

14 Does that need to be done by a face-to-face visit and
15 a letter? Probably not. We can definitely communicate,
16 and collaborate more effectively than we currently do, and
17 in rural and regional areas, that doesn't need the patient
18 coming in to see a GP to be able to do that.
19

20 MR MUSTON: Without wanting to hypothetically burden your
21 books with unnecessary visits, is there still value in that
22 even if it is just an annual visit to get your referral
23 updated because it gives you that opportunity to deliver
24 some opportunistic care?
25

26 DR BONNING: I'm trying to think of the last time I saw
27 someone just for a referral, because you use that
28 opportunity, especially for someone who's otherwise
29 relatively well - you know, I have a great patient, he's in
30 his early 40s, he has had problematic hypertension since
31 his 30s, and that is common for some people. He has no
32 other health problems - fit, runs, works, everything else
33 going fine.
34

35 But the opportunity at his age to think about other
36 interventions for lifestyle, for bending the curve of his
37 likelihood for other comorbidities and diseases across his
38 life course, is actually really useful on at least a once
39 annually basis.
40

41 We also know there is a differential in presentations.
42 I would like to see more of the men who are on my books a
43 little more frequently, and that's one of the things where
44 we do miss those people. You only have to look at
45 cardiovascular disease as a whole group, it is about
46 2.8 million - there was a piece of study work that came
47 out a couple of weeks ago - maybe 2.8 million who are at

1 higher risk of cardiovascular disease. When you break down
2 what we actually do for them through the health system,
3 there is at least a few hundred thousand of them, maybe
4 pushing up towards 750,000, who are not seen regularly
5 enough to try and manage these conditions.
6

7 So, you know, we have this ticking kind of time bomb
8 out in the community of hundreds of thousands of people
9 who, if only we could intervene on some of their risk
10 factors, we would likely at least delay a major
11 cardiovascular event, a heart attack, a stroke, something
12 like that, and that has big impacts on both - because we've
13 also got to remember that benefits of good health don't
14 necessarily accrue to the health system. The best patient
15 is the one that the public health system will never see.
16

17 Good general practice is invisible because we look
18 after people on a regular basis and they never darken the
19 doorstep of an emergency department or specialist rooms or
20 anything else, and in that moment, the benefits accrue to
21 every other part of society.
22

23 THE COMMISSIONER: They remain economically active.
24

25 DR BONNING: But they also remain socially engaged. They
26 remain part of a carer pool for grandchildren or parents or
27 whoever. They remain people who, yes, contribute to the
28 economy both through their work but also through their
29 engagement with it in other ways. We always see that as
30 a bit of missing part of this. I can keep people really
31 well but no-one else sees it.
32

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

1
2
3
4
5
6
7
8
9
10
11
12
13
14
15
16
17
18
19
20
21
22
23
24
25
26
27
28
29
30
31
32
33
34
35
36
37
38
39
40
41
42
43
44
45
46
47

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

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

10
11 MR MUSTON: We touched on some of the challenges insofar
12 as they apply in rural and regional settings, and the sort
13 of patchy nature of that, there are patches where there is
14 good access to primary care, there are areas where there is
15 not. What about within metro areas in, say, metro Sydney,
16 Dr Hoffman?

17
18 DR HOFFMAN: Yes, so in metro Sydney, we actually have
19 less GP FTEs than we do in some of the modified Monash
20 three to four areas. There are definitely pockets of
21 Sydney where it's very difficult to find a GP, particularly
22 at short notice. We've released our "Health of the Nation"
23 survey last year which looks at 3,000 GPs, admittedly it is
24 across Australia, not just New South Wales and ACT.

25
26 We are starting to see a turn, a shift in this, and so
27 patients, about 54 per cent, say that they can access their
28 GP within 24 hours if they need to for an urgent reason,
29 and for a non-urgent reason, 90 per cent can access them
30 within two weeks. So we are starting to see that there is
31 a shift, there is an improvement. That's a big jump from
32 where we were at 12 months ago. But yes, we do have a long
33 way to go, but we're hopeful that we're starting to see an
34 improvement.

35
36 THE COMMISSIONER: What's that improvement? Do you have
37 any sense of what has caused that improvement?

38
39 DR HOFFMAN: Look, I'm going to step in and speak for
40 Georgina, but I'm really - RACGP has taken back over
41 training 18 months ago and 2017 was the last time that we
42 filled all of our registrar places. Next year, we've
43 filled them again for the first time, and not only have we
44 filled them, we have also been allowed to back-fill last
45 year's places as well. So although, yes, at the beginning
46 we said there's less people wanting to be a GP, we're again
47 seeing that improve. We're again seeing that change.

1 We've got more people wanting to be a GP next year than we
2 have places to train them. So we're actually now going
3 back to the federal government going, "Let's train more.
4 Let's not actually turn any junior doctors away that want
5 to be a GP." Because why would you? We need to train
6 them, we need bums on seats. We have the supervisors ready
7 to train them. We have places that are unfilled for
8 registrars. Let's actually use them and put them there.
9

10 So yes, although access is a problem, and it doesn't
11 take overnight to train a GP, it is still three, two years,
12 if you have got previous training, to get to be
13 a specialist GP at the end of the day; we're actually
14 starting to see some improvement in some numbers.
15

16 MR MUSTON: Just so I can understand the system, you said
17 a moment ago that you have filled the training places and
18 you have been allowed to back-fill the training from last
19 year. Could you just unpack that a little bit? You've got
20 a number of places which are available --
21

22 DR HOFFMAN: I will pass to Georgina.
23

24 MR MUSTON: -- which is, I gather from what you are
25 telling me, a lower number than the potential empty chairs
26 in practices that could be occupied by trainees; is that
27 right?
28

29 MS VAN DE WATER: Yes, absolutely. Just as an example,
30 for this current term we had over 1,400 available training
31 places within training practices. General practice is an
32 apprenticeship model for training, and so our practices
33 that are accredited to supervise registrars in their
34 practices told us they could host a cumulative total of
35 1,423. Now, in that, we only had, in full time equivalent,
36 around about - well, just under 1,000 places, registrars
37 available. That's in New South Wales.
38

39 MR MUSTON: Just pause there. What's the limiting factor?
40 What caps you at the thousand? It's funding of some
41 description I assume.
42

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

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

5
6 So it's the cumulative effect of undersubscription
7 over multiple years that has resulted in our inability to
8 meet the supply and demand - well, the supply and demand
9 modelling tells us that there is greater capacity for us to
10 train if there were more doctors in the system to train.

11
12 Now, more doctors in the training system means greater
13 distribution, it means greater access to care for
14 communities, and particularly those communities not only in
15 our rural and remote areas but also our outer metro.
16 That's something that we are growing more and more
17 concerned about, is with the urban sprawl, the growth of
18 population, the ability to access care in outer metro
19 communities.

20
21 MR MUSTON: Again just so I understand it, the funding
22 that you receive, or that is received from the Commonwealth
23 Government for the training of these registrars, how is it
24 channelled from the Commonwealth into the hands of the
25 person who receives it? If you could just talk me through
26 that funding stream as it applies to a particular
27 registrar, hypothetical registrar.

28
29 MS VAN DE WATER: The RACGP has a grant agreement with the
30 Department of Health to deliver the Australian General
31 Practice Training Program. So we are funded to support the
32 registrar training, which includes a range of activities as
33 well as placements into communities. So that money is
34 funded to the RACGP to deliver the education and training
35 program.

36
37 There are incentives for individuals. For instance,
38 in New South Wales, there are 239 GP catchment areas. We
39 are incentivising at least 40 of those catchments to ensure
40 that registrars have access to funding to support them
41 relocating, to support them accessing technology and
42 infrastructure that will help them when they relocate to
43 a location in one of these targeted areas.

44
45 One area is Armidale. The New England area of
46 New South Wales we know is incredibly under-serviced with
47 GPs. Moree is certainly an area that we are supporting

1 additional funding to those registrars and practices in
2 those regions.

3
4 It's a funding grant agreement from the Department of
5 Health to the RACGP. We then look at innovative approaches
6 that are relevant and locally defined to ensure that we're
7 doing - applying approaches to make placements attractive
8 in the areas of greatest need.

9
10 MR MUSTON: At a time when, I gather from the evidence
11 that we've heard already, there is a shortage of GPs or
12 a void in particular as a forward projection, a void that
13 needs to be filled, is there a dialogue between the college
14 and the Commonwealth about what can be done to avoid
15 turning candidates away?

16
17 MS VAN DE WATER: Frequently.

18
19 MR MUSTON: How does that dialogue go?

20
21 MS VAN DE WATER: Well, you know, it is an approach to the
22 department and supported by Minister Butler thankfully this
23 year, which was our approach that we have a number of
24 doctors who will be turned away if we're not able to be
25 flexible in our approach to distribution, in our approach
26 to offers that are made.

27
28 We have taken up, for instance, an arrangement where
29 we have a composite pathway. So registrars entering the
30 program may train for part of their training in an outer
31 metro area, but undertake a rotation into regions like New
32 England, Western New South Wales and the Murrumbidgee, for
33 instance.

34
35 What we're finding is that a large number of those
36 doctors, once they undertake a six-month placement in those
37 towns, are more likely to stay for longer. So if we can
38 develop an interest, enable a rotation into an area of
39 greater need, we know there is an increased likelihood that
40 those registrars will stay for longer and often after their
41 training as well. Those are the conversations.

42
43 MR MUSTON: Can I ask you quickly, at the time of the last
44 intake and as a result of the discussions that the college
45 had with the Commonwealth ministry, were there any
46 interested candidates who had to be knocked back or was an
47 arrangement able to be reached whereby all interested and

1 suitable candidates were offered a position?

2

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

9

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

17

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

24

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

29

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

38

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

44

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

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

10
11 MR MUSTON: So a double whammy of social determinants of
12 health are not favouring them and the same drivers which
13 lead to the social determinants of health not favouring
14 people in a particular community will often discourage
15 general practitioners from wanting to practise in that area
16 perhaps of the greatest need.

17
18 DR BONNING: That's entirely correct, an excellent kind of
19 summation of that, and we can see that around the world.
20 So the general view, and it's well backed-up
21 internationally, is that when you have a cohort of medical
22 practitioners - that's not just GPs, that's cardiologists
23 and nephrologists and surgeons and what-not - the overall
24 health of your community gets better the more generalists
25 you have.

26
27 The more the focus becomes on a sub-specialty and a
28 hyper sub-specialty or sub-sub-specialty, the more likely
29 you are to have significantly increased costs with overall
30 health outcomes that are, for the community, worse.

31
32 The reason we know that is because generalists and
33 generalism is often about looking after the whole person,
34 and when you do that, you find a lot of the things that
35 lead to lots of the reasons why you might have the need for
36 a sub-sub-specialist. None of us are just our left
37 ventricle plus our right foot plus one of the vessels in
38 our brain; we are a whole person. The thing I need you to
39 do is exercise and eat better, and those things will have
40 significant benefits for your right foot, your left
41 ventricle, and the vessel in your brain.

42
43 Again, the evidence is there to talk about that. The
44 Commonwealth funds put out their kind of league table of 10
45 relatively comparable nations. It includes Australia, UK,
46 Canada, Germany, the Netherlands, New Zealand, amongst
47 others, and still rates Australia as the best performing

1 system in the world. Part of that is because of access to
2 general practice, but general practice being a useful
3 coordinator and central player in the delivery of services,
4 because of that need to recognise that the person who walks
5 in, the one we always love in practice - the person who
6 walks in with fatigue is more complicated than most people
7 think. It is not, "Oh, I'm tired", because tiredness can
8 come from probably 15 different systems and have
9 significant impacts, and that actually needs to be worked
10 out in the context of the individual through a conversation
11 and understanding, rather than, "Oh, well, we just need to
12 do this procedure", or, "We just need to start this drug."
13

14 I think that's just a ringing endorsement, at an
15 international level, of how Australia performs both because
16 we sit in the middle of the pack of OECD when it comes to
17 spending on health care, but we actually sit at the top of
18 that particular tree, from the Commonwealth fund, in terms
19 of health outcomes. But there's inequity in the system.
20

21 MR MUSTON: In terms of the challenges that we've been
22 talking about, maldistribution sounds like it's part of the
23 problem, but is it not just maldistribution, it is also not
24 enough GPs system-wide to meet the primary care needs of
25 the population of New South Wales as it currently stands?
26 Would that be a fair assessment or are there enough GPs but
27 they're just not in the right place?
28

29 DR HOFFMAN: I would also just add to that, it is not just
30 GPs; it is across the whole primary care workforce.
31 There's not enough nurses, there's not enough allied
32 health, there's not enough pharmacists, there is not enough
33 of one individual specialty to serve the entire population
34 of New South Wales.
35

36 DR BONNING: So your comparator - you might think about
37 New Zealand. New Zealand is about four and a half,
38 five million people, so it's a bit smaller than us.
39 They've done actually really well in developing their
40 general practice workforce. They've paid much higher rates
41 to get general practice, and they've hit a different
42 problem.
43

44 MR MUSTON: Just pausing there. New Zealand, I think, is
45 a capitated model. Is my understanding correct?
46

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

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

10
11 So getting in to see the public nephrologist, you
12 might as well wait, you know, six months. That then
13 becomes, well, it's the same as almost not having someone,
14 because I need someone within three weeks for a patient
15 somewhere. Then you end up with, as Mr Sloane was talking
16 about, this scenario where people come via the emergency
17 department, when they have acutely deteriorated, for
18 something that was otherwise manageable with a little bit
19 of input.

20
21 One of the things that's in my witness statement is
22 about some different programs that exist out there to try
23 and intervene, whether it's in paediatrics, whether it's
24 the SUSTAIN program, which is useful, but lots of the
25 ability to get advice, to get support is also what augments
26 general practice to actually do its job really well.

27
28 Two minutes on the phone with a psychiatrist on Monday
29 gave me a plan for someone who is at the point in their
30 depression where they are becoming apathetic, they can't
31 work, they are unable to get out of bed. Rather than see
32 the public psychiatrist, who wouldn't be able to see them
33 for months, being able to talk to the public psychiatrist
34 for two minutes, here's a plan, I can initiate that
35 management plan, I can follow up every week with this
36 person or, you know, on the phone tomorrow, as I'm going
37 to.

38
39 That has meant that he will not end up in a situation
40 where he is an emergency presentation, maybe with a very
41 serious outcome, hopefully, because we'll keep close tabs
42 on him. We have, you know, a good relationship with him,
43 but also we've used the psychiatrist for the top end of
44 their spectrum of knowledge. They know this patient,
45 they've met them before and they are then able to say,
46 "Here are some things that might work. Work your way
47 through those. Talk to us in two or three months. If you

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

2

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

8

9 DR BONNING: Yes, he is --

10

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

13

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

22

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

31

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

39

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

47

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

7
8 DR BONNING: This is a great psychiatrist who will provide
9 his mobile number to GPs. Recognising that, again, I've
10 called him twice in five years, he would much prefer that
11 than seeing one of his patients, who he does care - you
12 know, or seeing someone who could have been prevented from
13 needing to see him in an emergency department. So I spoke
14 to him, and it was a public day for him so he was available
15 to take the call. But most of that is very patchy and it
16 is not systematised. We know that when we do systematise
17 these things, it gives someone like me, who is fairly
18 gregarious and able to get people's phone numbers - it's
19 helpful for me. But there are many GPs for whom those
20 networks aren't as easy to access, and I'm lucky, he's
21 lucky that we had that in the moment, but there are plenty
22 of patients for whom I don't have that either.

23
24 MR MUSTON: Dr Christmas, you have raised your hand. Do
25 you have a rural perspective on the way these networks work
26 in your practice?

27
28 DR CHRISTMAS: I do. I agree wholeheartedly with what
29 Dr Bonning has said about that slipping through the gaps -
30 the patients who are sick, not sick enough to go to an
31 emergency department, can't afford a private specialist.
32 That is my whole population here, really. We have no
33 public clinics, or minimal public clinics, in our hospitals
34 in Wagga and Griffith, which are my nearest centres. There
35 are a few, but they're sparse and oversubscribed, and, you
36 know, to get someone into a renal physician in the next
37 three months would be heaven. It is two years to get into
38 our neurologist. I can't manage someone with progressive
39 neurological things. As good as I might be as a GP, I'm
40 not that clever. We do need these specialists, and their
41 hands are tied because they are doing their best as well.

42
43 So access and looking after patients who are on that
44 fringe of how sick are they and when do we escalate their
45 care to the hospital system is a really delicate area.
46 I think GPs get very good skills and rurally we have to get
47 more proficient at dealing with sicker patients, because

1 we're looking after the heart failures who can't get into
2 the cardiologist; we're looking at the respiratory
3 patients, working them up, doing as much as we can. I
4 think there is little systemic support for accessing
5 specialist care but we use our network a lot.
6

7 One of the advantages of being rural is that we build
8 those networks with our specialist colleagues. I have my
9 favourite specialists that I speak to on speed dial, just
10 about. They know me, and whether they roll their eyes when
11 I'm calling or not - they never seem to when I speak to
12 them, so that's nice.
13

14 But, you know, you call in a favour. "Mr So-and-so
15 that you saw three months ago, can your secretary get the
16 notes? This, this, this is going on." I can say that my
17 specialty colleagues are really very helpful, most of the
18 time, because they understand that if we do our job well,
19 we support them better, and they know they're sending the
20 patients back to being looked after well in general
21 practice, which is reducing their re-presentation to
22 hospital and so on.
23

24 So that primary/secondary care, non-GP specialist/
25 GP specialist interrelationship, is incredibly important in
26 looking after our patients, especially as general practice
27 gets more complex.
28

29 This is my second point. I think the nature of
30 general practice is changing. We have increasing
31 complexity around management. If we look at diabetes and
32 the number of drugs that we now have for diabetes and the
33 considerations around renal disease, around heart disease
34 and heart failure and diabetes and the medications used to
35 manage that, the comorbidities that occur with these
36 illnesses.
37

38 So what used to be someone just went along 40 years
39 ago until they had their heart attack and then you put them
40 on a statin, that's not what happens these days. It's all
41 about identifying people early, treating them early with
42 lots of different ways of treatment.
43

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

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

10
11 It's sometimes a very thankless job and not
12 particularly sexy. If you're going to look at what people
13 want to do, managing someone's chronic ulcers when they've
14 got heart failure may not be the nicest job but it is
15 actually really important.

16
17 So I think we are diluting the number of GPs that we
18 have doing the general practice because it's actually
19 really hard work and you need to know a lot and you're
20 trying to work with many different systems with a lot of
21 shortfalls.

22
23 MR MUSTON: Dr Hoffman, is the anecdotal experience of the
24 sub-specialisation of general practice consistent with your
25 observation?

26
27 DR HOFFMAN: I have a few points, apologies. Not only is
28 that happening, but there's also really good evidence that
29 that is good for general practice. There is good evidence
30 out of Adelaide that diversification and sub-specialisation
31 of general practice means that GPs are more likely to stay
32 in the workforce for longer. The GPs who do have their
33 special interest or their thing that they get really,
34 really good at - and that might be children's health, that
35 might be writing novels, that might be educating the
36 public, that might be professional general practice and the
37 business of general practice - actually are more likely to
38 stay in the workforce for longer.

39
40 Your point previously for Dr Bonning in regards to,
41 "Was it a friend that you called or was it the hospital
42 advice line", with psychiatry, there actually are some
43 really good systems that you don't have to call a friend.
44 There is a GP advice line where GPs can directly call
45 a psychiatrist to get advice, but it's only in that
46 specialty. That's something, if that was replicated out to
47 other specialties, would be enormously beneficial to GPs.

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

5
6 If I dare take his example a little bit further - and
7 I do see a lot of mental health patients - yes, it's
8 probably going to be Michael who calls up tomorrow to check
9 that the patient is okay and he will probably call them
10 once a week ongoing until they are past this acute crisis,
11 but I would actually argue, does it need to be Michael
12 calling tomorrow? Does it need to be him next week and the
13 week after and the week after that? Realistically,
14 Medicare says yes, because otherwise there's no patient
15 rebate, and unless he, Michael, physically calls him,
16 no-one's getting paid for that time. But ideally, it's
17 not.

18
19 We work in a multidisciplinary team. I would far
20 rather it was my practice nurse who made that phone call,
21 or someone who was trained in mental health, to be able to
22 go, "Are you okay? How did you sleep last night? Do you
23 need an appointment with your doctor this week? Can I call
24 you again tomorrow and check in?" That doesn't need to be
25 me, and it probably shouldn't be me. It shouldn't be me,
26 and that's why I will stay at work until 10 o'clock at
27 night to make sure I've ticked all those boxes and made
28 sure everyone's okay, but I would much rather we did that
29 as a team-based approach.

30
31 MR MUSTON: I see general nodding from all of the
32 clinicians on the panel on that one. I take that as a yes.

33
34 MR SLOANE: Sorry, Mr Muston, can I bring you back to your
35 original question?

36
37 MR MUSTON: Please do.

38
39 MR SLOANE: I haven't referenced it in my witness
40 statement, but the distribution question, it's probably
41 good just to have it on record, there is a paper - and
42 I would have to dig it out to find it - on a very affluent
43 suburb, it is related to MBS funding and where it's spread,
44 so a very affluent suburb of Sydney. In this particular
45 study it showed that the MBS spend per person was \$900,
46 whereas in rural, regional and remote areas it was
47 somewhere in the realm of \$300 to \$350 per person.

1
2 There can be assumptions drawn, and there were from
3 this paper, around that distribution and access, more than
4 anything - perhaps workforce shortages or otherwise.
5 I don't think it's any narrative at all on general
6 practice, because I think some of the things that have been
7 said, at the moment - I did jot down a note - I think it
8 really needs to be mentioned that there is a dramatic
9 under-appreciation of what general practice does,
10 especially in the defined rural, regional and remote areas,
11 because, as you've heard here, you know, in the city, they
12 are very much that, similarly, integrated sort of anchor
13 for care for all patients that are actually seen, but in
14 the rural, regional and remote areas, they're quite often
15 not only doing that but also then putting on their other
16 superhero suit and doing the same thing at the hospital.
17

18 Everything I've learned from the interface between
19 NSW Health and general practice in rural, regional and
20 remote areas - not just in the work that they do in the
21 New South Wales public health system but also in that
22 private practice setting - is actually phenomenal. So
23 I want that to be heard.
24

25 I think there are three points, just following up from
26 that. I can't remember whether Dr Bonning or Dr Hoffman
27 said this, but those incentives - and I'm sure you've
28 talked about incentives a fair bit during the hearings -
29 there is that other side of, and I think Dr Hoffman has
30 touched on it a little bit, around those other incentives
31 around that sub-specialisation, and I know Dr Christmas
32 said so too - that is that change in workforce that we
33 talked about at the start of today's proceedings around
34 what is that attraction or the pull for people to come to?
35 It is not just that 100 per cent hands-on work anymore, it
36 is a blend of teaching, research, university appointments,
37 some virtual care, and we've seen that and we've heard
38 about models like the vRGS, because I know you've seen that
39 at Dubbo. But that blended model of that and hands on or
40 that and the sub-specialisation for GPs is what is keeping
41 them in some of these communities.
42

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

1 very relational.

2

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

6

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

18

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

28

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

41

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

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

22
23 But there is also a really interesting virtual program
24 that runs from Austin Hospital in Melbourne, so outside of
25 our jurisdiction obviously. It's around cardiac care, it's
26 about getting people home, it's about using not just the
27 virtual consultation model but remote monitoring.

28
29 There is a product called Biobeat, which you can stick
30 to the skin, it drops off after about seven days, it gives
31 intermittent monitoring. Someone who would otherwise be in
32 a hospital bed, which is very expensive, and also a long
33 way from home, can be at home, can be supported by their GP
34 with virtual long-term relationships with the cardiologists
35 and cardiothoracics teams that are involved, and we know
36 that that is both good for the health system down there,
37 financially it's very good; it's good for the patients
38 because they get home sooner; and it doesn't seem to have,
39 at this point, had any adverse outcomes, so people get home
40 soon and they do well.

41
42 We know that through other models, Hospital in the
43 Home, virtual care models - all of those are pathways that
44 we try and use but in a consistent fashion, because just
45 having someone come out is not the same as having - so that
46 is a person-based response, and Dr Christmas was talking
47 about that earlier. Rather than having it about a person,

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

7
8 MR MUSTON: We've touched on --

9
10 THE COMMISSIONER: Before we move on, can I just make sure
11 I have understood something Mr Sloane said a moment ago.

12
13 You were talking about one of the pilots for diabetes,
14 bringing down diabetes risk levels and there being no
15 mechanism for that to happen under the MBS, you then said:

16
17 *There's no real mechanism for that to*
18 *happen under the current MBS scheduling,*
19 *and reiterating around, you know,*
20 *Commonwealth responsibility around primary*
21 *care where really, in regional, rural and*
22 *remote areas, the blur of the line between*
23 *that and our reliance on it from a*
24 *NSW Health perspective is absolutely*
25 *pivotal.*

26
27 Tell me if I'm wrong, do I understand that to be in the
28 circumstances where, particularly in regional, rural and
29 remote areas, NSW Health is actually doing things or
30 funding things that you would call primary care, as
31 distinct from the Commonwealth, or were you making
32 a different point?

33
34 MR SLOANE: No, I would say that that is exactly the point
35 I'm making. Not only that --

36
37 THE COMMISSIONER: I thought it was. That's why I nodded
38 when you were talking, but I thought I had better
39 double-check.

40
41 MR SLOANE: Perhaps without remuneration from the
42 Commonwealth in order to do so, yes. I can elaborate on
43 that if you want me to.

44
45 THE COMMISSIONER: Please do if you want to.

46
47 MR SLOANE: I think we have worked through keen

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

13
14 In many of those instances, we are working with the
15 GPs in town and the MPS to seek section 19(2) Insurance Act
16 exemption under the Act in order to allow that doctor to be
17 able to perform those activities and their own private
18 practice billings but then also bill under the MBS scheme
19 and then enable a reinvestment, so we can reinvest in locum
20 employment if that doctor needs to go on annual leave, God
21 forbid.

22
23 Those are successful schemes. We do that in a lot of
24 places, but there are places where, unless the local health
25 district is providing a salaried model - and you would have
26 heard about the 4Ts model when you went to another version
27 of a single employer model - unless they are providing that
28 and providing that stability and salaried model for that
29 general practitioner, it would be very difficult to attract
30 someone there.

31
32 It's the balance between - let's not forget, as has
33 been mentioned today, in 90 per cent of these, they are
34 very small businesses in rural and regional areas, general
35 practices, and they've got to be a successful and fiscally
36 viable private businesses. Sometimes the volume - you talk
37 about the books being closed at 1,000, 2,000 patients in
38 some areas, there's a lot of areas where that's not the
39 case and the volume from an MBS billing point of view
40 doesn't make it a viable scenario. I'm not sure if
41 Dr Hoffman or Dr Bonning would back me up, but it does not
42 make that a viable way.

43
44 I mentioned it in my witness statement around salaried
45 medical positions. You know, currently as the NHRA itself
46 is being negotiated, we are embarking on some pilots where
47 there is a pool of funding from the Commonwealth at the

1 moment to perhaps provide some innovative pilots with
2 regards to block or salary funded primary care general
3 practice roles or nurse practitioner led models in certain
4 towns where there's thin or failing markets or totally
5 failed markets that we need to build back up.
6

7 I think there are, from a NSW Health perspective,
8 a lot of areas where they have, either on contract through
9 the Royal Flying Doctor Service or through other private
10 general practice arrangements, salaried or become the
11 single employer for a GP to ensure that that community or
12 communities have access to general practice.
13

14 Whilst we still access the 19(2) exemptions to be
15 able to remunerate that and that billing gets reinvested
16 through that, the primary care model in the town, it's not
17 exactly optimal.
18

19 THE COMMISSIONER: It's still a cost to New South Wales.
20

21 MR SLOANE: Yes. I don't think - I'm happy to be
22 corrected on the record into the future but I don't think
23 the primary healthcare networks necessarily have the fiscal
24 levers to do that at all from their commissioning model,
25 specifically with regards to salaried GPs. I don't
26 necessarily see it working like that, but NSW Health,
27 because we rely on those doctors, responsibility falls with
28 us as well to provide a GP VMO and someone to see at
29 hospital when they present to emergency, so that does
30 happen.
31

32 DR BONNING: Describing failing markets out there, and
33 there are some, I think it's important to recognise it's
34 much cheaper to intervene - Mr Sloane does this a lot more
35 than I do - before it becomes a failed market, like
36 building something up from where there's nothing anymore is
37 incredibly expensive. We say about cost to the health
38 system or to NSW Health, and what they need to spend to
39 support or do some of those things or have GP VMOs in their
40 hospitals, but on the flip side, if the primary care model
41 fails, then the flow-through to the hospitals is probably
42 many times more expensive. So, you know, I think we've got
43 to be intervening earlier or sooner otherwise the model
44 really, if it does fail, then it's very expensive to
45 rebuild.
46

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

1 a moment.

2

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

4

5 MR MUSTON: Please do.

6

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

16

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

27

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

37

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

43

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

1 policy and bulk billing arrangements, its impact on where
2 people present to and the impacts then on that private
3 practice again causing what could be that private practice
4 to fail because people are presenting to the emergency
5 before going to the primary care practice.
6

7 THE COMMISSIONER: Is an example of what you were talking
8 about before, where you might get access - New South Wales
9 might - NSW Health or the practitioner engaged by
10 NSW Health might get access to the MBS but there is still
11 a primary care cost to NSW Health - Bowraville, I think,
12 was a place we visited where there's a net cost to
13 New South Wales for providing the GP and other primary care
14 services at that care facility where the GP has retired?
15

16 MR SLOANE: Yes, exactly. And then the 19(2) exemption
17 only allows us to reinvest that in the primary care
18 practice - I think I outlined that in my first statement
19 in April - to certain items with regards to the primary
20 care practice, which is great because it does then allow us
21 to invest that in the locum setting so the general practice
22 can take leave or otherwise, and we've had quite successful
23 reinvestment in some areas where the community has done
24 that. But again, it's limited as to what it can be
25 reinvested in or subsidised salary for that doctor.
26

27 I think just on that, and I know I bang on a lot about
28 the single employer model and the rural generalist single
29 employer, our main focus in New South Wales was to really
30 maintain that focus on general practice and private
31 practice in these smaller towns. Sure, salaried benefiting
32 the hospital, of course, but we're extremely cognisant of
33 this model and setting it up and making sure that we're
34 investing in primary care and private practice for general
35 practice rather than a hospitalist model.
36

37 MR MUSTON: I will come to you in a moment, Dr Christmas,
38 I can see your hand is up.
39

40 Could I just ask a quick question about Bowraville
41 while we touch on it. My memory of the evidence, and I
42 will be corrected very quickly if it's wrong, is that the
43 shortfall to the state is something in the order of
44 \$400,000 a year.
45

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

1
2
3
4
5
6
7
8
9
10
11
12
13
14
15
16
17
18
19
20
21
22
23
24
25
26
27
28
29
30
31
32
33
34
35
36
37
38
39
40
41
42
43
44
45
46
47

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.

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

8
9 MR MUSTON: And that assumes we walk into the trap that
10 Dr Bonning urges us to avoid, which is viewing this
11 economically --

12
13 THE COMMISSIONER: Exactly.

14
15 MR MUSTON: -- trying to compare savings in the health
16 system with expense in the health system. If one says
17 a good primary clinic in, say, Bowraville, reduces
18 presentations in the emergency department, there is an
19 actual hard saving in the health system, which might even
20 eclipse \$300,000 - you'd have to do the numbers. If you
21 add to that the potential benefits of someone who is able
22 to remain in the workforce because their elderly parent can
23 continue to care for a child, for example, it's small
24 beans, the \$300,000 to \$400,000.

25
26 DR BONNING: While I note Dr Christmas has her hand up,
27 just to finish that thought, as we hear, there are certain
28 small communities where, you know, we probably had
29 a hospital there for historical reasons and only for
30 historical reasons. There are probably, you know, certain
31 economies of scale you need to reach before deciding
32 whether running a hospital in a community, versus someone
33 needing to go 20 kilometres up the road, you know, is
34 viable. I would imagine that that's the kind of financial
35 calculus that the health department needs to do to work
36 those things out.

37
38 MR MUSTON: It's a financial calculus that would
39 comfortably be managed if you were making a decision about
40 whether or not to build a new very small hospital in a
41 relatively small town, but where you have one already
42 there, one has to overlay a political calculus which
43 changes the dynamics somewhat; is that right Mr Sloane?

44
45 MR SLOANE: I think there are many aspects to add to that.
46 If you do build a hospital and set up a service there, it's
47 the volume from a safety and quality point of view to the

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

15
16 MR MUSTON: Dr Christmas, you've had your hand up for
17 a while. I know you put it up to comment in relation to
18 the discussion around providing primary care through
19 a public facility in a town and the impact on private
20 business, but I know you also have something, based on your
21 earlier evidence, to tell us about the risk of taking
22 services out of hospitals and the deskilling effect that
23 that can have on GP VMOs.

24
25 DR CHRISTMAS: Yes, that's right. But I guess my point -
26 it has moved on somewhat in the conversation since I first
27 thought of this - is slightly tangential. I think one of
28 the things we need to be aware of is that, in our rural
29 areas, a lot of the GPs in small towns are overseas trained
30 and a lot of them have not worked in the Australian
31 hospital system.

32
33 What that means is that they are not credentialled to
34 work within our emergency departments in these small towns.
35 So one of the things that is a barrier is actually getting
36 them into the hospital system to allow them to train up in
37 our system, so then they can actually provide services, be
38 credentialled to be VMOs in small country hospitals.

39
40 That's something that is an area for potential growth,
41 and I think there is a program somewhere in New South Wales
42 where that has happened, where they've trained up some -
43 it's just in the back of my mind at the moment, I can't
44 think of the exact details, but where we allow GPs from
45 overseas to spend time in our hospitals to learn that
46 system so then when they do go out into our communities in
47 rural areas, they actually are able to work as GP VMOs,

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

3
4 MR MUSTON: One thing, turning to the solutions to some of
5 these problems, and in particular a solution which seems to
6 commonly be offered up to deal with the increase in
7 presentations in emergency departments, is the urgent care
8 clinic or the concept of an urgent care clinic. Could
9 I perhaps invite whichever of you wants to go first to fire
10 away to express a view on --

11
12 DR HOFFMAN: I'm very happy to go first. They are both
13 looking towards me.

14
15 MR MUSTON: -- whether an urgent care clinic is a solution
16 to the real problem or whether it's dealing with a symptom
17 of the real problem?

18
19 DR HOFFMAN: I think urgent care clinics are incredibly
20 costly. They are clinics that see also very low numbers,
21 not low numbers compared to ED, but most urgent care
22 centres around Australia are seeing less than 30 patients
23 a day, and at a cost of somewhere \$200 and \$250 per
24 service, so they are very expensive services and very low
25 volume.

26
27 Where we have seen places where they don't have urgent
28 care centres and they have actually ingrained that back
29 into general practice, so the north coast - and Wagga's
30 about to start one similarly - we actually see patients
31 that are seen by their usual practice. GPs absolutely can
32 do urgent care. We're trained in urgent care. And the
33 ability to not silo urgent care to a separate location but
34 to do it with their practice who knows them, who knows
35 their social history, their financial history, knows so
36 much more about them than someone who has never met them
37 before, isn't only a cost saving, it is also often the
38 preferred option for the patient.

39
40 DR BONNING: The document I might direct you to is -
41 in Western Sydney they spent two or three years working
42 out a model of urgent care services. I use that term
43 specifically rather than "urgent care centres". Because
44 their idea was, there is a single front door, which
45 Dr Amith Shetty and others have talked about, Dr Walid
46 Jamal, Dr Kean-Seng Lim, all of whom are very across this,
47 have talked about, which is the idea that someone finds

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

14
15 If we think about New South Wales, we've got about
16 3,000 general practices, at best we're maybe going to have
17 100 urgent care clinics. So it's much more - and
18 I recognise this because of where some of the funding comes
19 from - if you look at it from an emergency department
20 presentation, where a non-admitted emergency patient costs
21 about \$600, \$700, a \$200 urgent care rather than showing up
22 to the hospital is good investment because otherwise it's
23 costly somewhere else, but compared to an \$82 bulk billed
24 appointment in general practice, you know, 20 to 40 minutes
25 with me, plus or minus the nurse and others in our
26 practice, the economies look very different depending on
27 which perspective you have.

28
29 The challenge is also that you need to then have -
30 because if you use a service-based approach, you have
31 a capacity in a community or in a region, as opposed to
32 "I have stood up X number of clinicians, practitioners, who
33 will sit at a site and see as many people who come through
34 the door." So that, you know, by definition is somewhat
35 inefficient, whereas your ability to use what exists out
36 there - and also, hopefully, to connect people back to
37 their regular GP. We function in our practice that if you
38 call, we will work out a way for you to be seen, because
39 the nurse will talk to you, and our nurse, who probably
40 knows you better than we do, because she's there every day
41 of the week and I'm not, will work out a way in which you
42 can be seen by someone who knows you.

43
44 That is far more useful most of the time than many
45 other things. A patient of ours who has a portacath for
46 their chemotherapy had something left in that portacath, so
47 in-dwelling in this portacath. A portacath is beneath the

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

13

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

16

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

22

23 MR MUSTON: There's a subtle distinction

24

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

26

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

35

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

47

1 So I think it is quite dangerous for us to talk
2 specifically about, you know, Australasian triage
3 categories, because that actually applies to when someone
4 arrives to emergency.
5

6 Speaking about it from a rural, regional and remote
7 perspective, because that's where I probably would come at
8 it, being involved in some of the urgent care services'
9 placements and topography, it's very difficult at the
10 moment because of that perhaps workforce shortage or access
11 to primary care to justify an urgent care service over -
12 and when I talk about "urgent care service", I'm
13 encompassing both Commonwealth centres and/or concept
14 services and models of care that have been installed from
15 the state point of view. In rural, regional and remote
16 areas, it's very difficult to justify that because we're
17 quite often putting it in a place that if we had a few more
18 general practices and some very healthy primary care
19 practices, perhaps we wouldn't necessarily need it. I
20 think it's a --
21

22 THE COMMISSIONER: I also assume, but I don't know, the
23 locations that are selected for these clinics - I assume
24 they're not selected in locations where there's a risk of
25 them cannibalising general practice business?
26

27 MR SLOANE: Yes, correct, and I think through the
28 decision-making process around that, that was a massive
29 consideration - thus NSW Health looking at expansion of
30 current services that are able to do the primary care
31 services that are already in place, that are able to then
32 either expand or adjust their service proper to encompass
33 that, what we would call an urgent care
34 service application --
35

36 THE COMMISSIONER: They are not advertised to be
37 a substitute for primary care, are they? They are
38 advertised, I think, to take pressure off EDs.
39

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

1 a need for that.

2

3

4

5

6

7

8

9

10

11

12

MR MUSTON: Dr Christmas?

13

14

15

16

17

18

19

20

21

22

23

24

25

26

27

28

29

30

31

32

33

34

35

36

37

38

39

40

41

42

43

44

45

46

47

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

1 urgent care service and we'll fund to you do it", but we
2 won't fund general practice to do the job that it does.
3 I think that discrepancy has been expressed by people that
4 you speak to around, you know, providing general practice
5 care and urgent care.
6

7 MR SLOANE: I totally agree with Rachel. I guess that's
8 what I'm alluding to from the spots that it's happened in
9 New South Wales, from NSW Health, it has been leveraging
10 and doing that for general practices that are already in
11 existence, with co-located services or otherwise.
12

13 DR BONNING: Also, generally what we see in these urgent
14 care clinics are GPs, so they were working somewhere and
15 now they're working here. We haven't increased the net
16 number of GPs available to the system.
17

18 One of the reasons why it can sometimes be hard to
19 manage urgent presentations in general practice is because
20 my books are - you know, I'm back to back for most of the
21 day. When I talk about how our nurse will fit things in,
22 it will be because we'll finish early and we'll have a bit
23 of time and I can call a patient or we'll get them in while
24 someone's lunch break is on. This is the flexibility of
25 the system, but also the willingness of - we would prefer
26 to see our own patients.
27

28 I love my patients, I love my job, but, as
29 Dr Christmas says, there are limits to being able to do
30 that, otherwise we would still be there, and we often are
31 there, at 10 o'clock at night. But we know that often the
32 best outcomes for things that are within our scope of
33 practice are achieved by us having the nuanced
34 understanding of our patients, their lives, their capacity,
35 even, you know, what is it going to be like to go home, you
36 know, if this issue is happening, if this is a pneumonia
37 that's safe to manage at home? Actually, it turns out the
38 person who is at home with you isn't just your wife or
39 husband or whatever, it's the person you actually are
40 already caring for, you're the carer, so that's not a safe
41 place to go home to for someone who is of diminished
42 capacity. All of those kinds of things are, I think,
43 things we inherently understand better for our own patients
44 and, you know, personally it is what I would prefer to do
45 as a practitioner.
46

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

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

5
6 DR CHRISTMAS: I think there is a role, there can be
7 a role for that after-hours care. People get unwell after
8 hours and that's again a capacity in general practice
9 thing. If you have a lot of GPs, they may be able to
10 stagger their work hours so you have some GPs who work
11 until 8pm and start at 10am or something, rather than 8
12 until 6 or whatever you are doing. So there is a capacity
13 to provide - well, it would be nice to have more capacity
14 to provide after-hours care through general practice, if
15 you have enough people to do that, where it's not just
16 adding increased workload to the GPs existing already -
17 anything to keep people out of the fragmented hospital
18 system which often over investigates and spends a lot of
19 money doing all of those things they do.

20
21 MR MUSTON: Can I ask a question about the drift away from
22 general practice that we've talked about. What could be
23 done to turn that around? In a way it sounds like some
24 success is being found in the training which is now being
25 managed and delivered through the college, but are there
26 other things that could be done to try and reverse that
27 trend?

28
29 MS VAN DE WATER: I might just lead off with adding on to
30 some of the previous discussion as well. I think all of
31 the doctors on the panel here today have spoken about the
32 cost in a patient turning up at the hospital and the urgent
33 care centres compared to that of general practice. We
34 released data last week that the average cost to the
35 government for a patient to visit an emergency department
36 is \$692. Now, that's for a patient who is not admitted to
37 the hospital. Whereas the patient spending 20 to 40
38 minutes with their GP is a cost of \$83. So managing the
39 funding and the distribution of that funding and the way in
40 which that funding can be accessed by a general practice
41 through the team provision of service to patients is
42 absolutely something that will support improved access, but
43 no doubt maximising the service that's provided by each of
44 the clinicians and team members within each of the primary
45 care settings.

46
47 DR BONNING: So given the question now is about what does

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

16
17 MR MUSTON: How do we do it is the question.

18
19 DR BONNING: What you achieve in all of this, though, is -
20 the last time, and Georgina, please correct me if I'm
21 wrong, I seem to remember that the commitment to go from
22 800 or 900 GP training places to 1,300 to 1,400 was by
23 Minister Roxon back in 2008 or 2009, so it's been quite
24 a while.

25
26 It used to be that about 40 per cent of the graduates
27 out of medical school went into general practice. Now we
28 know that number, depending on which year you pick, for
29 Australian medical graduates, is somewhere between 12 and
30 15 per cent. So your target, given that we are now in a
31 position where the college is delivering a program that is
32 being fully subscribed, is to grow the subscription limit,
33 and I think that's a clear recommendation.

34
35 The second is that every - you know, the college of
36 GPs, the College of Rural and Remote Medicine, the rural
37 doctors agencies, lots of others, we've all been saying,
38 you know, "How great is general practice", we're talking
39 about it here, Mr Sloane's been complimentary about it. It
40 would be lovely to see that the rest of the public knows
41 that, because otherwise it does become, "Why am I the
42 clerical staff" you know, the number of times I've been
43 asked in my career about, "Oh, Did you choose to be
44 specialise in anything?" I'm like, "Yeah, I'm really good
45 at this job, thanks very much" is quite challenging. It's
46 changing the public's mentality about what their GP is
47 there for.

1
2 Overall it is creating a future which requires public
3 education around the role of general practice, especially
4 if we want to keep healthcare costs under control. It
5 would be encouraging people to have a regular, consistent
6 relationship with their GPs and funding us into the system,
7 both by the Commonwealth and the state, to be able to do
8 those things that cross over between the two. So regular
9 general practice that is funded through Medicare but also
10 shared programs with hospital systems, so bridging that
11 divide and that gap so that our patients who are complex -
12 you know, we see programs and models of - they are called,
13 GPwSIs, GPs with special interests, who work across
14 hospital systems - it's more prominent in Queensland than
15 here, but we see it here as well. One of the great things
16 about that, I always say, is the ability of the GP to know
17 when to discharge the patient from the outpatient service,
18 or even the inpatient service, is often very good because
19 they know what's happening in the community. It's about
20 using those resources better.

21
22 The overall funding for unREFERRED medical services,
23 which is general practice, is about 6.5 per cent of the
24 total healthcare spend. What's his name again? He's from
25 Ochre Health. Hamish Meldrum did a survey of the public.
26 The public thinks that general practice services are funded
27 to somewhere between 20 and 40 per cent of the total health
28 care spend. So the public expects a lot of us, they think
29 there's a lot of money that goes there. There isn't that
30 much, or as much as they anticipate. So bringing more
31 people in the front door, giving people options, as was
32 talked about, with regards to keeping them in practice, so
33 they are interested in something, ways in which we take
34 that interest and make them excellent and as part of the
35 team, whether it's, you know, they want to be really good
36 at cardiology, they deliver great women's health services
37 in the community, you know, like me, I do lots of doctors'
38 health, so health care for other doctors - all of those
39 kinds of things we really double down into that.

40
41 I think lastly, we work with the federal government on
42 how to make general practice more viable, but also more
43 viable to do the things we've just talked about, to provide
44 care, more care out of hours, to be more able to fit in,
45 manage, support those people who need our care when they
46 need it, to make sure that there are systems in place
47 rather than just great people, so systems like we would

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

5
6 MR MUSTON: Dr Hoffman, from the college's perspective,
7 are there things that you think we could be doing to turn
8 the tide in terms of the drift away from general practice?
9

10 DR HOFFMAN: Absolutely. There are probably three
11 populations that I want to speak to. The first one is the
12 retiring GP or the GP that plans to retire in the next five
13 years. The second is the cohort of GPs who have obtained
14 their medical degree in another country and the third is
15 the cohort of Australian-trained doctors choosing to be
16 GPs.
17

18 Apologies, my PhD is on burnout in general practice,
19 so I will try to concise this down to a few minutes rather
20 than 40,000 words. Retiring GPs, we actually asked this in
21 our survey most recently a month ago - and there is a big
22 cohort of GPs who did come back during COVID that now plan
23 to retire in the next five years. When we asked them,
24 "What will keep you in the workforce? What will keep you
25 working for longer?" It's red tape and it's costs. So
26 being able to pay or incentivise pay more and reduce the
27 red tape, reduce the doctors sitting at their desks until
28 10pm at night, will absolutely increase the workforce.
29

30 The second one is our overseas trained doctors, our
31 doctors who are specialist GPs in other countries. As of
32 next Monday, will have an expedited pathway, if you trained
33 in the UK, in Ireland or New Zealand, to come to Australia
34 and work here. They will still have a moratorium, they
35 will still be required to work in Modified Monash areas 2
36 through 7, but there will be a significantly faster way for
37 them to come to Australia and work here.
38

39 We need to make sure that not only when they come
40 here, they are embraced, they understand the GPs and the
41 Australian hospital system, that they've got good reliable
42 networks and that they are safe. It's not yet clear from
43 the Ahpra and from the AMC, exactly how that's going to
44 work. I'm happy to stop at any point.
45

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

1 about retiring GPs and what are their frustrations. One
2 you said was red tape. I'm not a clinician. That could
3 mean anything. Can you tell me what you mean by red tape?
4

5 DR HOFFMAN: What I mean by red tape is paperwork. So it
6 really comes down - it's the patients asking for their
7 Centrelink certificate to be updated because it's been
8 three months since the last one was done or their WorkCover
9 certificate to be done because it's been 28 days since
10 their last one, and nothing has changed in that 28 days but
11 that's the time frame that's required for me to sign a new
12 piece of paper. The GP can't make the decision to extend
13 that out and say "They've broken their leg, it's going to
14 be six weeks" or "it's going to be three months." This
15 piece of paperwork should be able to be modified to be
16 three months. It's that, no, I've got to do this every
17 28 days, that we're not actually given permission to be
18 flexible with that.
19

20 If there was a little bit more flexibility around some
21 of that, it would be great. There's NDIS paperwork that we
22 don't have funding as GPs to be able to complete. So we
23 either charge the patient or we do it for free. The red
24 tape is the paperwork.
25

26 THE COMMISSIONER: Got it, thanks. Now, I interrupted
27 you. You were still talking maybe about overseas trained
28 doctors but heading to locals.
29

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

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

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

6
7 THE COMMISSIONER: I have asked someone previously what
8 that acronym stood for. I'm going to ask you again. What
9 did it stand for?

10
11 DR HOFFMAN: It's the postgraduate primary --

12
13 DR BONNING: Prevocational general practice placements
14 program.

15
16 DR HOFFMAN: Thank you.

17
18 THE COMMISSIONER: The person that I asked to describe the
19 acronym also said it was a terrific scheme, but no-one
20 could tell me why it was abandoned, other than it coincided
21 with a particular election.

22
23 DR HOFFMAN: I've spoken to HETI about this only
24 yesterday, and they've actually said it was too successful,
25 which I'm not sure if that's entirely true.

26
27 THE COMMISSIONER: Now we're in Utopia.

28
29 DR HOFFMAN: They needed the workforce in the hospital.

30
31 DR BONNING: It's expensive. It was always expensive for
32 hospitals. Just to comment, I think, on that, even prior
33 to that, so before general practice became as formalised as
34 it is now, many of the senior consultants you were seeing
35 in hospital used to moonlight in general practice, so this
36 is before 1996. They would be doing their registrar
37 training but then they would come and work for someone on
38 the weekends.

39
40 The reason I say - none of them went into general
41 practice, but they had an appreciation of what we did and
42 what was difficult about it, and many of them will say,
43 "I love what I do because I do the same thing. It's a nice
44 niche bubble. I hate what you do. I couldn't do what you
45 do" - because it's a fracture, followed by a complex mental
46 health, followed by a heart failure, followed by a child,
47 followed by someone with Alzheimer's. That's a pretty

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

9
10 But also it is about our rest of our colleagues,
11 and that's why PGPPP and other programs have been great,
12 because they reintroduced a whole generation of
13 hospital-based specialists to the idea of, "Oh, wow, the
14 patients I see in the hospital have often been kept
15 incredibly well for a very long time", and it promotes
16 a much more respectful discourse within our professions,
17 and that's important, too.

18
19 MR MUSTON: Dr Christmas, you wanted to add something?

20
21 DR CHRISTMAS: Yes, thank you. One of the things we know
22 about general practice, and especially in rural areas, is
23 that if you have exposure during the junior doctor years,
24 you are more likely to choose that as a specialty, whether
25 that be in the country or the city, especially, though, in
26 the country, because general practice in the country is
27 different to in the city because we do that public/private
28 thing where we're in the hospitals as well, and often
29 general practice suffers from that it's not as lucrative
30 financially, it's not a sexy profession, you don't go to
31 someone and say, "Hi, I'm a GP, pay me some kudos".

32
33 There's this whole idea, which is perpetuated through
34 medical school and through the hospital system, that
35 general practice really is the poor cousin, which we all
36 know in primary care is not the case; it is actually
37 incredibly important.

38
39 We know that if junior doctors are exposed to general
40 practice, we get them in that gap that you were talking
41 about - your name just suddenly has gone out of my head,
42 I'm so sorry - talking about getting people, at that time
43 in junior doctor years, before they get snaffled by the
44 consultant in cardiology or in surgery, that they also have
45 a great time with mentors in general practice.

46
47 The trick about this is in rural hospitals, we've got

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

8
9 The trouble with this is it is becoming a thing that
10 they will do if they can afford to part with their interns
11 or residents from the base hospital. So what we see is
12 these positions are not being prioritised and they're not
13 being filled because they want them back in the base
14 hospital to fill their night shift or to fill their
15 emergency or their whatever, medical rotation.

16
17 If there are KPIs around that, if there's, "Actually
18 we need to fill these positions, these are a priority",
19 because we realise that (a) it's a good support for someone
20 like me doing the job, because I am my own resident, my own
21 intern, my own registrar, consultant, I can actually really
22 do with that help and that would help ease the load on me
23 so I can do my job better, but it gives junior doctors from
24 metro and rural areas excellent experience and exposure so
25 they actually understand the breadth of general practice.
26 So even if they don't choose - as Dr Bonning was saying,
27 even if they don't choose general practice as a specialty,
28 they go into their specialties understanding more about it
29 and saying, "Oh, yeah, I've seen this kind of patient.
30 This is what I'm sending them home to and this is how
31 I need to communicate with the GP." Because if one more
32 junior doctor says, "And, GP, kindly chase results" - they
33 don't understand that, from a general practice point of
34 view, that doesn't --

35
36 THE COMMISSIONER: Had you finished what you wanted to
37 say, Dr Hoffman, when I interrupted you about the acronym?

38
39 DR HOFFMAN: No. I think what you're hearing from the
40 three doctors on the panel is that general practice is the
41 best career that is available of any of the medical
42 options, and if the junior doctors experience a quality
43 general practice, then we would have more numbers of
44 doctors wanting to be GPs. RACGP has the capacity to train
45 these junior doctors who want to be GPs, and again it's not
46 overnight, but it isn't a 15- till 2032-year solution but
47 it might be a three- to five-year solution, and that

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

3
4 MR MUSTON: Mr Sloane, do you have any insights into the
5 state's position or views on this, what might have been an
6 excessive successful scheme?

7
8 MR SLOANE: Look, I think again, what became very obvious
9 early on in my original post as coordinator general, and
10 then it still continues, is that models like the
11 Murrumbidgee model - you know, we've all heard a lot about
12 that and now we've expanded that across the state around
13 the rural generalist single employer model.

14
15 What we heard through the previous rural and remote
16 access to health care and hospital inquiry, from a lot of
17 doctors who were in the early stages of training, was when
18 they do go to specialise and are thinking about going into
19 general practice, one of the big barriers for them, at that
20 point in time, was the loss of their entitlements. When
21 they leave the public New South Wales health system, they
22 lose their maternity leave option and their annual leave,
23 any other entitlements that they have accrued during that
24 time, and it was a pretty big decision.

25
26 It became very obvious to us quickly, off the back of
27 the successes of the Murrumbidgee model, that if we could
28 somehow play our part from a NSW Health point of view in
29 providing a single employer model that works very closely
30 with the colleges with regards to the training and be able
31 to do so that, you know, as I said earlier in the day, very
32 much works to preserve private practice.

33
34 For me, I'm very biased, I want private primary health
35 care to stay in regions, because that's the reliance.
36 Doctors like Rachel work tirelessly out there and we needed
37 to do anything that we possibly could to play in that space
38 and play our part with regards to it. So we did seek
39 exemption from the Commonwealth in order to do so, in order
40 to make that both a hospital and private practice viable
41 model.

42
43 Early days, we only started last year, but we've
44 already increased the single employer model places across
45 the state from five in Murrumbidgee. I think we're
46 starting 29 at the start of next year and I might make it
47 very clear that this is advanced skill training positions

1 that are doing registrar training.

2
3 We know economically, not that I want to harp on about
4 that a lot, that that's far more cost effective than paying
5 some exorbitant prices for temporary medical officers, even
6 though they're a very valuable asset, for things like leave
7 or otherwise. So we know employing a registrar into
8 a salaried position, we still get an incredibly equipped
9 doctor and then we afford them the option to be able to
10 train and be exposed to primary care and private practice.

11
12 It's not smooth sailing, like we've had to work
13 through a couple of the rough edges of the model with
14 regards to the cost to the district. The remuneration is
15 not necessarily there from the Commonwealth. We have to
16 create some pretty significant engagement and trust and
17 assurance with the private practices that we're working
18 with, and so we've had to appoint a small team in order to
19 do that and travel around and actually have those
20 discussions with, whether it be the AMA, RACGP or ACRRM,
21 HETI, and most importantly all the private practice
22 providers, who are essentially donating their training
23 skills and ability in order to get this model off the
24 ground.

25
26 We've had amazing feedback from all of the candidates
27 involved so far. There has been a bit of interesting sort
28 of misinformation about how successful the Murrumbidgee
29 model has been, but of the five candidates they've had
30 through their program, three of them have been fellowed and
31 been retained in the district or in regional areas.
32 A lovely couple has sort of springboarded off that to stay
33 and be retained in Deniliquin and provide a very well-loved
34 service as general practitioners in that town.

35
36 So again it's not going to be one of those things - it
37 will piggyback off the stuff that Dr Hoffman and her team
38 are doing from the college point of view, and ACRRM as
39 well, but it's one of those things where, from a state
40 health point of view, we've had to recognise our
41 responsibility and play right up to that line of where the
42 Commonwealth responsibility starts and stops.

43
44 The sort of contribution has been not fiscal from
45 the Commonwealth whatsoever; it's been in the form of
46 19(2) exemptions, again, so it is another rerouted way of,
47 I guess, applying funding through a different mechanism or

1 otherwise. With all intents and purposes, we hope it
2 continues to be successful and grow as we go forward, with
3 a view that we will retain doctors in the regions with that
4 exposure, and we will hopefully ease the burden on and work
5 closely with primary practice in regional areas as well.
6

7 MR MUSTON: What are the tools that you've got available
8 when you're dealing, in a place-based way, with the thin,
9 failing or failed GP market? You referred to some success
10 in Braidwood. What worked there, just as a starter?
11

12 MR SLOANE: This is one of those tricky things because it
13 is from a state health point of view, ear to the ground.
14 It's close relationships between local health districts and
15 primary health networks. It's use of other non-government
16 organisations like the Rural Doctors Network to try and
17 understand - I am of the understanding that Department of
18 Health and Ageing have some form of tool, I believe it's
19 very manual, to track and have an overview of thin and
20 failing markets, but we do rely on negotiation between our
21 very well-organised local health districts, their local
22 communities and the GPs that are working in those towns.
23

24 Eden is a very good example of where again, the
25 doctor, a very small, very hard to keep viable business
26 because of low volumes or otherwise, and I think the -
27 again, I might be misquoting here but the GP there was
28 finding it very hard to go on leave, had been working
29 continuously for quite some time. If he was to hire
30 a locum in order to go on leave, he would have been - I'm
31 not talking about the locum pricing but that whole concept
32 itself would have been very hard for him to do that and
33 keep the business viable.
34

35 So it was escalated through me, just through good
36 relationships and knowledge, that that might be
37 a consideration and that would put that small community in
38 a bit of a spot, and so we worked very closely with RDN,
39 and then up through the Commonwealth, to go, "Right what's
40 happening from a thin markets' point of view to help this
41 person?" And RDN were able to successfully help him get
42 a cost-effective option in order to take that leave.
43

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

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

9
10 MR MUSTON: I might ask any of you to comment on this, but
11 in the context of a market which we might describe as
12 a failed market, so not jeopardising a thin or existing GP
13 market in a particular centre and no realistic prospect of
14 attracting a GP or GPs into a particular area to provide
15 primary care to that community, is a salaried model
16 something which is of interest or you think would be of
17 interest to the state and, Dr Hoffman, from your
18 perspective, something which you think would be of value to
19 the college from a training perspective but also as an
20 attractor to someone who might prefer to work in that type
21 of commercial environment?

22
23 DR HOFFMAN: Again I think one town is one town is one
24 town. What is attractive in one town would be very
25 different to another town. In Sydney we have Kurnell, on
26 the outskirts of Sydney, and it's a failed market. It
27 hasn't had a GP for two years and it's in Sydney. So
28 putting a salaried doctor there probably won't put a GP
29 there. There's complex reasons as to why they can't
30 attract and find a GP to stay there.

31
32 I might pass to Georgina, because we've had enormous
33 successes in Tasmania from the single employer model and
34 filling the Tasmanian market from offering similar.

35
36 MS VAN DE WATER: Our experience is there that, as you say
37 with each town, similarly for each doctor, and the single
38 employer models across Australia have had varied interest
39 and different levels of success. I think absolutely
40 I agree with what was said about the Murrumbidgee model,
41 and the retention of that is really going to be the proof
42 in the pudding, I think, of the success of that model and
43 the team down there have done a tremendous job.

44
45 From our perspective, we have implemented
46 opportunities for remote supervision for registrars, so
47 where there isn't a GP in a town, understanding from our

1 local teams on the ground, working with the local LHDs,
2 working with the PHNs and others to identify those areas
3 where there is a service gap and look at how we can
4 leverage safe and quality supervision through a remote
5 supervision arrangement that we've implemented in the last
6 12 months.

7
8 For instance, towns like Broken Hill have been able to
9 achieve that, as well as some other towns across New South
10 Wales - sorry, Bourke, not Broken Hill, where we've been
11 able to achieve registrars delivering service through
12 flexible funds that have been applied specifically for
13 relocation costs and support of return visits, and then
14 additionally with remote supervision.

15
16 I think absolutely we need to ensure that we are
17 creating opportunities for exposure for doctors within
18 those junior medical officer years, the prevocational
19 years, to experience quality general practice. At the same
20 time we need to make sure that we're setting expectations
21 around our Australian universities to create rotations and
22 opportunities for med student placements in general
23 practice in our rural and remote communities.

24
25 The other aspect that I think is really important as
26 we move forward is making sure that our international
27 medical graduates who take up placements in practices in
28 rural and remote communities are well supported to apply
29 their skills but also adapt their skills to the Australian
30 context. Part of that is helping the community to
31 understand the role that these doctors have and the ability
32 that those doctors bring through their own experience as
33 well.

34
35 It's a wrap-around comprehensive approach to making
36 sure that we're feeding in to the service capacity and
37 making sure that between the local health district, the
38 training programs in the region, as well as our other
39 agencies, that we're truly working collectively to make
40 sure we're supporting those doctors that are in situ to be
41 able to stay there.

42
43 MR SLOANE: Yes, I agree with all of what has been said.
44 I think the other thing we're doing from a NSW Health
45 perspective is we have, over the last 12 months, been in
46 consultation with the Department of Health and Ageing
47 around specific funding to trial that.

1
2 I one hundred per cent agree with Dr Hoffman's
3 comments. Planning for any sort of model needs to be place
4 based and contextualised. You can take any model on scale
5 but the success relies on the contextualisation to that.
6

7 We're currently looking, and have put out an EOI
8 recently, for access to a pool of funding - and I outline
9 this in my witness statement - that lies outside of the
10 current regulatory levers and funding mechanisms from the
11 Commonwealth. It's a small amount of funding, but to be
12 applied to test pilot sites - we often hear about pilots,
13 but if we don't try stuff, test it and evaluate it, we
14 can't really check - across a couple of different areas.
15

16 We're looking at Canowindra, first and foremost, in
17 western New South Wales. We'll be looking at a salaried
18 model there, very similar to HealthOne at Bowraville.
19 I will just point out there's other economic benefit to
20 Bowraville around cultural safety for the community there
21 that's probably very invisible, from the Aboriginal people
22 that are accessing health care there and the work they have
23 done.
24

25 We're looking at a cross-jurisdictional cross-PHN
26 trial with the Victorian town of Swan Hill and between the
27 Murrumbidgee PHN and the Murray PHN around almost a
28 4Ts-esque style model of salaried medical officer or
29 multidisciplinary team led model down there to cover off
30 four or five different communities that lie along the
31 inter-jurisdictional border there as well.
32

33 The other one is consideration for Balranald. We
34 haven't worked through all the details in that at the
35 moment, but we can see that again that low volume,
36 non-viable MBS billing funding which could hardly prop up
37 a viable small practice there and that's why it has been
38 very tricky for them to get a medical practitioner in that
39 town and I know it's very important to that town. We're
40 looking at how we could put perhaps a salaried model there.
41 It might not necessarily be medical led, but some form of
42 salaried model from a primary care perspective and in
43 collaboration with Far West Local Health District.
44

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

1 I probably don't need to.

2

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

7

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

12

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

15

16 DR HOFFMAN: No.

17

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

24

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

32

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

38

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

41

42 DR BONNING: No.

43

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

46

47 MR CHIU: We have no questions.

1
2
3
4
5
6
7
8
9
10
11
12
13
14
15
16
17
18
19
20
21
22
23
24
25
26
27
28
29
30
31
32
33
34
35
36
37
38
39
40
41
42
43
44
45
46
47

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

\$

\$200 [3] - 5798:27,
5842:23, 5843:21
\$23 [1] - 5775:18
\$250 [1] - 5842:23
\$300 [2] - 5811:40,
5830:47
\$300,000 [4] -
5838:46, 5840:4,
5840:20, 5840:24
\$350 [1] - 5830:47
\$400,000 [3] -
5838:44, 5840:4,
5840:24
\$600 [1] - 5843:21
\$692 [1] - 5848:36
\$700 [1] - 5843:21
\$82 [2] - 5811:47,
5843:23
\$83 [1] - 5848:38
\$900 [1] - 5830:45

0

056 [1] - 5763:24

1

1 [1] - 5797:44
1,000 [2] - 5819:36,
5835:37
1,300 [1] - 5849:22
1,350 [1] - 5819:46
1,400 [2] - 5819:30,
5849:22
1,423 [1] - 5819:35
1.20 [1] - 5801:7
10 [11] - 5767:4,
5772:40, 5785:37,
5787:21, 5817:30,
5818:5, 5823:44,
5830:26, 5847:31,
5853:3, 5863:11
10-hour [1] - 5808:25
100 [6] - 5770:42,
5786:47, 5787:13,
5789:26, 5831:35,
5843:17
100,000 [1] - 5846:5
10am [1] - 5848:11
10AM [1] - 5863:15
10pm [1] - 5851:28
11 [2] - 5772:25,
5852:35
12 [5] - 5763:22,
5818:32, 5849:29,
5860:6, 5860:45
12-week [1] - 5853:3
12.01pm [1] - 5764:16

121 [1] - 5763:18
13 [1] - 5771:40
14 [3] - 5771:41,
5795:10, 5795:12
15 [6] - 5769:19,
5818:5, 5823:1,
5824:8, 5849:30,
5855:46
150 [2] - 5788:1,
5798:23
16 [1] - 5763:22
160-odd [1] - 5812:3
17 [1] - 5863:15
170 [1] - 5798:23
18 [2] - 5771:41,
5818:41
185 [1] - 5835:3
19(2) [4] - 5835:15,
5836:14, 5838:16,
5857:46
1996 [1] - 5853:36

2

2 [5] - 5763:18,
5767:4, 5770:23,
5797:44, 5851:35
2,000 [1] - 5835:37
2.15 [2] - 5801:6,
5801:7
2.17pm [1] - 5802:1
2.5FTE [1] - 5807:8
2.8 [2] - 5815:46,
5815:47
20 [7] - 5769:19,
5810:22, 5822:6,
5840:33, 5843:24,
5848:37, 5850:27
2008 [1] - 5849:23
2009 [1] - 5849:23
2013 [1] - 5841:4
2017 [2] - 5818:41,
5819:45
2024 [6] - 5763:22,
5765:3, 5802:22,
5803:15, 5803:20,
5863:15
2025 [1] - 5820:1
2032-year [1] -
5855:46
2034 [1] - 5849:6
23 [1] - 5802:22
239 [1] - 5820:38
24 [1] - 5818:28
24-hour [1] - 5839:41
24/7 [1] - 5807:4
25 [1] - 5841:11
26 [1] - 5765:2
27 [1] - 5771:42
28 [3] - 5852:9,

5852:10, 5852:17
29 [1] - 5856:46

3

3 [5] - 5797:44,
5797:46, 5799:1,
5803:20
3,000 [3] - 5809:25,
5818:23, 5843:16
30 [4] - 5798:2,
5798:7, 5810:22,
5842:22
30s [1] - 5815:31
350 [1] - 5785:34

4

4 [3] - 5765:29,
5798:42, 5844:30
4.36PM [1] - 5863:14
40 [13] - 5770:43,
5785:35, 5786:31,
5786:42, 5787:44,
5798:1, 5820:39,
5828:38, 5843:24,
5848:37, 5849:26,
5850:27, 5852:33
40,000 [1] - 5851:20
40-odd [1] - 5770:40
40s [1] - 5815:30
46 [1] - 5798:14
4s [3] - 5844:38,
5844:40, 5844:42
4Ts [2] - 5835:26,
5861:28
4Ts-esque [1] -
5861:28

5

5 [4] - 5767:4,
5773:29, 5798:32,
5844:30
50 [5] - 5791:25,
5791:26, 5815:2,
5852:37, 5852:38
50,000 [1] - 5814:46
54 [1] - 5818:27
5s [3] - 5844:38,
5844:40, 5844:43

6

6 [4] - 5786:27,
5798:22, 5798:32,
5848:12
6.5 [1] - 5850:23
60 [5] - 5784:2,
5786:29, 5786:32,

5786:35, 5786:40
62.4 [1] - 5772:41
66 [1] - 5835:7

7

7 [4] - 5787:21,
5798:22, 5798:32,
5851:36
750,000 [1] - 5816:4

8

8 [2] - 5773:14,
5848:11
80 [1] - 5785:37
800 [2] - 5791:24,
5849:22
8pm [1] - 5848:11

9

9 [2] - 5775:18,
5803:15
90 [3] - 5790:22,
5818:29, 5835:33
900 [1] - 5849:22

A

abandoned [1] -
5853:20
ability [17] - 5772:5,
5772:36, 5779:46,
5783:26, 5792:32,
5797:19, 5812:41,
5820:18, 5825:25,
5826:20, 5827:1,
5834:5, 5842:33,
5843:35, 5850:16,
5857:23, 5860:31
able [51] - 5766:31,
5769:29, 5769:32,
5770:16, 5771:45,
5774:26, 5774:45,
5778:32, 5783:10,
5784:44, 5789:28,
5789:40, 5796:38,
5802:36, 5805:31,
5805:32, 5809:25,
5812:17, 5812:23,
5813:2, 5815:18,
5821:24, 5821:47,
5825:32, 5825:33,
5825:45, 5827:18,
5830:21, 5832:22,
5835:17, 5836:15,
5840:21, 5841:47,
5845:30, 5845:31,
5846:34, 5847:29,
5848:1, 5848:9,

5850:7, 5850:44,
5851:26, 5852:15,
5852:22, 5856:30,
5857:9, 5858:41,
5860:8, 5860:11,
5860:41, 5862:6
Aboriginal [1] -
5861:21
absent [1] - 5826:4
absolute [3] - 5798:2,
5798:3, 5800:3
absolutely [36] -
5768:38, 5769:13,
5774:33, 5778:37,
5783:15, 5783:40,
5789:38, 5792:11,
5793:6, 5799:33,
5807:17, 5808:12,
5808:32, 5808:34,
5810:7, 5812:15,
5814:37, 5815:11,
5817:14, 5819:29,
5822:11, 5832:17,
5834:24, 5835:8,
5835:9, 5837:29,
5839:22, 5842:31,
5844:46, 5848:42,
5851:10, 5851:28,
5856:1, 5859:2,
5859:39, 5860:16
accept [4] - 5822:14,
5822:15, 5832:30,
5859:7
acceptable [2] -
5811:14, 5811:15
accepted [2] -
5773:31, 5832:21
accepting [1] - 5773:3
access [49] - 5767:23,
5774:20, 5780:17,
5780:18, 5781:28,
5784:21, 5809:13,
5809:26, 5810:29,
5810:37, 5810:44,
5811:6, 5811:13,
5811:36, 5811:39,
5811:41, 5812:11,
5812:26, 5812:32,
5812:47, 5814:3,
5814:12, 5818:14,
5818:27, 5818:29,
5819:10, 5820:13,
5820:18, 5820:40,
5822:34, 5822:37,
5822:42, 5822:43,
5824:1, 5825:8,
5826:26, 5827:20,
5827:43, 5831:3,
5836:12, 5836:14,
5837:18, 5838:8,

5838:10, 5841:13,
5845:10, 5848:42,
5856:16, 5861:8
accessed [1] -
5848:40
accessing [9] -
5806:4, 5806:26,
5808:38, 5809:6,
5812:34, 5813:47,
5820:41, 5828:4,
5861:22
accord [1] - 5807:15
according [2] -
5770:40, 5789:21
accords [1] - 5805:37
accredit [2] - 5792:25,
5792:29
accredited [1] -
5819:33
accrue [2] - 5816:14,
5816:20
accrued [1] - 5856:23
accuracy [1] - 5776:39
accurate [10] -
5767:29, 5768:2,
5768:8, 5768:11,
5768:27, 5768:30,
5774:46, 5780:41,
5781:4, 5789:16
achieve [3] - 5849:19,
5860:9, 5860:11
achieved [2] -
5798:15, 5847:33
achieving [1] - 5800:6
acknowledgment [2] -
5846:39, 5846:43
acronym [4] - 5853:8,
5853:19, 5855:2,
5855:37
ACRRM [2] - 5857:20,
5857:38
Act [2] - 5835:15,
5835:16
ACT [4] - 5782:33,
5801:32, 5804:1,
5818:24
active [1] - 5816:23
activities [7] - 5768:3,
5768:16, 5771:9,
5774:41, 5789:41,
5820:32, 5835:17
activity [1] - 5766:43
actual [2] - 5829:2,
5840:19
acuity [1] - 5839:38
acute [8] - 5766:15,
5768:18, 5776:26,
5776:30, 5783:15,
5809:5, 5826:7,
5830:10
acutely [2] - 5825:6,
5825:17
ad [2] - 5788:34,
5827:6
adapt [1] - 5860:29
add [13] - 5771:22,
5777:8, 5788:26,
5799:37, 5807:23,
5809:44, 5810:5,
5817:2, 5817:33,
5824:29, 5840:21,
5840:45, 5854:19
add-on [1] - 5788:26
adding [4] - 5766:32,
5790:4, 5848:16,
5848:29
additional [4] -
5773:12, 5773:40,
5776:10, 5821:1
additionally [1] -
5860:14
addressed [2] -
5775:43, 5806:31
Adelaide [1] - 5829:30
adjacent [2] - 5805:15,
5811:10
adjourn [3] - 5801:6,
5801:7, 5863:11
adjust [1] - 5845:32
adjusted [1] - 5797:14
adjustment [1] -
5816:35
admin [1] - 5808:28
administer [2] -
5766:11, 5776:2
administered [1] -
5780:28
administering [1] -
5781:3
administration [4] -
5766:3, 5776:4,
5776:43, 5783:20
administrative [3] -
5808:20, 5808:34,
5817:14
admiration [1] -
5813:3
admission [4] -
5766:34, 5766:47,
5781:3, 5783:15
admitted [4] -
5766:45, 5775:29,
5843:20, 5848:36
admittedly [1] -
5818:23
adopted [1] - 5782:44
AdPha [1] - 5791:23
advance [2] - 5797:20,
5799:13
Advanced [4] -
5764:4, 5764:26,
5764:36, 5798:12
advanced [16] -
5778:24, 5778:25,
5778:27, 5778:29,
5779:3, 5779:6,
5779:21, 5779:25,
5791:10, 5792:44,
5793:2, 5798:10,
5799:19, 5805:2,
5856:47
advantages [1] -
5828:7
adverse [6] - 5767:41,
5769:22, 5775:26,
5775:42, 5783:38,
5833:39
adversely [1] -
5767:35
advertise [3] -
5788:30, 5788:38,
5788:41
advertised [4] -
5788:32, 5845:36,
5845:38, 5845:41
advertisement [1] -
5788:24
advice [5] - 5772:15,
5825:25, 5829:42,
5829:44, 5829:45
advocacy [1] -
5764:25
advocate [1] - 5784:25
affect [2] - 5837:22,
5837:35
affects [1] - 5775:43
affirmation [2] -
5764:14, 5801:45
affirmed [5] - 5764:16,
5802:3, 5802:5,
5802:7, 5802:9
affluent [2] - 5830:42,
5830:44
afford [7] - 5796:28,
5812:17, 5812:24,
5825:7, 5827:31,
5855:10, 5857:9
affordable [2] -
5812:25, 5822:43
after-hours [2] -
5848:7, 5848:14
afternoon [4] -
5764:1, 5801:25,
5805:10, 5848:4
afternoon's [1] -
5801:27
afterwards [1] -
5786:18
age [3] - 5769:16,
5805:6, 5815:35
age-related [1] -
5769:16
aged [3] - 5769:9,
5839:7, 5839:10
Ageing [2] - 5858:18,
5860:46
ageing [1] - 5849:13
agencies [2] -
5849:37, 5860:39
ago [20] - 5782:10,
5782:22, 5784:1,
5788:29, 5793:10,
5793:28, 5793:31,
5799:28, 5809:16,
5811:9, 5815:47,
5818:5, 5818:32,
5818:41, 5819:17,
5828:15, 5828:39,
5834:11, 5851:21,
5852:47
agree [9] - 5805:41,
5810:45, 5811:1,
5811:3, 5827:28,
5847:7, 5859:40,
5860:43, 5861:2
agreement [5] -
5782:42, 5783:3,
5783:46, 5820:29,
5821:4
agreements [1] -
5782:34
ahead [1] - 5849:1
Ahpra [1] - 5851:43
aim [1] - 5769:24
aimed [1] - 5794:2
aims [1] - 5793:22
Airds [1] - 5823:4
Aitken [1] - 5763:36
alcohol [1] - 5829:6
all-round [1] - 5832:38
allergy [2] - 5818:4,
5818:5
allied [12] - 5799:31,
5806:42, 5810:24,
5811:28, 5812:11,
5812:33, 5813:20,
5813:47, 5814:9,
5814:24, 5824:31,
5834:4
allocations [1] -
5862:19
allow [4] - 5835:16,
5838:20, 5841:36,
5841:44
allowances [1] -
5798:14
allowed [3] - 5770:11,
5818:44, 5819:18
allows [1] - 5838:17
alluding [1] - 5847:8
almost [3] - 5780:44,
5825:13, 5861:27
alone [4] - 5787:4,
5812:17, 5812:32,
5833:20
alongside [1] -
5766:25
alternative [2] -
5809:31, 5822:13
Alzheimer's [1] -
5853:47
AMA [5] - 5801:29,
5802:17, 5802:19,
5802:44, 5857:20
amazing [3] - 5771:30,
5799:42, 5857:26
AMC [1] - 5851:43
Amith [1] - 5842:45
amount [10] - 5768:29,
5771:13, 5781:33,
5785:36, 5807:8,
5825:6, 5839:33,
5861:11, 5862:36
amounts [2] -
5808:19, 5810:36
anchor [1] - 5831:12
anecdotal [1] -
5829:23
anecdotally [2] -
5829:1, 5846:31
anecdote [1] -
5813:19
anecdotes [1] -
5813:1
annotating [1] -
5776:45
annual [5] - 5798:26,
5815:5, 5815:22,
5835:20, 5856:22
annually [2] - 5815:39,
5817:9
answer [7] - 5770:25,
5784:41, 5785:20,
5798:38, 5799:32,
5814:43, 5816:37
answers [1] - 5783:36
ANTHONY [1] -
5802:5
Anthony [1] - 5803:7
anti [4] - 5767:21,
5775:40, 5775:41,
5775:45
anti-depressant [1] -
5767:21
anti-microbial [2] -
5775:41, 5775:45
anti-microbials [1] -
5775:40
anticipate [1] -
5850:30

- anyway** ^[1] - 5855:2
ANZCAP ^[1] - 5798:14
apathetic ^[1] - 5825:30
apixaban ^[2] - 5784:5, 5784:9
apologies ^[2] - 5829:27, 5851:18
apologise ^[1] - 5863:5
applicant ^[1] - 5789:19
applicants ^[2] - 5788:1, 5790:22
application ^[3] - 5787:43, 5845:34, 5845:45
applications ^[4] - 5787:40, 5787:44, 5789:9, 5789:18
applied ^[2] - 5860:12, 5861:12
applies ^[4] - 5770:24, 5781:47, 5820:26, 5845:3
apply ^[10] - 5769:2, 5769:14, 5785:41, 5788:6, 5788:20, 5788:22, 5788:25, 5818:12, 5842:2, 5860:28
applying ^[5] - 5769:27, 5785:36, 5788:4, 5821:7, 5857:47
appoint ^[1] - 5857:18
appointment ^[4] - 5810:40, 5812:41, 5830:23, 5843:24
appointments ^[1] - 5831:36
apportion ^[1] - 5769:47
appreciate ^[1] - 5789:11
appreciation ^[3] - 5831:9, 5853:41, 5854:1
apprenticeship ^[1] - 5819:32
approach ^[13] - 5769:15, 5769:27, 5796:4, 5807:35, 5813:5, 5821:21, 5821:23, 5821:25, 5830:29, 5843:30, 5846:29, 5860:35
approaches ^[3] - 5821:5, 5821:7, 5822:7
appropriate ^[10] - 5766:21, 5766:28, 5767:6, 5769:20, 5774:13, 5776:29, 5789:22, 5790:19, 5790:36, 5793:24
appropriately ^[8] - 5775:43, 5776:2, 5780:26, 5780:27, 5793:8, 5793:37, 5797:35, 5843:2
appropriateness ^[1] - 5774:18
approval ^[1] - 5791:37
April ^[2] - 5803:15, 5838:19
area ^[26] - 5766:32, 5778:28, 5780:21, 5782:5, 5782:6, 5782:7, 5791:32, 5793:3, 5794:19, 5794:23, 5798:29, 5805:26, 5805:27, 5805:38, 5805:41, 5820:45, 5820:47, 5821:31, 5821:38, 5822:22, 5822:35, 5823:15, 5827:45, 5841:40, 5859:14
areas ^[58] - 5770:18, 5770:32, 5779:32, 5779:34, 5783:24, 5792:9, 5797:2, 5797:21, 5797:29, 5798:34, 5805:15, 5807:2, 5807:23, 5810:3, 5813:41, 5815:17, 5818:14, 5818:15, 5818:20, 5820:15, 5820:38, 5820:43, 5821:8, 5822:11, 5822:31, 5822:36, 5822:39, 5829:8, 5830:46, 5831:10, 5831:14, 5831:20, 5832:15, 5832:27, 5834:22, 5834:29, 5835:34, 5835:38, 5836:8, 5838:23, 5841:8, 5841:29, 5841:47, 5845:16, 5845:42, 5845:47, 5846:5, 5846:7, 5846:14, 5851:35, 5854:22, 5855:24, 5857:31, 5858:5, 5860:2, 5861:14, 5862:33
argue ^[3] - 5795:29, 5830:11, 5844:38
arm ^[1] - 5769:6
Armidale ^[1] - 5820:45
arms ^[1] - 5849:15
army ^[1] - 5811:26
arrangement ^[4] - 5821:28, 5821:47, 5827:3, 5860:5
arrangements ^[4] - 5782:24, 5822:13, 5836:10, 5838:1
array ^[2] - 5778:29, 5779:23
arrives ^[1] - 5845:4
aspect ^[1] - 5860:25
aspects ^[3] - 5806:43, 5807:10, 5840:45
assess ^[1] - 5783:10
assessing ^[1] - 5774:17
assessment ^[2] - 5775:32, 5824:26
assessments ^[1] - 5769:14
asset ^[1] - 5857:6
assignment ^[1] - 5793:45
assist ^[4] - 5765:3, 5791:9, 5802:22, 5803:14
Assisting ^[5] - 5763:26, 5763:27, 5763:28, 5763:29, 5763:30
associated ^[4] - 5782:22, 5783:2, 5792:46, 5804:44
association ^[1] - 5800:2
Association ^[3] - 5801:40, 5804:39, 5832:44
assume ^[7] - 5769:1, 5774:24, 5778:4, 5792:45, 5819:41, 5845:22, 5845:23
assumes ^[1] - 5840:9
assuming ^[1] - 5780:34
assumption ^[2] - 5780:39, 5790:15
assumptions ^[1] - 5831:2
assurance ^[1] - 5857:17
AT ^[2] - 5863:14, 5863:15
attached ^[1] - 5775:27
attack ^[4] - 5783:18, 5815:10, 5816:11, 5828:39
attend ^[1] - 5837:28
attendance ^[1] - 5801:12
attended ^[1] - 5827:4
attention ^[3] - 5777:4, 5791:18, 5792:37
attract ^[6] - 5786:6, 5798:36, 5813:36, 5835:29, 5859:30, 5862:6
attracted ^[3] - 5786:2, 5809:23, 5810:10
attracting ^[4] - 5797:35, 5809:35, 5810:10, 5859:14
attraction ^[1] - 5831:34
attractive ^[2] - 5821:7, 5859:24
attractor ^[1] - 5859:20
augments ^[1] - 5825:25
Austin ^[1] - 5833:24
Australasian ^[1] - 5845:2
Australia ^[16] - 5764:4, 5764:26, 5764:36, 5781:30, 5791:21, 5806:13, 5806:18, 5818:24, 5819:47, 5823:45, 5823:47, 5824:15, 5842:22, 5851:33, 5851:37, 5859:38
Australia's ^[2] - 5806:9, 5806:16
Australian ^[19] - 5782:6, 5782:12, 5782:16, 5797:26, 5798:11, 5801:33, 5801:36, 5804:1, 5804:21, 5820:30, 5832:43, 5841:30, 5843:8, 5849:3, 5849:29, 5851:15, 5851:41, 5860:21, 5860:29
Australian-trained ^[1] - 5851:15
automatically ^[1] - 5846:16
availability ^[1] - 5773:35
available ^[14] - 5781:24, 5790:35, 5808:35, 5812:17, 5814:40, 5819:20, 5819:30, 5819:37, 5827:14, 5832:26, 5833:15, 5847:16, 5855:41, 5858:7
average ^[2] - 5807:20, 5848:34
avoid ^[2] - 5821:14, 5840:10
avoidable ^[1] - 5840:6
award ^[22] - 5797:12, 5797:13, 5797:17, 5797:37, 5797:39, 5797:42, 5798:3, 5798:11, 5798:17, 5798:23, 5798:33, 5798:36, 5798:42, 5798:45, 5799:3, 5799:11, 5799:12, 5799:16, 5799:39, 5799:41, 5800:3, 5800:9
awards ^[5] - 5780:10, 5786:22, 5799:25, 5799:27, 5799:35
aware ^[8] - 5770:28, 5777:16, 5781:23, 5795:20, 5800:35, 5837:32, 5839:4, 5841:28
awfully ^[1] - 5813:13

B

- back-fill** ^[2] - 5818:44, 5819:18
backed ^[1] - 5823:20
backed-up ^[1] - 5823:20
background ^[1] - 5801:37
backing ^[1] - 5807:6
bag ^[1] - 5769:10
balance ^[7] - 5807:4, 5807:10, 5808:24, 5813:33, 5835:32, 5837:11, 5837:24
ball ^[1] - 5782:43
Ballpark ^[1] - 5839:2
Balranald ^[1] - 5861:33
bang ^[1] - 5838:27
barrier ^[3] - 5791:33, 5841:35, 5846:25
barriers ^[1] - 5856:19
base ^[4] - 5774:47, 5790:18, 5855:11, 5855:13
based ^[16] - 5769:15, 5769:26, 5769:27, 5784:2, 5788:15, 5805:28, 5830:29, 5832:33, 5832:34, 5833:46, 5841:20, 5843:30, 5846:29,

- 5854:13, 5858:8,
5861:4
baseline [1] - 5805:36
basement [1] -
5774:19
basic [2] - 5767:47,
5797:17
basis [2] - 5815:39,
5816:18
beans [1] - 5840:24
bear [1] - 5779:25
Beasley [1] - 5763:14
became [3] - 5853:33,
5856:8, 5856:26
become [5] - 5775:17,
5817:10, 5836:10,
5849:41, 5862:37
becomes [6] -
5795:25, 5806:14,
5823:27, 5825:13,
5836:35, 5841:12
becoming [7] -
5810:21, 5817:8,
5825:30, 5828:44,
5832:21, 5832:25,
5855:9
bed [3] - 5771:39,
5825:31, 5833:32
beds [2] - 5769:43,
5771:29
bedside [1] - 5766:18
beginning [5] -
5770:13, 5770:16,
5775:11, 5775:20,
5818:45
behind [5] - 5764:7,
5769:44, 5802:42,
5803:38, 5822:5
bending [1] - 5815:36
beneath [1] - 5843:47
beneficial [1] -
5829:47
benefit [6] - 5765:31,
5775:27, 5794:43,
5794:46, 5799:42,
5861:19
benefiting [1] -
5838:31
benefits [18] -
5773:41, 5781:28,
5783:2, 5786:8,
5787:42, 5789:26,
5792:46, 5793:1,
5795:27, 5816:13,
5816:20, 5816:33,
5817:23, 5823:40,
5840:2, 5840:7,
5840:21
Benefits [1] - 5781:29
best [23] - 5765:17,
5766:16, 5767:44,
5770:15, 5771:11,
5774:26, 5777:18,
5779:16, 5780:46,
5781:21, 5785:19,
5792:33, 5796:43,
5797:36, 5799:8,
5802:37, 5816:14,
5823:47, 5827:41,
5834:5, 5843:16,
5847:32, 5855:41
better [20] - 5773:35,
5775:25, 5780:44,
5791:43, 5792:4,
5792:5, 5795:31,
5795:39, 5798:7,
5816:37, 5823:24,
5823:39, 5828:19,
5828:45, 5834:38,
5843:40, 5847:43,
5850:20, 5855:23
between [21] -
5787:21, 5798:4,
5810:40, 5816:44,
5821:13, 5826:5,
5831:18, 5832:16,
5832:33, 5834:22,
5835:11, 5835:32,
5837:23, 5839:9,
5849:29, 5850:8,
5850:27, 5858:14,
5858:20, 5860:37,
5861:26
beyond [2] - 5768:13,
5791:20
biased [1] - 5856:34
big [7] - 5781:9,
5816:12, 5818:31,
5826:46, 5851:21,
5856:19, 5856:24
bigger [1] - 5835:4
bill [7] - 5811:33,
5811:35, 5811:47,
5835:18, 5846:41,
5846:42
billed [3] - 5843:23,
5862:10, 5862:29
billing [5] - 5835:39,
5836:15, 5837:47,
5838:1, 5861:36
billings [1] - 5835:18
bills [1] - 5796:30
Biobeat [1] - 5833:29
bit [23] - 5773:46,
5776:37, 5778:23,
5784:45, 5798:7,
5798:31, 5814:20,
5814:26, 5816:30,
5819:19, 5822:45,
5824:38, 5825:18,
5830:6, 5831:28,
5831:30, 5832:20,
5844:37, 5846:35,
5847:22, 5852:20,
5857:27, 5858:38
bits [1] - 5825:3
blend [1] - 5831:36
blended [1] - 5831:39
block [2] - 5800:37,
5836:2
blood [2] - 5767:20,
5778:46
blunt [1] - 5780:35
blur [2] - 5832:15,
5834:22
bodies [1] - 5797:25
body [1] - 5806:32
bomb [1] - 5816:7
Bonning [13] -
5763:38, 5801:28,
5802:11, 5802:14,
5811:9, 5817:6,
5827:29, 5829:40,
5831:26, 5835:41,
5840:10, 5855:26,
5858:45
BONNING [38] -
5802:3, 5802:14,
5802:19, 5802:24,
5802:28, 5802:33,
5802:40, 5805:44,
5806:8, 5806:28,
5806:35, 5807:28,
5808:45, 5810:17,
5811:1, 5811:23,
5815:26, 5816:25,
5822:30, 5823:18,
5824:36, 5824:47,
5826:9, 5826:14,
5827:8, 5832:3,
5832:42, 5836:32,
5840:26, 5842:40,
5847:13, 5848:47,
5849:19, 5853:13,
5853:31, 5862:18,
5862:33, 5862:42
Bonning's [2] -
5837:19, 5840:1
books [7] - 5810:39,
5814:8, 5815:21,
5815:42, 5835:37,
5847:20
boost [1] - 5845:44
border [1] - 5861:31
borrow [2] - 5826:27,
5826:28
bottom [1] - 5805:20
boundaries [1] -
5862:18
Bourke [1] - 5860:10
Bowraville [5] -
5838:11, 5838:40,
5840:17, 5861:18,
5861:20
boxes [1] - 5830:27
Braidwood [3] -
5809:15, 5809:17,
5858:10
brain [2] - 5823:38,
5823:41
branch [1] - 5764:36
breadth [1] - 5855:25
break [3] - 5800:19,
5816:1, 5847:24
bridged [2] - 5780:17,
5780:22
bridging [1] - 5850:10
bring [4] - 5778:32,
5779:25, 5830:34,
5860:32
bringing [2] - 5834:14,
5850:30
brings [1] - 5776:21
broader [2] - 5777:21,
5783:46
broken [1] - 5852:13
Broken [2] - 5860:8,
5860:10
brought [1] - 5778:14
bubble [1] - 5853:44
budget [5] - 5786:43,
5787:13, 5798:26,
5798:30
build [4] - 5828:7,
5836:5, 5840:40,
5840:46
building [1] - 5836:36
bulk [11] - 5811:33,
5811:34, 5811:47,
5837:47, 5838:1,
5843:23, 5846:41,
5846:42, 5862:10,
5862:28
bums [1] - 5819:6
burden [3] - 5789:46,
5815:20, 5858:4
Bureau [1] - 5849:3
burnout [1] - 5851:18
busiest [1] - 5794:8
business [11] -
5829:37, 5837:25,
5837:36, 5837:40,
5841:20, 5845:25,
5858:25, 5858:33,
5862:13, 5862:31
businesses [3] -
5816:42, 5835:34,
5835:36
busy [1] - 5810:37
Butler [1] - 5821:22

C

- calculated** [1] -
5780:27
calculus [3] - 5840:35,
5840:38, 5840:42
Campbelltown [1] -
5823:4
Canada [1] - 5823:46
Canberra [1] -
5814:16
cancer [3] - 5779:43,
5780:23, 5780:24
candidate [1] -
5798:34
candidates [6] -
5789:10, 5821:15,
5821:46, 5822:1,
5857:26, 5857:29
cannibalising [1] -
5845:25
cannot [1] - 5787:4
Canowindra [1] -
5861:16
capable [2] - 5768:14,
5777:32
capacity [18] -
5788:20, 5791:27,
5792:11, 5795:4,
5795:5, 5795:36,
5820:9, 5832:47,
5834:2, 5843:5,
5843:31, 5847:34,
5847:42, 5848:8,
5848:12, 5848:13,
5855:44, 5860:36
capita [1] - 5822:42
capital [1] - 5816:45
capitated [1] -
5824:45
caps [1] - 5819:40
cardiac [1] - 5833:25
cardiologist [3] -
5777:13, 5817:9,
5828:2
cardiologists [4] -
5777:13, 5823:22,
5831:45, 5833:34
cardiology [3] -
5777:14, 5850:36,
5854:44
cardiothoracics [1] -
5833:35
cardiovascular [3] -
5815:45, 5816:1,
5816:11
care [185] - 5765:40,
5765:41, 5769:9,
5771:12, 5779:5,
5779:9, 5779:17,

5779:38, 5780:3,
5780:4, 5781:17,
5781:18, 5781:22,
5782:5, 5782:14,
5783:9, 5783:44,
5783:47, 5784:6,
5784:11, 5784:22,
5784:26, 5784:37,
5790:9, 5792:47,
5795:24, 5795:33,
5797:34, 5798:37,
5799:7, 5799:8,
5799:10, 5799:14,
5805:27, 5806:5,
5806:10, 5806:21,
5806:23, 5806:26,
5806:38, 5806:41,
5806:44, 5807:2,
5808:30, 5808:39,
5809:6, 5809:14,
5809:27, 5809:36,
5811:14, 5811:29,
5812:13, 5812:24,
5812:34, 5812:40,
5812:45, 5813:44,
5813:47, 5814:3,
5814:4, 5814:6,
5814:18, 5814:22,
5814:24, 5814:31,
5815:24, 5816:40,
5816:43, 5817:7,
5817:16, 5817:36,
5818:14, 5820:13,
5820:18, 5824:17,
5824:24, 5824:30,
5826:7, 5827:11,
5827:45, 5828:5,
5828:24, 5831:13,
5831:37, 5832:14,
5832:25, 5832:38,
5832:39, 5832:46,
5833:10, 5833:11,
5833:14, 5833:25,
5833:43, 5834:1,
5834:21, 5834:30,
5836:2, 5836:16,
5836:40, 5837:26,
5837:36, 5838:5,
5838:11, 5838:13,
5838:14, 5838:17,
5838:20, 5838:34,
5839:7, 5839:11,
5839:12, 5839:15,
5839:20, 5839:43,
5840:23, 5841:18,
5842:7, 5842:8,
5842:15, 5842:19,
5842:21, 5842:28,
5842:32, 5842:33,
5842:42, 5842:43,
5843:17, 5843:21,
5844:14, 5844:18,
5844:19, 5844:20,
5845:8, 5845:11,
5845:12, 5845:14,
5845:18, 5845:30,
5845:33, 5845:37,
5845:44, 5845:45,
5845:46, 5846:8,
5846:15, 5846:16,
5846:26, 5846:27,
5846:38, 5846:44,
5847:1, 5847:5,
5847:14, 5848:1,
5848:2, 5848:3,
5848:7, 5848:14,
5848:33, 5848:45,
5850:28, 5850:38,
5850:44, 5850:45,
5854:36, 5856:1,
5856:16, 5856:35,
5857:10, 5859:8,
5859:15, 5861:22,
5861:42

Care [1] - 5797:27
career [15] - 5771:20,
5785:21, 5786:20,
5794:3, 5794:38,
5795:3, 5795:17,
5797:23, 5797:40,
5799:10, 5799:13,
5806:24, 5849:43,
5855:41
carer [2] - 5816:26,
5847:40
carers [1] - 5768:26
caring [1] - 5847:40
case [7] - 5787:1,
5788:30, 5790:42,
5817:15, 5817:30,
5835:39, 5854:36
cases [1] - 5809:14
casual [1] - 5837:17
catchment [1] -
5820:38
catchments [1] -
5820:39
categories [1] -
5845:3
category [4] -
5810:42, 5844:10,
5844:30
caused [1] - 5818:37
causes [1] - 5808:37
causing [3] - 5776:9,
5785:6, 5838:3
cautious [1] - 5837:20
CBD [1] - 5823:1
ceased [1] - 5776:8
ceiling [1] - 5797:21
cent [26] - 5772:40,
5772:41, 5785:37,
5786:29, 5786:31,
5786:32, 5786:35,
5786:40, 5786:42,
5786:47, 5787:13,
5790:22, 5818:27,
5818:29, 5831:35,
5835:33, 5849:26,
5849:30, 5850:23,
5850:27, 5852:33,
5852:35, 5852:37,
5852:38, 5861:2
central [6] - 5789:19,
5791:14, 5811:16,
5811:21, 5811:24,
5824:3
centralisation [1] -
5800:43
centralised [11] -
5786:36, 5787:32,
5787:35, 5787:39,
5787:40, 5788:6,
5788:27, 5789:1,
5791:12, 5791:40,
5792:34
centre [5] - 5811:10,
5811:13, 5846:16,
5848:2, 5859:13
Centrelink [1] -
5852:7
centres [10] - 5810:20,
5812:29, 5827:34,
5842:22, 5842:28,
5844:33, 5845:13,
5846:15, 5846:38,
5848:33
centres" [1] - 5842:43
CEO [2] - 5801:35,
5804:21
certain [7] - 5811:40,
5814:9, 5816:36,
5836:3, 5838:19,
5840:27, 5840:30
certainly [15] -
5768:18, 5774:34,
5778:13, 5779:19,
5780:7, 5786:35,
5790:7, 5790:9,
5791:17, 5791:43,
5817:23, 5817:38,
5817:40, 5820:47,
5826:41
certificate [2] -
5852:7, 5852:9
cetera [2] - 5773:36,
5835:5
chain [1] - 5798:30
chair [3] - 5764:35,
5801:32, 5803:47
chairs [1] - 5819:25
challenge [8] -
5805:41, 5806:4,
5806:8, 5806:30,
5808:38, 5809:39,
5812:7, 5843:29
challenges [10] -
5774:23, 5785:11,
5805:25, 5805:37,
5805:38, 5806:25,
5813:10, 5818:11,
5824:21, 5862:35
challenging [4] -
5808:42, 5809:7,
5811:45, 5849:45
chambers [1] -
5800:23
chance [2] - 5788:1,
5802:30
change [8] - 5794:36,
5799:22, 5799:26,
5807:1, 5818:47,
5831:32, 5837:11,
5856:1
changed [4] -
5774:20, 5799:29,
5815:9, 5852:10
changes [3] - 5776:7,
5783:11, 5840:43
changing [4] -
5776:26, 5808:3,
5828:30, 5849:46
channelled [1] -
5820:24
Chapman [2] -
5763:38, 5802:43
charge [1] - 5852:23
chart [6] - 5766:20,
5772:11, 5776:41,
5780:25, 5784:10,
5789:43
charted [3] - 5766:46,
5776:8, 5780:26
charting [12] -
5766:20, 5766:25,
5768:2, 5772:27,
5774:12, 5776:13,
5776:35, 5776:36,
5776:41, 5780:32,
5780:36, 5781:9
charts [1] - 5772:35
chase [1] - 5855:32
cheaper [1] - 5836:34
check [4] - 5830:8,
5830:24, 5834:39,
5861:14
checking [1] -
5768:19
checks [1] - 5766:1
chemotherapy [5] -
5778:28, 5779:44,
5780:3, 5780:7,
5843:46
Cheney [2] - 5763:35,
5862:44
child [2] - 5840:23,
5853:46
children's [1] -
5829:34
chime [1] - 5805:16
chip [1] - 5770:24
CHIU [7] - 5800:17,
5800:25, 5800:29,
5800:35, 5800:42,
5801:4, 5862:47
Chiu [3] - 5763:35,
5800:15, 5862:45
choice [3] - 5794:19,
5813:35, 5837:28
choices [1] - 5813:40
cholesterol [2] -
5767:20, 5778:45
choose [5] - 5779:24,
5849:43, 5854:24,
5855:26, 5855:27
choosing [2] -
5775:40, 5851:15
Christmas [17] -
5801:38, 5804:33,
5804:36, 5807:29,
5807:47, 5809:43,
5812:9, 5827:24,
5831:31, 5833:3,
5833:46, 5838:37,
5840:26, 5841:16,
5846:12, 5847:29,
5854:19
CHRISTMAS [17] -
5802:7, 5804:36,
5804:41, 5804:47,
5805:4, 5806:1,
5807:23, 5808:12,
5809:46, 5812:15,
5813:46, 5817:5,
5827:28, 5841:25,
5846:14, 5848:6,
5854:21
chronic [2] - 5822:40,
5829:13
circumstances [3] -
5810:30, 5834:28,
5844:31
city [6] - 5807:33,
5822:28, 5831:11,
5832:11, 5854:25,
5854:27
clear [5] - 5787:2,
5807:32, 5849:33,
5851:42, 5856:47
clearance [1] -
5791:37

clerical [1] - 5849:42
clever [1] - 5827:40
clinic [6] - 5839:20, 5840:17, 5842:8, 5842:15, 5848:2
Clinical [2] - 5780:8, 5797:25
clinical [17] - 5766:29, 5768:45, 5770:3, 5772:5, 5781:20, 5781:36, 5784:38, 5790:8, 5792:39, 5796:4, 5796:15, 5796:28, 5797:21, 5797:25, 5798:45, 5798:46
clinician [2] - 5817:39, 5852:2
clinicians [9] - 5767:44, 5799:1, 5808:40, 5830:32, 5832:30, 5841:11, 5843:32, 5844:38, 5848:44
clinics [9] - 5827:33, 5842:19, 5842:20, 5843:17, 5844:18, 5844:19, 5845:23, 5847:14
clinics/centres [2] - 5844:15, 5844:18
close [4] - 5825:41, 5858:14, 5862:21, 5862:22
closed [2] - 5810:39, 5835:37
closely [3] - 5856:29, 5858:5, 5858:38
closer [2] - 5779:44, 5862:18
co [3] - 5809:21, 5833:16, 5847:11
co-consultation [1] - 5833:16
co-located [2] - 5809:21, 5847:11
coalesce [1] - 5811:24
coalface [1] - 5829:2
coast [1] - 5842:29
cognisant [3] - 5837:47, 5838:32, 5859:3
cognitive [3] - 5766:29, 5770:3, 5784:38
cohort [5] - 5823:21, 5851:13, 5851:15, 5851:22, 5852:45
cohorts [2] - 5816:36
coincided [1] - 5853:20
collaborate [1] - 5815:16
collaboration [3] - 5776:22, 5835:1, 5861:43
collaboratively [2] - 5776:16, 5780:32
collateral [1] - 5837:45
colleagues [3] - 5828:8, 5828:17, 5854:10
collect [1] - 5766:10
collectively [1] - 5860:39
College [6] - 5798:12, 5801:33, 5801:36, 5804:1, 5804:22, 5849:36
college [9] - 5800:9, 5817:45, 5821:13, 5821:44, 5848:25, 5849:31, 5849:35, 5857:38, 5859:19
college's [1] - 5851:6
colleges [2] - 5799:30, 5856:30
colloquialism [1] - 5809:13
colloquialisms [1] - 5839:30
combination [1] - 5777:45
comfortable [2] - 5843:8, 5843:10
comfortably [1] - 5840:39
coming [13] - 5779:5, 5779:40, 5785:9, 5785:34, 5790:15, 5805:29, 5808:5, 5808:7, 5808:13, 5812:38, 5815:18, 5837:18, 5854:1
commas [1] - 5839:13
comment [10] - 5789:13, 5806:37, 5807:29, 5810:18, 5813:43, 5813:46, 5837:3, 5841:17, 5853:32, 5859:10
commenting [1] - 5808:47
comments [1] - 5861:3
commercial [1] - 5859:21
COMMISSION [1] - 5863:14
Commission [7] - 5763:7, 5782:6, 5782:12, 5782:16, 5797:26, 5833:19
Commissioner [10] - 5763:13, 5764:7, 5800:13, 5800:17, 5801:4, 5801:27, 5802:43, 5803:38, 5811:1, 5861:45
COMMISSIONER [63] - 5764:1, 5764:10, 5764:43, 5765:27, 5770:22, 5771:6, 5771:39, 5772:8, 5772:19, 5772:32, 5772:44, 5773:14, 5773:18, 5773:22, 5773:27, 5773:33, 5778:4, 5778:8, 5782:12, 5782:19, 5787:27, 5800:15, 5800:22, 5800:27, 5800:33, 5800:40, 5801:2, 5801:6, 5801:11, 5801:25, 5801:42, 5802:46, 5803:40, 5810:29, 5816:23, 5818:36, 5826:3, 5826:11, 5834:10, 5834:37, 5834:45, 5836:19, 5838:7, 5838:46, 5840:1, 5840:13, 5844:17, 5844:25, 5845:22, 5845:36, 5851:46, 5852:26, 5853:7, 5853:18, 5853:27, 5855:36, 5862:3, 5862:13, 5862:25, 5862:39, 5862:44, 5863:2, 5863:11
commissioning [1] - 5836:24
commitment [1] - 5849:21
committed [1] - 5822:12
committee [1] - 5764:36
common [3] - 5815:31, 5833:6, 5854:1
commonly [2] - 5842:6, 5852:45
Commonwealth [22] - 5820:22, 5820:24, 5821:14, 5821:45, 5823:44, 5824:18, 5832:14, 5834:20, 5834:42, 5835:1, 5835:47, 5839:10, 5844:19, 5845:13, 5850:7, 5856:39, 5857:15, 5857:42, 5857:45, 5858:39, 5861:11
communicate [2] - 5815:15, 5855:31
communicating [1] - 5844:2
communities [20] - 5807:31, 5810:21, 5810:23, 5813:1, 5813:24, 5820:14, 5820:19, 5820:33, 5822:34, 5831:41, 5832:11, 5836:12, 5840:28, 5841:46, 5846:42, 5858:22, 5860:23, 5860:28, 5861:30
community [36] - 5765:40, 5768:21, 5777:5, 5781:23, 5790:25, 5791:1, 5795:22, 5795:25, 5806:26, 5807:35, 5807:41, 5816:8, 5823:5, 5823:7, 5823:14, 5823:24, 5823:30, 5833:1, 5833:8, 5836:11, 5838:23, 5839:7, 5839:26, 5840:32, 5843:6, 5843:31, 5850:19, 5850:37, 5851:1, 5853:1, 5858:37, 5859:5, 5859:6, 5859:15, 5860:30, 5861:20
comorbidities [2] - 5815:37, 5828:35
companies [1] - 5797:28
comparable [1] - 5823:45
comparatively [1] - 5769:41
comparator [1] - 5824:36
compare [1] - 5840:15
compared [5] - 5767:39, 5793:39, 5842:21, 5843:23, 5848:33
compelling [1] - 5806:47
competencies [1] - 5774:34
competency [1] - 5775:5
competent [1] - 5774:38
competing [1] - 5780:34
competitive [1] - 5797:24
complete [2] - 5785:28, 5852:22
completed [2] - 5775:30, 5791:25
completely [1] - 5769:20
completes [1] - 5785:26
complex [13] - 5786:4, 5825:2, 5825:5, 5826:29, 5828:27, 5828:44, 5844:45, 5850:11, 5853:45, 5859:29, 5862:5, 5862:9, 5862:29
complexity [1] - 5828:31
complicated [3] - 5768:24, 5824:6, 5826:21
complimentary [1] - 5849:39
composite [1] - 5821:29
compounded [2] - 5775:47, 5780:27
comprehensive [6] - 5768:1, 5768:7, 5768:11, 5768:30, 5790:9, 5860:35
comprehensively [1] - 5794:17
concept [5] - 5826:12, 5842:8, 5844:29, 5845:13, 5858:31
concern [1] - 5846:38
concerned [1] - 5820:17
concise [1] - 5851:19
conditions [2] - 5816:5, 5833:6
conduct [1] - 5796:43
confident [1] - 5802:37
confined [1] - 5805:17
conglomerate [1] - 5837:39
connect [1] - 5843:36
connecting [1] - 5832:20
connection [1] -

- 5827:5
cons [1] - 5814:33
conscious [2] - 5775:2, 5813:35
consequence [1] - 5787:16
consequences [3] - 5771:43, 5783:38, 5806:4
consider [3] - 5779:2, 5807:39
consideration [4] - 5845:29, 5845:43, 5858:37, 5861:33
considerations [1] - 5828:33
considered [2] - 5771:33, 5782:6
consistent [3] - 5829:24, 5833:44, 5850:5
consolidate [1] - 5794:4
consolidated [1] - 5798:10
consolidates [1] - 5796:26
consolidating [1] - 5794:9
constantly [5] - 5777:41, 5795:31, 5795:32, 5795:39
constellation [1] - 5812:11
constrained [1] - 5805:33
consult [5] - 5813:6, 5832:23, 5832:24, 5862:30, 5862:40
consultant [5] - 5778:40, 5798:13, 5800:8, 5854:44, 5855:21
consultants [2] - 5832:9, 5853:34
consultation [3] - 5833:16, 5833:27, 5860:46
consulting [1] - 5826:37
consuming [1] - 5846:36
contacting [1] - 5768:24
contents [3] - 5765:18, 5802:37, 5803:33
context [5] - 5777:20, 5793:43, 5824:10, 5859:11, 5860:30
contextual [1] - 5809:12
contextualisation [1] - 5861:5
contextualised [1] - 5861:4
continual [1] - 5768:44
continually [3] - 5773:42, 5776:27, 5782:7
continue [6] - 5767:24, 5770:44, 5782:30, 5815:7, 5839:10, 5840:23
continued [1] - 5809:19
continues [3] - 5782:30, 5856:10, 5858:2
continuing [1] - 5780:30
continuity [3] - 5814:21, 5817:46, 5818:8
continuously [1] - 5858:29
contract [1] - 5836:8
contraption [1] - 5844:8
contribute [3] - 5789:42, 5812:12, 5816:27
contributes [2] - 5832:35, 5832:46
contributing [1] - 5806:25
contribution [3] - 5771:26, 5796:38, 5857:44
control [2] - 5792:34, 5850:4
convened [1] - 5791:23
conversation [3] - 5771:1, 5824:10, 5841:26
conversations [1] - 5821:41
conversely [1] - 5822:39
coordinate [1] - 5781:41
coordination [2] - 5781:22, 5792:35
coordinator [2] - 5824:3, 5856:9
copies [1] - 5803:24
copy [3] - 5764:6, 5765:4, 5802:26
core [3] - 5765:44, 5774:6, 5775:5
corollary [1] - 5828:46
correct [17] - 5764:28, 5764:38, 5765:18, 5772:12, 5772:34, 5802:38, 5803:12, 5803:34, 5804:4, 5804:14, 5804:24, 5804:47, 5817:6, 5823:18, 5824:45, 5845:27, 5849:20
corrected [2] - 5836:22, 5838:42
correctly [4] - 5773:47, 5775:47, 5792:45, 5804:45
cost [18] - 5780:37, 5780:41, 5796:27, 5814:39, 5816:41, 5836:19, 5836:37, 5838:11, 5838:12, 5840:3, 5842:23, 5842:37, 5848:32, 5848:34, 5848:38, 5857:4, 5857:14, 5858:42
cost-effective [3] - 5814:39, 5816:41, 5858:42
costly [2] - 5842:20, 5843:23
costs [6] - 5816:43, 5823:29, 5843:20, 5850:4, 5851:25, 5860:13
Counsel [5] - 5763:26, 5763:27, 5763:28, 5763:29, 5763:30
counselling [3] - 5780:19, 5781:44, 5789:44
countries [4] - 5806:14, 5816:34, 5842:2, 5851:31
country [6] - 5779:36, 5841:38, 5851:14, 5854:25, 5854:26
couple [8] - 5800:18, 5800:22, 5813:21, 5815:47, 5835:1, 5857:13, 5857:32, 5861:14
course [7] - 5765:25, 5771:10, 5792:16, 5801:2, 5808:3, 5815:38, 5838:32
court [2] - 5782:43, 5800:25
cousin [1] - 5854:35
cover [1] - 5861:29
covered [1] - 5817:47
COVID [2] - 5807:4, 5851:22
create [2] - 5857:16, 5860:21
creating [2] - 5850:2, 5860:17
credentialled [2] - 5841:33, 5841:38
crisis [3] - 5796:27, 5830:10, 5852:44
critically [2] - 5812:44, 5844:44
Crookwell [1] - 5809:15
cross [3] - 5850:8, 5861:25
cross-jurisdictional [1] - 5861:25
cross-PHN [1] - 5861:25
cultural [1] - 5861:20
culture [2] - 5795:35, 5810:9
cultures [1] - 5775:44
cumulative [2] - 5819:34, 5820:6
curiosity [1] - 5862:4
current [10] - 5792:41, 5797:40, 5798:3, 5798:46, 5819:30, 5832:13, 5834:18, 5837:47, 5845:30, 5861:10
curve [2] - 5794:9, 5815:36
cut [1] - 5771:18
cycle [1] - 5790:31
-
- D**
-
- D6** [1] - 5803:38
daily [1] - 5776:12
damages [1] - 5837:45
danger [2] - 5817:8, 5817:13
dangerous [1] - 5845:1
Daniel [1] - 5763:30
dare [1] - 5830:6
dark [1] - 5826:43
darken [1] - 5816:18
data [6] - 5774:43, 5785:37, 5811:4, 5829:1, 5848:34, 5849:2
date [1] - 5809:38
dated [4] - 5765:2, 5802:22, 5803:15, 5803:19
daylight [1] - 5839:39
days [19] - 5766:10, 5767:25, 5770:12, 5777:1, 5783:19, 5783:22, 5783:26, 5783:29, 5783:30, 5784:13, 5787:25, 5807:21, 5828:40, 5833:30, 5852:9, 5852:10, 5852:17, 5856:43
days' [1] - 5781:31
de [4] - 5801:35, 5804:16, 5804:19, 5817:47
DE [15] - 5802:1, 5804:19, 5804:24, 5804:28, 5808:32, 5817:33, 5819:29, 5819:43, 5820:29, 5821:17, 5821:21, 5822:3, 5822:25, 5848:29, 5859:36
deal [4] - 5780:36, 5826:46, 5842:6, 5846:18
dealing [16] - 5778:33, 5779:42, 5780:37, 5792:3, 5804:10, 5804:43, 5812:29, 5814:33, 5827:47, 5828:45, 5842:16, 5844:11, 5846:21, 5846:29, 5858:8
dealt [1] - 5780:31
decade [1] - 5852:47
decades [4] - 5793:10, 5793:20, 5793:31, 5799:28
decide [1] - 5852:45
deciding [2] - 5809:33, 5840:31
decision [4] - 5840:39, 5845:28, 5852:12, 5856:24
decision-making [1] - 5845:28
decisions [5] - 5768:2, 5771:20, 5780:31, 5781:20, 5781:36
dedicated [2] - 5786:46, 5799:8
deemed [1] - 5766:27
define [1] - 5813:44
defined [2] - 5821:6, 5831:10
defining [1] - 5806:38
definitely [8] -

5785:41, 5786:6,
5807:17, 5813:23,
5815:15, 5818:20,
5841:10, 5845:40
definition [1] -
5843:34
definitional [1] -
5812:38
degree [5] - 5778:32,
5785:27, 5796:35,
5851:14
delay [1] - 5816:10
delicate [1] - 5827:45
deliver [9] - 5772:28,
5779:46, 5787:14,
5792:15, 5792:25,
5815:23, 5820:30,
5820:34, 5850:36
delivered [9] - 5791:7,
5792:5, 5792:7,
5792:28, 5792:34,
5832:31, 5839:43,
5848:1, 5848:25
delivering [6] -
5792:23, 5798:37,
5832:38, 5832:39,
5849:31, 5860:11
delivery [6] - 5779:43,
5780:3, 5792:47,
5812:12, 5812:44,
5824:3
demand [3] - 5814:5,
5820:8
demands [1] -
5779:33
demonstrate [1] -
5792:26
Deniliquin [1] -
5857:33
department [27] -
5765:38, 5768:34,
5769:7, 5771:29,
5774:3, 5775:28,
5776:1, 5790:8,
5796:39, 5797:27,
5798:30, 5816:19,
5821:22, 5825:7,
5825:17, 5826:16,
5826:24, 5827:13,
5827:31, 5840:18,
5840:35, 5843:19,
5844:6, 5844:10,
5844:37, 5844:39,
5848:35
Department [5] -
5819:46, 5820:30,
5821:4, 5858:17,
5860:46
departments [16] -
5768:44, 5769:30,
5769:47, 5770:35,
5770:46, 5771:2,
5771:3, 5771:8,
5772:47, 5784:36,
5794:30, 5839:14,
5841:34, 5842:7,
5844:43, 5844:46
deployed [2] -
5791:41, 5843:8
depressant [1] -
5767:21
depression [2] -
5825:30, 5826:17
deputy [3] - 5798:43,
5801:30, 5803:9
describe [3] -
5798:25, 5853:18,
5859:11
described [9] -
5766:13, 5766:16,
5768:9, 5772:4,
5785:4, 5789:15,
5789:16, 5791:21,
5791:39
describing [2] -
5836:32, 5848:4
description [1] -
5819:41
desirable [1] -
5770:38
deskilling [1] -
5841:22
desks [1] - 5851:27
detail [2] - 5777:26,
5828:46
details [2] - 5841:44,
5861:34
detained [1] - 5774:1
detect [1] - 5770:15
detected [5] -
5770:12, 5770:18,
5772:17, 5772:21,
5775:43
detecting [1] -
5774:17
deteriorated [1] -
5825:17
determinants [4] -
5822:33, 5822:41,
5823:11, 5823:13
devalues [1] - 5817:10
develop [3] - 5794:16,
5795:18, 5821:38
developed [1] -
5793:6
developing [3] -
5792:40, 5794:9,
5824:39
development [1] -
5785:45
diabetes [9] -
5811:43, 5828:31,
5828:32, 5828:34,
5832:10, 5833:4,
5833:6, 5834:13,
5834:14
diabetic [1] - 5832:8
diagnosed [1] -
5775:37
diagnosing [1] -
5814:38
diagnosis [1] -
5814:39
dial [1] - 5828:9
dialogue [2] -
5821:13, 5821:19
dictates [1] - 5770:15
dietetics [1] - 5814:10
dietician [1] - 5833:4
difference [2] -
5788:39, 5832:32
differences [1] -
5816:38
different [32] -
5770:26, 5771:44,
5773:39, 5775:1,
5778:25, 5779:38,
5788:41, 5794:15,
5794:27, 5797:21,
5799:46, 5805:30,
5814:47, 5823:4,
5823:5, 5823:6,
5824:8, 5824:41,
5824:47, 5825:22,
5828:42, 5829:20,
5834:32, 5835:2,
5843:26, 5854:27,
5857:47, 5859:25,
5859:39, 5861:14,
5861:30
differential [1] -
5815:41
difficult [12] - 5791:37,
5806:5, 5811:31,
5812:35, 5818:21,
5835:29, 5845:9,
5845:16, 5853:42,
5858:47, 5862:23
difficulty [1] - 5809:6
dig [1] - 5830:42
digitally [1] - 5780:16
diluting [1] - 5829:17
diminished [1] -
5847:41
dip [1] - 5798:16
direct [3] - 5799:14,
5842:40, 5843:2
directionally [1] -
5810:18
directly [1] - 5829:44
directors [2] -
5798:42, 5798:43
directorships [1] -
5798:19
dis [1] - 5783:2
dis-benefits [1] -
5783:2
disadvantage [1] -
5862:27
discharge [11] -
5765:39, 5781:14,
5781:16, 5781:31,
5782:22, 5782:37,
5784:22, 5784:37,
5785:4, 5795:25,
5850:17
discharged [1] -
5781:13
disciplines [2] -
5791:3, 5798:14
discourage [1] -
5823:14
discourse [1] -
5854:16
discrepancies [1] -
5768:4
discrepancy [2] -
5846:47, 5847:3
discussed [2] -
5800:2, 5846:3
discussing [1] -
5848:4
discussion [5] -
5766:35, 5799:35,
5841:13, 5841:18,
5848:30
discussions [2] -
5821:44, 5857:20
disease [6] - 5779:6,
5815:45, 5816:1,
5822:40, 5828:33
diseases [3] -
5793:11, 5798:3,
5815:37
disincentive [1] -
5807:24
dispensary [2] -
5766:26, 5794:12
dispense [2] -
5774:14, 5782:35
dispensing [2] -
5768:22, 5789:29
disrepute [1] - 5778:2
distinct [3] - 5771:40,
5793:29, 5834:31
distinction [2] -
5798:4, 5844:23
distribute [1] -
5766:11
distribution [7] -
5774:2, 5788:26,
5820:13, 5821:25,
5830:40, 5831:3,
5848:39
District [1] - 5861:43
district [7] - 5823:3,
5835:25, 5839:27,
5839:29, 5857:14,
5857:31, 5860:37
districts [2] - 5858:14,
5858:21
dive [2] - 5822:31,
5852:41
diversification [1] -
5829:30
divide [1] - 5850:11
doctor [30] - 5766:8,
5766:25, 5767:46,
5768:31, 5772:11,
5772:15, 5774:20,
5775:32, 5776:16,
5776:23, 5778:34,
5780:38, 5784:24,
5813:2, 5814:2,
5817:10, 5830:23,
5835:8, 5835:16,
5835:20, 5837:15,
5838:25, 5844:30,
5854:23, 5854:43,
5855:32, 5857:9,
5858:25, 5859:28,
5859:37
Doctor [1] - 5836:9
doctoring [1] - 5835:9
Doctors [2] - 5804:38,
5858:16
doctors [54] - 5768:4,
5771:30, 5774:46,
5775:4, 5776:35,
5777:18, 5777:31,
5777:42, 5778:1,
5778:13, 5781:6,
5781:10, 5790:44,
5806:17, 5806:25,
5807:36, 5808:4,
5810:9, 5810:10,
5819:4, 5820:2,
5820:10, 5820:12,
5821:24, 5821:36,
5823:8, 5836:27,
5841:5, 5848:31,
5849:37, 5850:38,
5851:15, 5851:27,
5851:30, 5851:31,
5852:28, 5852:30,
5852:32, 5852:41,
5854:39, 5855:3,
5855:23, 5855:40,
5855:42, 5855:44,
5855:45, 5856:17,

5856:36, 5858:3,
5860:17, 5860:31,
5860:32, 5860:40,
5862:20
Doctors' [2] - 5801:39,
5837:33
doctors' [2] - 5780:35,
5850:37
document [1] -
5842:40
dollar [1] - 5775:18
dollars [1] - 5816:44
domestically [1] -
5806:24
Dominish [2] -
5800:36, 5800:44
donating [1] - 5857:22
done [23] - 5767:30,
5772:37, 5776:16,
5776:35, 5779:18,
5780:33, 5784:35,
5790:2, 5798:16,
5799:28, 5807:5,
5808:17, 5815:14,
5821:14, 5824:39,
5838:23, 5848:23,
5848:26, 5852:8,
5852:9, 5852:47,
5859:43, 5861:23
door [3] - 5842:44,
5843:34, 5850:31
doorstep [1] - 5816:19
dosage [2] - 5766:3,
5767:39
dosages [1] - 5776:28
dose [6] - 5772:12,
5775:41, 5776:42,
5777:28, 5777:30,
5780:26
doses [1] - 5777:26
dosing [2] - 5775:46,
5776:44
double [3] - 5823:11,
5834:39, 5850:39
double-check [1] -
5834:39
doubling [1] - 5767:8
doubt [2] - 5789:8,
5848:43
down [18] - 5766:26,
5770:31, 5770:45,
5772:4, 5774:3,
5776:42, 5781:45,
5816:1, 5823:4,
5831:7, 5832:10,
5833:36, 5834:14,
5850:39, 5851:19,
5852:6, 5859:43,
5861:29
downplay [2] -
5774:30, 5774:47
DPAs [1] - 5862:19
Dr [57] - 5763:28,
5763:38, 5764:43,
5764:47, 5774:40,
5778:37, 5785:19,
5789:15, 5796:10,
5801:38, 5802:11,
5802:14, 5803:42,
5803:45, 5804:33,
5804:36, 5807:29,
5807:47, 5809:43,
5811:9, 5812:9,
5814:29, 5817:6,
5817:43, 5818:16,
5827:24, 5827:29,
5829:23, 5829:40,
5831:26, 5831:29,
5831:31, 5833:3,
5833:46, 5835:41,
5837:19, 5838:37,
5840:1, 5840:10,
5840:26, 5841:16,
5842:45, 5842:46,
5846:12, 5847:29,
5851:6, 5854:19,
5855:26, 5855:37,
5857:37, 5858:45,
5859:17, 5861:2
DR [111] - 5764:33,
5764:38, 5764:45,
5765:8, 5765:15,
5765:22, 5771:22,
5772:25, 5772:34,
5774:43, 5777:8,
5778:18, 5780:41,
5780:46, 5781:16,
5782:14, 5785:26,
5786:17, 5787:9,
5787:24, 5787:30,
5787:39, 5788:37,
5789:5, 5789:33,
5794:27, 5795:1,
5795:12, 5796:42,
5798:41, 5799:37,
5801:19, 5802:14,
5802:19, 5802:24,
5802:28, 5802:33,
5802:40, 5803:45,
5804:4, 5804:8,
5804:14, 5804:36,
5804:41, 5804:47,
5805:4, 5805:44,
5806:1, 5806:8,
5806:28, 5806:35,
5807:17, 5807:23,
5807:28, 5808:12,
5808:45, 5809:46,
5810:5, 5810:17,
5811:1, 5811:23,
5812:15, 5813:46,
5814:36, 5815:26,
5816:25, 5817:5,
5817:43, 5818:18,
5818:39, 5819:22,
5822:30, 5823:18,
5824:29, 5824:36,
5824:47, 5826:9,
5826:14, 5827:8,
5827:28, 5829:27,
5832:3, 5832:42,
5836:32, 5840:26,
5841:25, 5842:12,
5842:19, 5842:40,
5846:14, 5847:13,
5848:6, 5848:47,
5849:19, 5851:10,
5852:5, 5852:30,
5853:11, 5853:13,
5853:16, 5853:23,
5853:29, 5853:31,
5854:21, 5855:39,
5859:23, 5862:8,
5862:16, 5862:18,
5862:33, 5862:42
drain [1] - 5826:20
dramatic [2] - 5781:4,
5831:8
drawing [1] - 5809:3
drawn [1] - 5831:2
drift [3] - 5806:23,
5848:21, 5851:8
drive [3] - 5811:12,
5811:15, 5854:4
drivers [1] - 5823:12
dropped [2] - 5849:10,
5852:35
drops [1] - 5833:30
drug [6] - 5776:42,
5777:22, 5798:26,
5824:12, 5829:5
drugs [1] - 5828:32
Dubbo [4] - 5810:11,
5811:11, 5831:39,
5835:5
due [4] - 5765:24,
5771:20, 5780:20,
5780:21
during [7] - 5771:19,
5789:39, 5808:20,
5831:28, 5851:22,
5854:23, 5856:23
duty [2] - 5767:16,
5791:3
dwelling [1] - 5843:47
dying [1] - 5810:3
dynamics [1] -
5840:43
E
ear [1] - 5858:13
early [13] - 5774:18,
5785:44, 5785:46,
5793:34, 5795:2,
5805:24, 5815:30,
5828:41, 5847:22,
5856:9, 5856:17,
5856:43
ease [2] - 5855:22,
5858:4
easiest [1] - 5854:6
easily [1] - 5844:6
easy [3] - 5775:20,
5789:29, 5827:20
eat [1] - 5823:39
eclipse [1] - 5840:20
economic [2] -
5817:43, 5861:19
economically [5] -
5816:23, 5839:18,
5840:11, 5857:3,
5862:30
economies [3] -
5839:8, 5840:31,
5843:26
economist [1] -
5840:5
economy [1] -
5816:28
ED [2] - 5785:7,
5842:21
Ed [1] - 5763:26
Eden [1] - 5858:24
edges [1] - 5857:13
EDs [3] - 5785:2,
5840:3, 5845:38
educated [1] -
5793:21
educating [1] -
5829:35
education [14] -
5781:44, 5785:22,
5791:19, 5791:35,
5791:45, 5792:2,
5792:6, 5792:7,
5792:16, 5792:22,
5798:15, 5820:34,
5833:18, 5850:3
educational [1] -
5793:44
educator [4] -
5795:29, 5796:5,
5796:16, 5833:5
educators [9] -
5786:23, 5786:26,
5791:7, 5791:9,
5791:32, 5791:40,
5792:7, 5792:38,
5797:3
effect [4] - 5789:47,
5820:6, 5841:22,
5844:29
effective [6] - 5780:37,
5780:41, 5814:39,
5816:41, 5857:4,
5858:42
effectively [2] -
5774:1, 5815:16
effects [6] - 5776:11,
5777:16, 5781:38,
5788:26, 5837:40,
5859:5
efficient [4] - 5789:23,
5816:40, 5826:38,
5839:18
efforts [2] - 5770:8,
5787:43
eight [1] - 5771:39
either [7] - 5791:24,
5810:38, 5827:22,
5832:35, 5836:8,
5845:32, 5852:23
elaborate [1] -
5834:42
elderly [1] - 5840:22
election [1] - 5853:21
electronically [3] -
5766:10, 5780:11,
5792:28
eligible [1] - 5820:2
embarking [1] -
5835:46
embedded [1] -
5766:17
embraced [1] -
5851:40
emergency [37] -
5765:38, 5768:40,
5769:7, 5771:28,
5784:43, 5811:4,
5811:6, 5816:19,
5825:7, 5825:16,
5825:40, 5826:15,
5826:23, 5827:13,
5827:31, 5836:29,
5838:4, 5839:14,
5839:19, 5840:18,
5841:34, 5842:7,
5843:19, 5843:20,
5844:5, 5844:10,
5844:33, 5844:36,
5844:37, 5844:39,
5844:43, 5844:46,
5845:4, 5846:4,
5846:6, 5848:35,
5855:15
Emily [1] - 5763:36
emotionally [1] -

5788:5	enhances [1] -	5858:35	5808:19, 5856:6	5778:27, 5778:32,
employ [1] - 5837:33	5796:25	especially [10] -	excited [3] - 5777:29,	5785:46, 5790:24,
employed [3] -	enhancing [1] -	5768:39, 5809:17,	5777:31, 5777:32	5805:29, 5807:15,
5769:34, 5774:1,	5793:1	5813:41, 5815:28,	excitement [1] -	5808:5, 5809:3,
5791:41	enjoy [1] - 5778:20	5828:26, 5831:10,	5778:8	5829:23, 5852:43,
employer [10] -	enjoys [1] - 5777:38	5846:40, 5850:3,	excuse [2] - 5801:9,	5855:24, 5855:42,
5835:27, 5836:11,	enormous [1] -	5854:22, 5854:25	5801:11	5859:36, 5860:19,
5838:28, 5838:29,	5859:32	esque [1] - 5861:28	excused [1] - 5863:7	5860:32
5853:4, 5856:13,	enormously [1] -	essence [1] - 5795:44	execute [1] - 5833:1	experienced [3] -
5856:29, 5856:44,	5829:47	essential [1] - 5814:37	exemption [3] -	5776:36, 5776:38,
5859:33, 5859:38	ensure [6] - 5769:28,	essentially [2] -	5835:16, 5838:16,	5780:2
employing [1] -	5793:20, 5820:39,	5769:33, 5857:22	5856:39	experiences [2] -
5857:7	5821:6, 5836:11,	et [2] - 5773:36,	exemptions [2] -	5795:2, 5862:34
employment [1] -	5860:16	5835:5	5836:14, 5857:46	expertise [1] -
5835:20	ensuring [1] - 5792:39	evaluate [1] - 5861:13	exercise [6] - 5811:38,	5798:46
empty [1] - 5819:25	enter [1] - 5782:42	evaluated [1] - 5781:2	5812:22, 5812:26,	experts [2] - 5798:2,
enable [8] - 5769:35,	entering [5] - 5766:45,	event [3] - 5783:17,	5814:10, 5823:39,	5798:3
5786:14, 5794:44,	5783:2, 5789:2,	5815:11, 5816:11	5833:3	explain [3] - 5765:32,
5795:43, 5795:45,	5794:3, 5821:29	evidence [26] -	exercises [1] - 5835:3	5766:38, 5785:20
5814:11, 5821:38,	enters [1] - 5766:39	5765:11, 5766:35,	exhausting [2] -	explore [2] - 5792:13,
5835:19	entire [2] - 5765:39,	5767:43, 5769:39,	5787:45, 5788:5	5814:29
enact [1] - 5782:41	5824:33	5772:25, 5773:2,	exhibit [1] - 5764:8	explored [2] -
enacted [1] - 5833:10	entirely [4] - 5768:2,	5781:1, 5790:20,	exist [4] - 5799:44,	5769:26, 5796:19
encompass [1] -	5817:10, 5823:18,	5791:21, 5793:34,	5799:45, 5825:22,	expose [1] - 5794:20
5845:32	5853:25	5799:17, 5800:36,	5843:3	exposed [4] -
encompassing [1] -	entitlements [2] -	5801:39, 5802:31,	existence [1] -	5794:15, 5794:23,
5845:13	5856:20, 5856:23	5803:29, 5805:10,	5847:11	5854:39, 5857:10
encouraging [1] -	entry [4] - 5765:37,	5807:7, 5808:2,	existing [7] - 5774:28,	exposure [7] -
5850:5	5785:40, 5786:39,	5809:38, 5821:10,	5789:36, 5790:4,	5795:13, 5795:16,
end [25] - 5766:15,	5787:3	5823:43, 5829:28,	5808:15, 5827:2,	5795:34, 5854:23,
5770:7, 5770:18,	environment [9] -	5829:29, 5838:41,	5848:16, 5859:12	5855:24, 5858:4,
5770:31, 5772:17,	5768:18, 5774:10,	5838:47, 5841:21	exists [4] - 5830:4,	5860:17
5772:22, 5774:19,	5786:4, 5795:13,	exacerbated [1] -	5834:3, 5843:5,	express [1] - 5842:10
5775:11, 5775:21,	5795:32, 5795:33,	5782:23	5843:35	expressed [1] -
5785:30, 5789:27,	5797:5, 5813:37,	exact [3] - 5839:4,	exorbitant [1] - 5857:5	5847:3
5790:31, 5790:39,	5859:21	5841:44, 5862:35	expand [3] - 5786:30,	extend [1] - 5852:12
5790:45, 5791:4,	EOI [2] - 5773:8,	exactly [5] - 5834:34,	5794:4, 5845:32	extended [2] -
5810:20, 5819:13,	5861:7	5836:17, 5838:16,	expanded [1] -	5806:15, 5807:31
5822:6, 5823:8,	EPC [1] - 5812:24	5840:13, 5851:43	5856:12	extension [1] -
5825:3, 5825:15,	episodic [1] - 5848:2	exam [1] - 5785:30	expansion [1] -	5772:29
5825:39, 5825:43,	equally [3] - 5785:13,	examination [1] -	5845:29	extent [8] - 5766:6,
5851:3	5805:14, 5805:18	5815:1	expect [3] - 5767:22,	5768:13, 5790:17,
endocrinology [1] -	equipped [1] - 5857:8	example [19] - 5769:4,	5768:31, 5776:22	5790:28, 5792:46,
5832:8	equity [2] - 5788:26,	5769:9, 5772:46,	expectation [3] -	5795:42, 5802:46,
endorsement [1] -	5841:13	5778:39, 5779:43,	5793:16, 5862:10,	5806:30
5824:14	equivalent [3] -	5783:43, 5787:9,	5862:27	external [1] - 5782:27
engage [1] - 5782:27	5839:12	5809:17, 5819:29,	expectations [2] -	extra [10] - 5771:9,
engaged [2] -	era [1] - 5807:4	5822:18, 5822:23,	5807:1, 5860:20	5773:43, 5776:21,
5816:25, 5838:9	error [4] - 5770:18,	5826:3, 5826:5,	expecting [2] -	5776:27, 5783:27,
engagement [2] -	5772:17, 5772:19,	5827:1, 5830:6,	5779:19, 5809:24	5795:36, 5798:1,
5816:29, 5857:16	5772:21	5838:7, 5840:23,	expects [1] - 5850:28	5808:29, 5811:20
engaging [1] -	errors [10] - 5768:5,	5858:24, 5862:26	expedited [1] -	extremely [3] -
5852:46	5770:4, 5770:5,	exams [1] - 5788:8	5851:32	5766:32, 5785:44,
England [4] - 5820:45,	5770:11, 5770:15,	Excellence [1] -	expense [1] - 5840:16	5838:32
5821:32, 5839:24,	5772:40, 5774:17,	5797:26	expensive [9] -	extremis [1] - 5826:24
5862:34	5777:36, 5781:4,	excellent [4] - 5798:5,	5814:41, 5833:32,	eyes [1] - 5828:10
enhance [1] - 5779:45	5793:1	5823:18, 5850:34,	5836:44, 5837:20,	
enhanced [3] -	escalate [1] - 5827:44	5855:24	5842:24, 5853:31	
5793:2, 5812:24,	escalated [1] -	except [1] - 5852:43	experience [15] -	
5814:4		excessive [2] -		

F

fabulous [1] - 5830:3

face [8] - 5792:3, 5813:2, 5815:14, 5832:24
face-to-face [4] - 5792:3, 5813:2, 5815:14, 5832:24
faced [1] - 5806:26
facilitate [2] - 5786:18, 5792:29
facilities [8] - 5769:35, 5771:30, 5773:46, 5779:22, 5789:8, 5792:9, 5794:45, 5835:3
facility [11] - 5768:36, 5769:9, 5781:12, 5784:4, 5793:46, 5799:23, 5811:5, 5837:22, 5838:14, 5841:19, 5846:7
fact [5] - 5765:30, 5782:24, 5807:43, 5808:9, 5820:1
factor [2] - 5806:25, 5819:39
factors [5] - 5769:16, 5777:3, 5779:1, 5816:10, 5823:7
faculties [1] - 5805:6
faculty [3] - 5764:40, 5801:32, 5804:1
fail [2] - 5836:44, 5838:4
failed [6] - 5810:31, 5836:5, 5836:35, 5858:9, 5859:12, 5859:26
failing [6] - 5782:8, 5800:4, 5836:4, 5836:32, 5858:9, 5858:20
fails [1] - 5836:41
failure [4] - 5776:30, 5828:34, 5829:14, 5853:46
failures [1] - 5828:1
fair [5] - 5780:39, 5814:26, 5824:26, 5831:28, 5862:3
fairly [9] - 5766:14, 5770:44, 5786:36, 5786:39, 5787:3, 5797:21, 5797:22, 5814:38, 5827:17
faith [1] - 5813:3
fall [2] - 5795:34, 5812:35
falls [1] - 5836:27
familiar [1] - 5765:45
family [2] - 5813:32, 5817:16
Far [1] - 5861:43
far [11] - 5769:44, 5791:23, 5811:31, 5830:19, 5832:25, 5843:44, 5846:6, 5851:3, 5857:4, 5857:27
fashion [2] - 5812:42, 5833:44
faster [2] - 5775:16, 5851:36
fatal [1] - 5784:14
fatigue [1] - 5824:6
fault [1] - 5784:23
favour [2] - 5810:1, 5828:14
favouring [2] - 5823:12, 5823:13
favourite [2] - 5828:9, 5852:31
features [1] - 5826:16
federal [5] - 5782:41, 5782:43, 5782:45, 5819:3, 5850:41
fee [2] - 5846:28, 5862:36
feedback [3] - 5781:5, 5841:10, 5857:26
feeding [1] - 5860:36
fell [1] - 5800:29
fellowed [1] - 5857:30
fellowship [1] - 5841:7
fellowships [1] - 5799:44
felt [2] - 5813:24, 5849:8
females [1] - 5807:18
few [9] - 5780:9, 5783:19, 5816:3, 5827:35, 5829:27, 5837:10, 5844:11, 5845:17, 5851:19
figure [3] - 5794:31, 5795:7, 5839:4
figures [1] - 5822:32
fill [5] - 5818:44, 5819:18, 5855:14, 5855:18
filled [7] - 5818:42, 5818:43, 5818:44, 5819:17, 5820:1, 5821:13, 5855:13
filling [2] - 5787:16, 5859:34
final [2] - 5794:19, 5794:21
finally [1] - 5804:33
financial [6] - 5775:26, 5783:1, 5810:27, 5840:34, 5840:38, 5842:35
financially [3] - 5833:37, 5846:31, 5854:30
fine [4] - 5792:27, 5815:33, 5837:8, 5837:23
finish [2] - 5840:27, 5847:22
finished [1] - 5855:36
fire [1] - 5842:9
first [20] - 5764:3, 5783:19, 5785:14, 5789:26, 5800:29, 5803:15, 5805:38, 5813:26, 5813:28, 5814:2, 5818:43, 5820:1, 5832:24, 5838:18, 5841:26, 5842:9, 5842:12, 5844:36, 5851:11, 5861:16
fiscal [3] - 5836:23, 5839:35, 5857:44
fiscally [1] - 5835:35
fit [6] - 5769:4, 5777:20, 5815:32, 5816:44, 5847:21, 5850:44
five [20] - 5767:22, 5767:25, 5769:21, 5781:31, 5783:22, 5784:13, 5797:47, 5807:35, 5824:38, 5826:35, 5827:10, 5844:7, 5844:10, 5851:12, 5851:23, 5855:47, 5856:45, 5857:29, 5861:30, 5863:4
five-day [1] - 5767:22
five-year [1] - 5855:47
fix [1] - 5775:21
fixed [1] - 5775:20
fixing [1] - 5775:19
flexibility [2] - 5847:24, 5852:20
flexible [4] - 5821:25, 5822:26, 5852:18, 5860:12
flies [1] - 5832:33
flip [1] - 5836:40
floor [1] - 5811:32
flow [3] - 5768:41, 5836:41, 5859:5
flow-on [1] - 5859:5
flow-through [1] - 5836:41
flows [1] - 5794:15
fluids [1] - 5846:20
fly [1] - 5832:31
fly-in/fly-out [1] - 5832:31
Flying [1] - 5836:9
Flynn [1] - 5855:1
focus [11] - 5770:8, 5775:1, 5776:27, 5777:9, 5784:25, 5823:27, 5825:1, 5825:2, 5838:29, 5838:30, 5854:5
focused [1] - 5778:41
foil [1] - 5769:10
follow [4] - 5783:9, 5808:28, 5814:7, 5825:35
follow-up [3] - 5783:9, 5808:28, 5814:7
followed [4] - 5853:45, 5853:46, 5853:47
following [1] - 5831:25
foot [2] - 5823:37, 5823:40
forbid [1] - 5835:21
forced [2] - 5770:6, 5780:16
foremost [1] - 5861:16
forestall [1] - 5811:43
forget [2] - 5818:6, 5835:32
forgetting [1] - 5825:3
form [8] - 5765:24, 5798:47, 5808:40, 5810:33, 5832:36, 5857:45, 5858:18, 5861:41
formalised [2] - 5793:15, 5853:33
formally [1] - 5799:25
former [3] - 5801:29, 5802:16, 5839:29
forms [1] - 5779:21
formulations [2] - 5775:3, 5777:27
forward [4] - 5821:12, 5849:4, 5858:2, 5860:26
four [16] - 5783:47, 5784:33, 5787:15, 5787:22, 5787:24, 5788:4, 5788:40, 5788:43, 5794:6, 5795:14, 5796:16, 5807:20, 5807:35, 5818:20, 5824:37, 5861:30
fracture [1] - 5853:45
fractures [2] - 5843:12, 5846:21
fragmented [1] - 5848:17
frame [1] - 5852:11
Fraser [1] - 5763:29
free [3] - 5770:24, 5795:44, 5852:23
frequently [2] - 5815:43, 5821:17
friend [2] - 5829:41, 5829:43
fringe [1] - 5827:44
front [3] - 5777:19, 5842:44, 5850:31
frustrating [1] - 5799:4
frustrations [1] - 5852:1
FTE [5] - 5789:26, 5807:7, 5808:6, 5808:8, 5808:10
FTEs [2] - 5808:6, 5818:19
full [19] - 5764:21, 5764:30, 5774:1, 5788:7, 5793:46, 5796:29, 5797:5, 5802:11, 5803:4, 5803:42, 5804:16, 5804:33, 5807:5, 5807:19, 5807:24, 5810:37, 5813:14, 5814:8, 5819:35
full-time [3] - 5788:7, 5793:46, 5807:5
Fuller [1] - 5763:30
fully [2] - 5794:28, 5849:32
function [5] - 5772:13, 5775:46, 5826:25, 5839:12, 5843:37
fund [7] - 5771:16, 5773:12, 5787:4, 5791:27, 5824:18, 5847:1, 5847:2
fundamentally [1] - 5846:44
funded [10] - 5786:29, 5786:31, 5819:46, 5820:31, 5820:34, 5836:2, 5844:19, 5846:44, 5850:9, 5850:26
funding [59] - 5769:26, 5769:33, 5770:26, 5770:30, 5770:31, 5770:36, 5770:45, 5771:1,

5771:20, 5773:34,
5773:43, 5780:20,
5784:35, 5786:37,
5786:46, 5787:34,
5790:46, 5791:19,
5791:27, 5791:46,
5794:29, 5794:30,
5794:44, 5795:43,
5796:4, 5796:33,
5814:12, 5816:39,
5819:40, 5820:21,
5820:26, 5820:40,
5821:1, 5821:4,
5830:43, 5831:43,
5834:30, 5835:47,
5839:9, 5843:18,
5844:28, 5844:34,
5846:39, 5846:40,
5848:39, 5848:40,
5850:6, 5850:22,
5852:22, 5854:4,
5855:3, 5857:47,
5860:47, 5861:8,
5861:10, 5861:11,
5861:36

Funding [1] - 5763:9
funds [2] - 5823:44,
5860:12
future [7] - 5787:18,
5809:18, 5813:39,
5836:22, 5849:1,
5850:2, 5854:2

G

gained [1] - 5794:46
gap [7] - 5780:17,
5780:22, 5826:5,
5839:9, 5850:11,
5854:40, 5860:3
gaps [1] - 5827:29
gash [1] - 5769:5
gather [4] - 5788:46,
5819:24, 5821:10,
5847:47
General [5] - 5801:33,
5801:36, 5804:1,
5804:22, 5820:30
general [154] -
5768:39, 5779:23,
5779:26, 5779:30,
5788:15, 5793:13,
5794:13, 5801:29,
5802:16, 5804:11,
5805:40, 5806:10,
5806:11, 5806:32,
5806:39, 5806:44,
5806:46, 5807:14,
5807:32, 5808:25,
5808:27, 5808:41,

5809:26, 5810:29,
5812:5, 5813:3,
5814:26, 5814:32,
5816:17, 5817:21,
5818:6, 5819:31,
5820:3, 5822:34,
5822:35, 5822:37,
5822:42, 5823:15,
5823:20, 5824:2,
5824:40, 5824:41,
5825:4, 5825:26,
5826:6, 5826:28,
5828:20, 5828:26,
5828:30, 5828:44,
5829:2, 5829:4,
5829:5, 5829:6,
5829:9, 5829:18,
5829:24, 5829:29,
5829:31, 5829:36,
5829:37, 5830:31,
5831:5, 5831:9,
5831:19, 5832:9,
5832:22, 5832:37,
5832:42, 5833:14,
5835:10, 5835:29,
5835:34, 5836:2,
5836:10, 5836:12,
5837:12, 5837:24,
5837:39, 5838:21,
5838:30, 5838:34,
5839:33, 5840:7,
5842:29, 5843:16,
5843:24, 5844:6,
5844:40, 5844:42,
5845:18, 5845:25,
5845:46, 5846:8,
5846:15, 5846:17,
5846:18, 5846:19,
5846:25, 5846:33,
5846:35, 5846:41,
5846:45, 5847:2,
5847:4, 5847:10,
5847:19, 5848:8,
5848:14, 5848:22,
5848:33, 5848:40,
5849:5, 5849:14,
5849:27, 5849:38,
5850:3, 5850:9,
5850:23, 5850:26,
5850:42, 5851:8,
5851:18, 5852:39,
5852:43, 5852:46,
5853:2, 5853:13,
5853:33, 5853:35,
5853:40, 5854:22,
5854:26, 5854:29,
5854:35, 5854:39,
5854:45, 5855:1,
5855:5, 5855:7,
5855:25, 5855:27,
5855:33, 5855:40,

5855:43, 5856:9,
5856:19, 5857:34,
5860:19, 5860:22
generalisation [1] -
5777:38

generalism [1] -
5823:33

generalist [4] -
5777:12, 5820:4,
5838:28, 5856:13

generalists [3] -
5778:38, 5823:24,
5823:32

generally [7] -
5771:33, 5777:38,
5781:30, 5788:16,
5805:41, 5807:15,
5847:13

generation [4] -
5796:9, 5807:18,
5808:4, 5854:12

generational [2] -
5805:39, 5806:46

gentleman [1] -
5826:34

Georgina [7] -
5801:35, 5804:19,
5817:47, 5818:40,
5819:22, 5849:20,
5859:32

GEORGINA [1] -
5802:1

geriatric [1] - 5800:8

Germany [1] - 5823:46

given [10] - 5770:22,
5772:12, 5783:29,
5785:4, 5793:26,
5801:7, 5838:47,
5848:47, 5849:30,
5852:17

givers [1] - 5783:9

glory [1] - 5839:29

Glover [1] - 5763:27

God [1] - 5835:20

Goulburn [1] -
5809:15

Government [7] -
5773:3, 5773:28,
5773:33, 5782:39,
5782:44, 5800:30,
5820:23

government [11] -
5782:33, 5782:41,
5782:45, 5786:29,
5786:38, 5786:40,
5786:47, 5819:3,
5848:35, 5850:41,
5858:15

government's [1] -
5782:43

GP [80] - 5768:25,
5781:32, 5783:25,
5783:30, 5784:42,
5784:46, 5804:44,
5809:17, 5809:20,
5809:23, 5810:7,
5810:8, 5810:31,
5810:37, 5810:41,
5811:11, 5811:17,
5811:19, 5811:25,
5812:42, 5812:43,
5814:20, 5815:18,
5817:28, 5817:34,
5817:44, 5818:19,
5818:21, 5818:28,
5818:46, 5819:1,
5819:5, 5819:11,
5819:13, 5820:38,
5827:39, 5828:24,
5828:25, 5829:44,
5833:33, 5835:11,
5836:11, 5836:28,
5836:39, 5838:13,
5838:14, 5839:20,
5839:24, 5839:46,
5840:2, 5841:23,
5841:47, 5843:37,
5844:31, 5848:38,
5849:22, 5849:46,
5850:16, 5851:12,
5852:12, 5852:34,
5852:45, 5854:3,
5854:31, 5855:31,
5855:32, 5858:9,
5858:27, 5859:4,
5859:12, 5859:14,
5859:27, 5859:28,
5859:30, 5859:47,
5862:6

GP's [1] - 5862:30

GPs [58] - 5806:12,
5807:20, 5807:24,
5808:15, 5808:34,
5808:39, 5810:23,
5810:44, 5811:25,
5812:5, 5814:46,
5817:45, 5818:23,
5820:47, 5821:11,
5823:22, 5824:24,
5824:26, 5824:30,
5827:9, 5827:19,
5827:46, 5829:4,
5829:8, 5829:17,
5829:31, 5829:32,
5829:44, 5829:47,
5831:40, 5831:47,
5834:4, 5835:15,
5836:25, 5841:29,
5841:44, 5842:31,
5847:14, 5847:16,
5848:9, 5848:10,

5848:16, 5849:36,
5850:6, 5850:13,
5851:13, 5851:16,
5851:20, 5851:22,
5851:31, 5851:40,
5852:1, 5852:22,
5854:5, 5855:44,
5855:45, 5858:22,
5859:14

GPwSIs [1] - 5850:13

grad [1] - 5798:16

grade [9] - 5797:44,
5797:46, 5798:22,
5798:32, 5798:42,
5799:1, 5799:18

graduates [4] -

5808:4, 5849:26,
5849:29, 5860:27

grandchildren [1] -
5816:26

grant [2] - 5820:29,
5821:4

granted [2] - 5802:46,
5803:2

grateful [3] - 5773:3,
5801:14, 5863:5

great [17] - 5797:32,
5806:18, 5812:1,
5815:29, 5816:44,
5827:8, 5838:20,
5843:12, 5849:38,
5850:15, 5850:36,
5850:47, 5852:11,
5854:4, 5854:11,
5854:45, 5863:2

great [1] - 5778:21

greater [5] - 5805:32,
5820:9, 5820:12,
5820:13, 5821:39

greatest [3] - 5821:8,
5823:16, 5826:33

gregarious [1] -
5827:18

Griffith [1] - 5827:34

ground [7] - 5780:1,
5792:8, 5831:47,
5834:3, 5857:24,
5858:13, 5860:1

group [2] - 5788:40,
5815:45

groups [1] - 5798:5

grow [3] - 5849:11,
5849:32, 5858:2

growing [3] - 5808:42,
5820:16, 5849:13

growth [2] - 5820:17,
5841:40

guess [12] - 5775:35,
5776:6, 5777:1,
5793:33, 5793:35,

5796:3, 5800:1,
5839:7, 5841:25,
5846:38, 5847:7,
5857:47
guide [1] - 5775:45
guiding [1] - 5791:9

H

H7.9 [1] - 5802:42
half [7] - 5788:38,
5804:29, 5806:12,
5808:26, 5812:2,
5824:37, 5861:46
Hamish [1] - 5850:25
hand [6] - 5784:10,
5827:24, 5832:34,
5838:38, 5840:26,
5841:16
handful [2] - 5822:4,
5822:6
hands [5] - 5820:24,
5827:41, 5831:35,
5831:39, 5832:24
hands-on [2] -
5831:35, 5832:24
happy [8] - 5778:9,
5788:19, 5792:12,
5800:6, 5836:21,
5842:12, 5843:12,
5851:44
hard [13] - 5777:36,
5797:4, 5797:7,
5807:44, 5808:13,
5816:33, 5829:19,
5840:19, 5847:18,
5858:25, 5858:28,
5858:32, 5862:21
hardly [1] - 5861:36
harm [3] - 5776:9,
5776:10, 5781:18
harp [1] - 5857:3
hate [1] - 5853:44
HBA1C [1] - 5832:10
head [2] - 5764:25,
5854:41
heading [1] - 5852:28
health [81] - 5776:26,
5777:2, 5779:5,
5779:16, 5784:2,
5786:41, 5795:32,
5799:31, 5801:31,
5803:10, 5805:42,
5806:43, 5807:14,
5809:35, 5809:36,
5810:2, 5810:24,
5811:28, 5812:11,
5812:16, 5812:34,
5812:40, 5813:20,
5813:22, 5813:39,

5813:47, 5814:9,
5814:24, 5815:32,
5816:2, 5816:13,
5816:14, 5816:15,
5816:43, 5822:41,
5823:12, 5823:13,
5823:24, 5823:30,
5824:17, 5824:19,
5824:32, 5829:4,
5829:7, 5829:34,
5830:7, 5830:21,
5831:21, 5833:36,
5834:4, 5835:24,
5836:37, 5837:46,
5839:6, 5839:27,
5839:28, 5840:7,
5840:15, 5840:16,
5840:19, 5840:35,
5850:27, 5850:36,
5850:38, 5853:46,
5856:1, 5856:16,
5856:21, 5856:34,
5857:40, 5858:13,
5858:14, 5858:15,
5858:21, 5859:7,
5860:37, 5861:22,
5862:9, 5862:39
Health [34] - 5763:36,
5768:20, 5773:6,
5794:45, 5797:27,
5797:28, 5803:10,
5813:27, 5818:22,
5819:46, 5820:30,
5821:5, 5831:19,
5832:17, 5834:24,
5834:29, 5836:7,
5836:26, 5836:38,
5837:14, 5838:9,
5838:10, 5838:11,
5839:36, 5845:29,
5847:9, 5849:3,
5850:25, 5856:28,
5858:18, 5859:1,
5860:44, 5860:46,
5861:43
Health's [1] - 5800:31
healthcare [12] -
5770:33, 5771:10,
5785:45, 5786:22,
5791:2, 5792:15,
5796:9, 5798:29,
5799:29, 5836:23,
5850:4, 5850:24
Healthcare [2] -
5763:9, 5782:17
Healthdirect [1] -
5843:4
HealthOne [1] -
5861:18
healthy [3] - 5813:39,

5845:18, 5851:4
heap [1] - 5833:15
hear [6] - 5771:1,
5796:44, 5813:1,
5814:18, 5840:27,
5861:12
heard [16] - 5766:35,
5801:38, 5808:2,
5809:38, 5813:28,
5814:16, 5821:11,
5831:11, 5831:23,
5831:37, 5835:26,
5839:27, 5846:31,
5856:11, 5856:15
hearing [3] - 5796:24,
5808:33, 5855:39
hearings [3] -
5805:24, 5831:28
heart [10] - 5783:18,
5796:7, 5815:9,
5816:11, 5828:1,
5828:33, 5828:34,
5828:39, 5829:14,
5853:46
heaven [1] - 5827:37
heavily [1] - 5817:45
held [1] - 5804:6
help [12] - 5790:44,
5795:16, 5795:17,
5799:45, 5820:42,
5826:29, 5833:17,
5855:22, 5858:40,
5858:41, 5859:1
helped [1] - 5811:44
helpful [5] - 5794:32,
5805:34, 5813:13,
5827:19, 5828:17
helping [2] - 5826:43,
5860:30
helps [2] - 5795:23,
5795:30
hepatic [1] - 5775:46
HETI [2] - 5853:23,
5857:21
hi [1] - 5854:31
high [10] - 5768:40,
5769:28, 5777:33,
5781:17, 5782:5,
5788:2, 5794:14,
5799:1, 5844:2,
5862:8
high-risk [3] -
5769:28, 5781:17,
5782:5
higher [6] - 5790:10,
5798:15, 5816:1,
5822:36, 5822:37,
5824:40
highest [2] - 5779:16,
5780:14

highlight [1] - 5798:41
highlights [1] -
5778:19
Hilbert [1] - 5763:35
Hill [3] - 5860:8,
5860:10, 5861:26
Hills [1] - 5823:3
hire [6] - 5771:31,
5787:6, 5787:15,
5791:35, 5858:29
historians [1] -
5768:19
historical [2] -
5840:29, 5840:30
historically [2] -
5770:34, 5796:22
histories [2] -
5774:35, 5796:44
history [12] - 5766:44,
5767:29, 5767:45,
5768:28, 5768:30,
5768:41, 5769:17,
5814:47, 5817:16,
5817:35, 5842:35
hit [2] - 5797:22,
5824:41
hoc [1] - 5827:6
Hoffman [14] -
5801:31, 5803:42,
5803:45, 5814:29,
5818:16, 5829:23,
5831:26, 5831:29,
5835:41, 5851:6,
5855:37, 5857:37,
5858:45, 5859:17
HOFFMAN [27] -
5802:9, 5803:45,
5804:4, 5804:8,
5804:14, 5807:17,
5810:5, 5814:36,
5817:43, 5818:18,
5818:39, 5819:22,
5824:29, 5829:27,
5842:12, 5842:19,
5851:10, 5852:5,
5852:30, 5853:11,
5853:16, 5853:23,
5853:29, 5855:39,
5859:23, 5862:8,
5862:16
Hoffman's [1] - 5861:2
hold [1] - 5770:10
holes [1] - 5787:16
holistic [1] - 5778:43
hollowing [2] -
5810:19, 5811:9
home [16] - 5766:46,
5767:17, 5767:40,
5783:19, 5783:28,
5833:26, 5833:33,

5833:38, 5833:39,
5846:23, 5847:35,
5847:37, 5847:38,
5847:41, 5855:30
Home [1] - 5833:43
hope [3] - 5810:43,
5826:40, 5858:1
hopeful [2] - 5818:33,
5826:45
hopefully [4] -
5825:41, 5826:15,
5843:36, 5858:4
hoping [1] - 5805:23
hospital [126] -
5765:32, 5765:33,
5765:35, 5765:37,
5765:40, 5766:8,
5766:9, 5766:30,
5766:37, 5766:39,
5766:45, 5766:47,
5767:3, 5767:12,
5767:16, 5767:26,
5767:27, 5768:43,
5769:34, 5769:40,
5769:42, 5769:43,
5770:35, 5770:37,
5770:38, 5771:23,
5771:27, 5771:39,
5773:34, 5774:24,
5776:35, 5779:5,
5781:19, 5783:17,
5784:8, 5784:10,
5784:43, 5785:11,
5785:23, 5785:35,
5785:38, 5785:41,
5786:2, 5786:7,
5786:37, 5786:41,
5786:42, 5787:11,
5787:27, 5788:16,
5788:22, 5788:24,
5788:30, 5789:12,
5789:17, 5790:20,
5790:22, 5790:27,
5790:29, 5790:36,
5790:38, 5794:6,
5794:8, 5794:44,
5795:5, 5795:13,
5795:16, 5795:20,
5795:23, 5795:27,
5795:30, 5796:6,
5796:17, 5797:1,
5798:24, 5808:21,
5808:24, 5809:21,
5809:24, 5809:27,
5811:5, 5812:29,
5827:45, 5828:22,
5829:41, 5831:16,
5831:46, 5833:32,
5836:29, 5837:13,
5837:29, 5837:34,

5837:47, 5838:32, 5839:29, 5839:36, 5840:3, 5840:6, 5840:29, 5840:32, 5840:40, 5840:46, 5841:31, 5841:36, 5843:22, 5846:17, 5846:19, 5846:34, 5848:17, 5848:32, 5848:37, 5850:10, 5850:14, 5851:1, 5851:41, 5853:29, 5853:35, 5854:13, 5854:14, 5854:34, 5855:4, 5855:11, 5855:14, 5856:16, 5856:40	5817:38, 5825:5 hundred [2] - 5816:3, 5861:2 hundreds [2] - 5816:8, 5816:43 Hunter [2] - 5839:24, 5862:34 husband [1] - 5847:39 hyper [1] - 5823:28 hypertension [1] - 5815:30 hypothetical [8] - 5766:39, 5774:22, 5774:24, 5774:25, 5775:29, 5780:30, 5781:12, 5820:27 hypothetically [1] - 5815:20	5824:9, 5838:2 impairment [1] - 5777:28 implemented [3] - 5772:27, 5859:45, 5860:5 implementing [3] - 5771:28, 5771:29 importance [4] - 5774:30, 5785:10, 5791:8, 5792:39 important [29] - 5765:36, 5766:1, 5774:9, 5779:1, 5780:13, 5783:7, 5783:13, 5784:5, 5784:20, 5785:44, 5794:38, 5796:5, 5807:45, 5812:34, 5812:44, 5814:9, 5817:7, 5817:20, 5828:25, 5829:15, 5832:32, 5833:7, 5836:33, 5849:12, 5854:17, 5854:37, 5859:6, 5860:25, 5861:39 importantly [1] - 5857:21 impossible [1] - 5783:25 impressively [1] - 5809:28 improve [3] - 5776:38, 5790:14, 5818:47 improved [2] - 5815:5, 5848:42 improvement [5] - 5818:31, 5818:34, 5818:36, 5818:37, 5819:14 in-dwelling [1] - 5843:47 in-person [1] - 5780:14 in/fly [1] - 5832:31 inability [2] - 5812:11, 5820:7 inappropriate [2] - 5769:21, 5790:23 incentive [1] - 5862:10 incentives [4] - 5820:37, 5831:27, 5831:28, 5831:30 incentivise [2] - 5798:36, 5851:26 incentivising [1] - 5820:39 inclined [2] - 5807:19, 5841:5	include [1] - 5768:20 includes [3] - 5806:11, 5820:32, 5823:45 including [8] - 5779:7, 5781:42, 5788:32, 5808:24, 5820:3, 5832:36, 5832:37, 5835:5 income [1] - 5786:32 inconsistent [1] - 5767:34 increase [10] - 5773:34, 5785:14, 5785:15, 5789:27, 5790:7, 5790:35, 5808:33, 5842:6, 5846:4, 5851:28 increased [5] - 5821:39, 5823:29, 5847:15, 5848:16, 5856:44 increasing [10] - 5785:23, 5786:6, 5789:25, 5789:47, 5790:1, 5790:2, 5790:13, 5790:18, 5790:34, 5828:30 increasingly [1] - 5808:42 incredible [2] - 5810:8, 5844:41 incredibly [11] - 5814:41, 5816:40, 5818:7, 5820:46, 5828:25, 5828:44, 5836:37, 5842:19, 5854:15, 5854:37, 5857:8 independently [2] - 5774:38, 5785:29 index [1] - 5822:40 indexes [1] - 5822:37 indicated [1] - 5802:43 indicating [1] - 5799:12 individual [4] - 5808:9, 5817:37, 5824:10, 5824:33 individuals [3] - 5817:39, 5820:37, 5822:27 industry [1] - 5800:2 inefficient [1] - 5843:35 inequity [1] - 5824:19 infection [2] - 5775:39, 5844:3 infectious [2] -	5793:11, 5798:3 infer [3] - 5782:10, 5782:21, 5793:28 influence [1] - 5799:26 influences [1] - 5806:41 influx [1] - 5849:9 inform [2] - 5775:46, 5776:12 infrastructure [2] - 5797:3, 5820:42 infusion [1] - 5776:3 infusions [1] - 5846:21 ingrained [1] - 5842:28 inherently [1] - 5847:43 initial [3] - 5785:40, 5813:6, 5814:36 initiate [1] - 5825:34 initiatives [2] - 5773:40, 5835:2 injection [1] - 5776:3 injury [1] - 5839:16 inner [1] - 5822:46 innovative [3] - 5821:5, 5822:7, 5836:1 inpatient [6] - 5765:39, 5766:7, 5767:22, 5775:36, 5776:6, 5850:18 inpatients [1] - 5775:35 input [1] - 5825:19 inquiries [2] - 5767:2, 5783:11 Inquiry [5] - 5763:7, 5765:3, 5802:22, 5803:15, 5805:12 inquiry [7] - 5773:2, 5773:16, 5773:28, 5784:1, 5784:34, 5800:31, 5856:16 INQUIRY [1] - 5863:14 insights [1] - 5856:4 insofar [1] - 5818:11 installed [1] - 5845:14 installing [1] - 5845:43 instance [7] - 5777:12, 5820:37, 5821:28, 5821:33, 5832:24, 5858:47, 5860:8 instances [3] - 5822:14, 5822:26, 5835:14
---	--	---	---	--

Institute [1] - 5849:3	5855:10	5784:28, 5784:34,	5852:41, 5854:23,	5802:38, 5825:44,
instructions [1] -	internship [3] -	5800:42, 5806:47,	5854:39, 5854:43,	5858:36
5800:45	5785:21, 5785:28,	5812:38, 5847:36	5855:3, 5855:23,	known [2] - 5810:23,
insufficient [1] -	5791:20	issues [15] - 5765:30,	5855:32, 5855:42,	5826:33
5769:34	internships [2] -	5768:9, 5769:26,	5855:45, 5860:18	knows [8] - 5776:2,
Insurance [1] -	5770:36, 5785:35	5775:42, 5776:4,	jurisdiction [1] -	5781:41, 5842:34,
5835:15	interpreting [1] -	5776:44, 5777:21,	5833:25	5842:35, 5843:40,
intake [2] - 5821:44,	5775:44	5778:33, 5784:16,	jurisdictional [2] -	5843:42, 5849:40
5822:3	interrelationship [1] -	5785:5, 5805:11,	5861:25, 5861:31	KPIs [1] - 5855:17
integrated [1] -	5828:25	5805:14, 5805:21,	justify [2] - 5845:11,	kudos [1] - 5854:31
5831:12	interrupted [2] -	5807:43, 5822:41	5845:16	Kurnell [3] - 5859:25,
intents [1] - 5858:1	5852:26, 5855:37	it [1] - 5777:44		5862:5, 5862:25
inter [1] - 5861:31	intervene [3] - 5816:9,	it;s [1] - 5842:16	<hr/> K <hr/>	
inter-jurisdictional [1]	5825:23, 5836:34	item [1] - 5812:25	Kean [1] - 5842:46	<hr/> L <hr/>
- 5861:31	intervening [2] -	items [1] - 5838:19	Kean-Seng [1] -	L13 [2] - 5764:7,
interact [1] - 5777:17	5816:39, 5836:43	itself [3] - 5809:40,	5842:46	5764:8
interactions [1] -	intervention [1] -	5835:45, 5858:32	keen [1] - 5834:47	L3 [1] - 5803:38
5777:22	5836:47		keep [17] - 5773:42,	labs [1] - 5781:37
interest [8] - 5773:10,	interventions [3] -	<hr/> J <hr/>	5785:46, 5788:4,	lack [3] - 5778:8,
5805:12, 5821:38,	5810:32, 5815:36,	Jamal [1] - 5842:46	5790:38, 5790:47,	5791:32, 5794:30
5829:33, 5850:34,	5826:4	jeopardising [1] -	5795:30, 5795:39,	lacks [1] - 5797:39
5859:16, 5859:17,	interview [3] -	5859:12	5799:2, 5816:30,	landscape [2] -
5859:38	5787:47, 5788:2,	Jerry [2] - 5764:12,	5825:41, 5848:17,	5799:12, 5799:29
interested [5] -	5789:9	5764:23	5850:4, 5851:24,	large [5] - 5788:16,
5814:28, 5820:3,	interviews [1] -	JERRY [1] - 5764:16	5858:25, 5858:33	5798:25, 5798:31,
5821:46, 5821:47,	5787:41	job [21] - 5771:19,	keeping [4] - 5774:1,	5821:35, 5837:39
5850:33	introduced [1] -	5787:39, 5787:47,	5791:4, 5831:40,	larger [2] - 5788:24,
interesting [3] -	5783:12	5788:9, 5789:10,	5850:32	5788:30
5833:23, 5841:9,	introduction [1] -	5790:24, 5793:17,	kept [2] - 5799:28,	largest [2] - 5787:9,
5857:27	5806:31	5796:30, 5825:26,	5854:14	5787:12
interests [1] - 5850:13	invaluable [3] -	5828:18, 5829:11,	key [5] - 5765:30,	laser [1] - 5778:41
interface [1] - 5831:18	5817:36, 5817:37	5829:14, 5839:25,	5774:33, 5805:25,	last [18] - 5783:20,
intermittent [1] -	inverted [1] - 5839:13	5839:46, 5846:40,	5805:38, 5805:41	5784:33, 5797:11,
5833:31	invest [1] - 5838:21	5847:2, 5847:28,	kilometres [3] -	5813:20, 5815:26,
intern [21] - 5785:15,	investigates [1] -	5849:45, 5855:20,	5823:1, 5840:33,	5818:23, 5818:41,
5785:21, 5785:23,	5848:18	5855:23, 5859:43	5841:11	5818:44, 5819:18,
5786:28, 5786:33,	investing [1] -	jobs [1] - 5790:22	kind [15] - 5780:3,	5821:43, 5830:22,
5786:40, 5788:32,	5838:34	John [1] - 5855:1	5799:37, 5806:16,	5848:34, 5849:20,
5789:2, 5789:25,	investment [5] -	joined [1] - 5819:44	5807:33, 5816:7,	5852:8, 5852:10,
5789:38, 5789:40,	5770:32, 5773:39,	Jonathan [2] -	5822:36, 5823:18,	5856:43, 5860:5,
5790:13, 5790:34,	5784:28, 5794:33,	5764:13, 5764:33	5823:44, 5826:4,	5860:45
5790:39, 5790:44,	5843:22	JONATHAN [1] -	5826:16, 5826:46,	lastly [1] - 5850:41
5790:45, 5791:10,	invisible [3] - 5816:17,	5764:18	5840:34, 5849:14,	laypeople [1] -
5794:5, 5800:43,	5818:1, 5861:21	jot [1] - 5831:7	5854:5, 5855:29	5765:32
5830:1, 5855:21	invite [3] - 5805:14,	journey [6] - 5765:39,	kindly [1] - 5855:32	lead [4] - 5768:4,
intern's [1] - 5786:43	5832:29, 5842:9	5775:29, 5775:36,	kindness [1] - 5796:7	5823:13, 5823:35,
international [3] -	involve [1] - 5768:13	5778:35, 5780:31,	kinds [4] - 5775:19,	5848:29
5806:17, 5824:15,	involved [11] -	5793:44	5833:5, 5847:42,	leadership [1] -
5860:26	5766:24, 5775:16,	joys [1] - 5786:7	5850:39	5798:20
internationally [3] -	5775:17, 5781:10,	July [1] - 5802:22	knee [1] - 5811:44	league [1] - 5823:44
5806:32, 5823:21,	5791:14, 5792:47,	jump [1] - 5818:31	knife [1] - 5811:26	learn [3] - 5793:17,
5862:20	5817:45, 5833:21,	June [1] - 5809:28	knock [1] - 5822:21	5796:26, 5841:45
interns [16] - 5770:43,	5833:35, 5845:8,	junior [23] - 5772:10,	knocked [2] -	learned [1] - 5831:18
5774:36, 5774:41,	5857:27	5772:15, 5774:29,	5821:46, 5822:4	learning [6] - 5795:32,
5774:45, 5786:9,	involves [1] - 5766:40	5775:6, 5776:35,	knowing [1] - 5826:44	5795:36, 5795:37,
5786:15, 5786:37,	Ireland [1] - 5851:33	5778:13, 5778:34,	knowledge [9] -	5796:25, 5796:46,
5787:6, 5787:10,	iron [1] - 5846:21	5789:27, 5789:28,	5765:18, 5774:47,	5796:47
5787:21, 5789:47,	isolated [1] - 5862:26	5819:4, 5830:2,	5777:10, 5786:3,	least [17] - 5769:36,
5790:3, 5791:15,	issue [9] - 5770:27,	5852:30, 5852:31,	5790:18, 5792:38,	5775:26, 5777:8,
5792:40, 5852:42,	5783:24, 5783:46,			

- 5788:47, 5789:2,
5793:28, 5797:41,
5801:27, 5806:24,
5806:31, 5811:32,
5812:9, 5815:38,
5816:3, 5816:10,
5818:9, 5820:39
leave [16] - 5786:6,
5802:46, 5812:20,
5812:31, 5813:32,
5831:46, 5835:20,
5838:22, 5852:38,
5856:21, 5856:22,
5857:6, 5858:28,
5858:30, 5858:42
leaves [1] - 5812:36
leaving [3] - 5807:36,
5813:20, 5813:21
led [8] - 5800:2,
5809:35, 5813:11,
5817:43, 5836:3,
5861:29, 5861:41
left [7] - 5764:12,
5801:28, 5810:32,
5823:36, 5823:40,
5843:46, 5852:33
leg [1] - 5852:13
length [2] - 5772:39,
5781:3
lens [1] - 5797:41
less [17] - 5775:26,
5776:36, 5789:21,
5791:26, 5795:5,
5807:38, 5818:19,
5818:46, 5839:15,
5839:18, 5839:37,
5839:40, 5841:5,
5842:22, 5843:10,
5851:3
letter [1] - 5815:15
level [12] - 5769:29,
5774:26, 5785:40,
5791:10, 5792:34,
5797:45, 5797:46,
5798:22, 5798:33,
5799:46, 5824:15,
5852:36
Level [1] - 5763:18
levels [5] - 5771:14,
5832:10, 5834:14,
5841:7, 5859:39
leverage [2] - 5788:14,
5860:4
leveraging [1] -
5847:9
levers [2] - 5836:24,
5861:10
LHD [2] - 5771:15,
5791:37
LHDs [5] - 5770:46,
5773:9, 5773:10,
5791:42, 5860:1
lie [1] - 5861:30
lies [1] - 5861:9
life [5] - 5783:17,
5783:20, 5815:38,
5817:19, 5817:38
life's [1] - 5826:45
life/work [3] -
5807:10, 5813:32,
5837:11
lifestyle [3] - 5813:41,
5815:36, 5817:18
lifetime [1] - 5817:19
likelihood [2] -
5815:37, 5821:39
likely [9] - 5775:38,
5790:35, 5807:38,
5816:10, 5821:37,
5823:28, 5829:31,
5829:37, 5854:24
Lim [1] - 5842:46
limit [1] - 5849:32
limited [4] - 5770:44,
5798:42, 5798:43,
5838:24
limiting [3] - 5792:19,
5795:34, 5819:39
limits [1] - 5847:29
line [9] - 5829:42,
5829:44, 5832:16,
5834:22, 5837:8,
5837:9, 5837:23,
5857:41, 5862:21
lines [1] - 5843:4
link [1] - 5832:22
listening [1] - 5817:40
lists [1] - 5781:45
literally [1] - 5844:7
live [3] - 5779:44,
5783:32, 5792:18
liveability [1] -
5809:32
lives [1] - 5847:34
living [4] - 5780:21,
5796:27, 5809:8,
5826:19
load [6] - 5771:35,
5808:20, 5808:21,
5808:34, 5855:22,
5862:8
local [12] - 5810:21,
5823:2, 5834:2,
5835:24, 5839:27,
5839:28, 5858:14,
5858:21, 5860:1,
5860:37
Local [1] - 5861:43
locally [1] - 5821:6
locals [1] - 5852:28
located [4] - 5809:21,
5813:4, 5813:5,
5847:11
location [4] - 5811:24,
5820:43, 5842:33,
5846:9
locations [4] -
5845:23, 5845:24,
5845:42, 5845:47
lockstep [1] - 5839:35
locum [5] - 5835:19,
5837:46, 5838:21,
5858:30, 5858:31
logical [1] - 5790:13
long-term [2] -
5818:3, 5833:34
longitudinally [1] -
5817:20
longstanding [1] -
5837:41
look [30] - 5768:22,
5770:30, 5778:43,
5780:6, 5780:16,
5780:24, 5786:5,
5786:11, 5790:17,
5791:17, 5796:3,
5797:17, 5797:41,
5798:41, 5800:38,
5809:11, 5815:44,
5816:17, 5818:39,
5821:5, 5822:12,
5823:3, 5828:31,
5829:12, 5839:5,
5843:19, 5843:26,
5849:1, 5856:8,
5860:3
looked [5] - 5786:23,
5796:32, 5828:20,
5845:42, 5846:10
looking [25] - 5769:15,
5769:42, 5775:45,
5786:13, 5786:17,
5798:19, 5805:28,
5813:8, 5816:35,
5822:7, 5823:33,
5827:43, 5828:1,
5828:2, 5828:26,
5839:25, 5842:13,
5845:29, 5846:32,
5861:7, 5861:16,
5861:17, 5861:25,
5861:40
looks [3] - 5791:19,
5817:46, 5818:23
loose [1] - 5856:22
lose [2] - 5811:44,
5817:15
loss [1] - 5856:20
love [10] - 5777:26,
5777:43, 5777:44,
5789:5, 5799:7,
5799:41, 5824:5,
5847:28, 5853:43
loved [1] - 5857:33
lovely [2] - 5849:40,
5857:32
low [10] - 5797:21,
5839:38, 5841:3,
5842:20, 5842:21,
5842:24, 5858:26,
5861:35
lower [8] - 5767:19,
5767:20, 5771:36,
5813:31, 5819:25,
5822:39, 5832:10,
5846:9
lucky [3] - 5811:39,
5827:20, 5827:21
lucrative [1] - 5854:29
Luke [4] - 5801:30,
5803:7, 5809:46,
5813:46
LUKE [1] - 5802:5
lunch [1] - 5847:24
-
- M**
-
- Macquarie** [1] -
5763:18
magicians [1] -
5826:41
main [3] - 5777:8,
5787:42, 5838:29
maintain [5] - 5833:1,
5838:30, 5841:6,
5841:7
major [3] - 5783:17,
5787:20, 5816:10
majority [1] - 5768:43
maldistribution [2] -
5824:22, 5824:23
males [1] - 5807:18
manage [9] - 5809:25,
5816:5, 5825:5,
5827:38, 5828:35,
5846:35, 5847:19,
5847:37, 5850:45
manageable [1] -
5825:18
managed [4] -
5806:14, 5840:39,
5846:23, 5848:25
management [8] -
5766:18, 5798:20,
5798:43, 5806:43,
5816:37, 5825:35,
5828:31, 5833:2
managing [5] -
5798:26, 5798:30,
5829:13, 5846:28,
5848:38
manner [1] - 5781:25
manual [1] - 5858:19
market [8] - 5810:31,
5836:35, 5858:9,
5859:11, 5859:12,
5859:13, 5859:26,
5859:34
markets [4] - 5836:4,
5836:5, 5836:32,
5858:20
markets' [1] - 5858:40
massive [2] - 5780:17,
5845:28
masters [1] - 5798:16
matched [1] - 5789:21
matches [1] - 5773:35
material [1] - 5799:22
maternity [4] -
5812:20, 5812:31,
5813:32, 5856:22
matter [4] - 5777:27,
5781:46, 5800:42
matters [2] - 5800:18,
5800:22
maximising [1] -
5848:43
MBS [10] - 5830:43,
5830:45, 5832:13,
5834:15, 5834:18,
5835:18, 5835:39,
5838:10, 5861:36,
5862:14
mean [8] - 5767:34,
5786:30, 5787:39,
5788:37, 5851:2,
5852:3, 5852:5
meaning [1] - 5823:8
meaningful [1] -
5796:38
means [16] - 5778:8,
5780:17, 5780:22,
5781:32, 5787:5,
5787:42, 5788:16,
5791:47, 5796:29,
5797:39, 5808:22,
5820:12, 5820:13,
5822:10, 5829:31,
5841:33
meant [1] - 5825:39
meantime [1] - 5815:9
mechanism [5] -
5831:43, 5832:12,
5834:15, 5834:17,
5857:47
mechanisms [1] -
5861:10
Med [1] - 5780:18
med [1] - 5860:22
Medical [1] - 5832:43

medical [30] - 5769:16, 5775:31, 5778:19, 5805:39, 5806:13, 5808:40, 5823:21, 5835:45, 5837:13, 5837:17, 5837:21, 5841:1, 5849:27, 5849:29, 5850:22, 5851:14, 5852:32, 5852:33, 5852:34, 5852:38, 5854:34, 5855:15, 5855:41, 5857:5, 5860:18, 5860:27, 5861:28, 5861:38, 5861:41
Medicare [2] - 5830:14, 5850:9
medication [48] - 5766:8, 5766:18, 5766:19, 5766:36, 5766:42, 5767:1, 5767:13, 5767:28, 5767:29, 5767:43, 5767:45, 5767:47, 5768:3, 5768:8, 5768:28, 5768:30, 5768:41, 5769:24, 5770:4, 5772:26, 5772:35, 5772:37, 5774:2, 5774:28, 5774:35, 5775:25, 5775:30, 5776:7, 5776:41, 5776:46, 5777:39, 5778:29, 5780:25, 5781:17, 5781:29, 5781:45, 5782:29, 5783:11, 5783:37, 5784:40, 5785:5, 5786:3, 5789:42, 5789:43, 5796:44
medication-related [1] - 5781:17
medications [6] - 5772:36, 5777:10, 5777:11, 5777:14, 5783:12, 5828:34
Medicine [1] - 5849:36
medicine [29] - 5766:2, 5766:4, 5766:21, 5766:22, 5767:5, 5767:39, 5768:39, 5768:40, 5770:9, 5770:19, 5772:11, 5772:23, 5775:47, 5776:2, 5776:8, 5779:30, 5780:25, 5783:41, 5783:44, 5784:5, 5784:10, 5784:12, 5784:34, 5784:44, 5794:13, 5800:9, 5811:27, 5825:9
medicine-related [1] - 5784:34
medicines [54] - 5765:36, 5765:44, 5765:47, 5766:44, 5766:46, 5767:4, 5767:6, 5767:9, 5767:13, 5767:15, 5767:17, 5767:21, 5767:23, 5767:25, 5767:27, 5767:30, 5767:31, 5767:33, 5769:17, 5769:18, 5769:19, 5770:8, 5774:7, 5774:9, 5774:12, 5774:13, 5775:38, 5776:7, 5776:10, 5776:13, 5776:27, 5776:28, 5776:31, 5776:32, 5776:37, 5776:38, 5776:41, 5777:4, 5777:15, 5778:42, 5778:44, 5778:45, 5781:24, 5781:33, 5781:37, 5782:36, 5783:22, 5783:27, 5783:28, 5784:19, 5784:21, 5784:25, 5785:3
meet [4] - 5797:18, 5811:17, 5820:8, 5824:24
meeting [1] - 5774:10
melancholic [1] - 5826:17
Melbourne [1] - 5833:24
Meldrum [1] - 5850:25
member [2] - 5764:40, 5859:2
members [4] - 5799:4, 5808:33, 5814:29, 5848:44
memory [2] - 5804:45, 5838:41
men [1] - 5815:42
menopausal [1] - 5829:5
mental [7] - 5829:7, 5830:7, 5830:21, 5853:45, 5862:9, 5862:39
mentality [1] - 5849:46
mentally [1] - 5788:5
mentioned [4] - 5792:2, 5831:8, 5835:33, 5835:44
mentioning [2] - 5837:44, 5839:23
mentors [2] - 5792:22, 5854:45
mentorship [6] - 5785:43, 5786:14, 5786:23, 5786:27, 5794:29, 5795:18
message [1] - 5794:40
met [4] - 5769:29, 5769:32, 5825:45, 5842:36
metro [20] - 5771:41, 5771:45, 5788:15, 5812:7, 5818:15, 5818:18, 5820:15, 5820:18, 5821:31, 5822:22, 5822:31, 5822:46, 5832:33, 5832:34, 5834:6, 5846:7, 5855:24, 5856:2
metro-based [2] - 5832:33, 5832:34
metropolitan [2] - 5779:32, 5779:34
MICHAEL [1] - 5802:3
Michael [9] - 5763:38, 5801:28, 5802:14, 5813:37, 5817:41, 5817:43, 5830:8, 5830:11, 5830:15
microbial [2] - 5775:41, 5775:45
microbials [1] - 5775:40
middle [1] - 5824:16
might [86] - 5765:38, 5765:41, 5765:42, 5765:45, 5766:6, 5766:47, 5767:3, 5767:5, 5767:7, 5767:8, 5767:12, 5767:31, 5767:41, 5768:8, 5768:22, 5768:23, 5768:26, 5769:20, 5770:26, 5774:40, 5776:22, 5776:30, 5776:46, 5777:14, 5778:41, 5779:24, 5780:1, 5783:2, 5783:12, 5787:1, 5788:23, 5792:33, 5794:21, 5794:22, 5794:24, 5796:46, 5798:41, 5799:22, 5799:37, 5801:6, 5805:16, 5807:5, 5807:8, 5808:9, 5810:39, 5810:41, 5811:12, 5813:10, 5817:33, 5822:19, 5823:35, 5824:36, 5825:12, 5825:46, 5827:39, 5829:34, 5829:35, 5829:36, 5837:35, 5837:39, 5838:8, 5838:9, 5838:10, 5839:13, 5840:19, 5842:40, 5844:28, 5844:34, 5845:43, 5846:18, 5848:29, 5853:3, 5855:47, 5856:5, 5856:46, 5858:27, 5858:36, 5859:10, 5859:11, 5859:20, 5859:32, 5861:41
million [4] - 5798:27, 5815:46, 5815:47, 5824:38
millions [1] - 5816:44
mind [1] - 5841:43
minds [1] - 5826:28
minimal [1] - 5827:33
Minister [2] - 5821:22, 5849:23
ministry [7] - 5771:15, 5791:12, 5791:14, 5791:19, 5791:41, 5801:31, 5821:45
Ministry [3] - 5773:6, 5797:27, 5803:10
minus [1] - 5843:25
minute [1] - 5862:40
minutes [7] - 5825:28, 5825:34, 5826:36, 5843:24, 5844:7, 5848:38, 5851:19
Minutes [1] - 5784:2
misinformation [1] - 5857:28
mismatch [1] - 5822:45
misquoting [1] - 5858:27
miss [2] - 5783:29, 5815:44
missed [4] - 5777:34, 5781:43, 5783:43, 5784:12
missing [2] - 5777:46, 5816:30
mistakes [1] - 5787:44
MM1 [1] - 5862:11
MMM1 [1] - 5862:22
MMM2 [1] - 5862:22
mobile [1] - 5827:9
mode [1] - 5776:43
model [52] - 5766:14, 5772:27, 5775:13, 5778:18, 5786:37, 5793:19, 5793:20, 5809:35, 5810:25, 5819:32, 5824:45, 5831:39, 5832:21, 5833:27, 5835:12, 5835:25, 5835:26, 5835:27, 5835:28, 5836:16, 5836:24, 5836:40, 5836:43, 5837:11, 5838:28, 5838:33, 5838:35, 5842:42, 5846:27, 5853:4, 5856:11, 5856:13, 5856:27, 5856:29, 5856:41, 5856:44, 5857:13, 5857:23, 5857:29, 5859:15, 5859:33, 5859:40, 5859:42, 5861:3, 5861:4, 5861:18, 5861:28, 5861:29, 5861:40, 5861:42, 5862:36
modelling [1] - 5820:9
models [15] - 5779:38, 5813:8, 5814:4, 5831:38, 5832:4, 5832:19, 5833:11, 5833:42, 5833:43, 5836:3, 5845:14, 5850:12, 5854:4, 5856:10, 5859:38
Modified [1] - 5851:35
modified [2] - 5818:19, 5852:15
mollified [1] - 5772:1
moment [30] - 5770:34, 5779:18, 5782:10, 5782:21, 5785:6, 5788:29, 5788:31, 5791:44, 5793:28, 5799:21, 5805:40, 5811:8, 5814:1, 5816:20, 5819:17, 5822:4, 5826:19, 5827:21, 5831:7, 5831:44, 5834:11, 5836:1, 5837:1, 5838:37, 5839:23, 5839:36, 5841:43, 5845:10, 5861:35, 5862:45
Monash [2] - 5818:19, 5851:35

- Monday** [2] - 5825:28, 5851:32
- money** [9] - 5773:12, 5775:24, 5790:43, 5799:18, 5810:36, 5812:1, 5820:33, 5848:19, 5850:29
- monitored** [2] - 5777:17, 5781:37
- monitoring** [2] - 5833:27, 5833:31
- month** [7] - 5783:5, 5788:43, 5788:44, 5794:6, 5795:12, 5821:36, 5851:21
- month's** [2] - 5782:35, 5783:26
- months** [19] - 5788:40, 5794:12, 5794:13, 5795:14, 5804:8, 5804:28, 5818:32, 5818:41, 5825:12, 5825:33, 5825:47, 5827:37, 5828:15, 5852:8, 5852:14, 5852:16, 5860:6, 5860:45
- moonlight** [1] - 5853:35
- moot** [1] - 5845:45
- moral** [1] - 5796:8
- moratorium** [1] - 5851:34
- Moree** [1] - 5820:47
- most** [22] - 5770:6, 5770:38, 5786:4, 5787:12, 5793:8, 5793:37, 5814:38, 5822:26, 5823:8, 5824:6, 5827:15, 5828:17, 5830:2, 5833:6, 5842:21, 5843:44, 5847:20, 5851:21, 5852:45, 5857:21, 5859:6
- mostly** [1] - 5810:8
- mother** [1] - 5826:19
- move** [9] - 5797:29, 5806:18, 5806:46, 5813:39, 5822:20, 5826:38, 5834:10, 5841:4, 5860:26
- moved** [3] - 5813:30, 5841:11, 5841:26
- moving** [4] - 5809:33, 5852:30, 5852:31, 5859:2
- MPS** [2] - 5835:9, 5835:15
- multi** [1] - 5835:7
- multi-purpose** [1] - 5835:7
- multidisciplinary** [8] - 5806:40, 5813:5, 5813:12, 5813:14, 5814:25, 5830:19, 5832:36, 5861:29
- multifactorial** [1] - 5808:38
- multiple** [5] - 5781:2, 5782:40, 5788:25, 5789:9, 5820:7
- Murray** [1] - 5861:27
- Murrumbidgee** [7] - 5821:32, 5856:11, 5856:27, 5856:45, 5857:28, 5859:40, 5861:27
- Muston** [3] - 5763:26, 5770:24, 5830:34
- MUSTON** [152] - 5764:3, 5764:12, 5764:20, 5764:25, 5764:30, 5764:35, 5764:40, 5764:47, 5765:10, 5765:17, 5765:24, 5765:29, 5766:6, 5766:34, 5767:33, 5768:11, 5768:33, 5768:47, 5769:32, 5773:45, 5774:22, 5775:23, 5776:15, 5776:21, 5778:23, 5779:21, 5779:42, 5780:30, 5780:44, 5781:12, 5782:10, 5782:21, 5783:1, 5783:9, 5783:34, 5784:40, 5785:9, 5785:19, 5786:13, 5786:26, 5787:32, 5788:29, 5788:46, 5789:8, 5789:25, 5789:35, 5789:46, 5790:12, 5791:6, 5792:2, 5792:32, 5792:43, 5793:26, 5793:41, 5794:43, 5795:10, 5795:42, 5796:37, 5797:11, 5797:39, 5799:16, 5800:12, 5801:9, 5801:27, 5801:44, 5802:11, 5802:16, 5802:21, 5802:26, 5802:30, 5802:35, 5802:42, 5803:2, 5803:9, 5803:14, 5803:19, 5803:24, 5803:28, 5803:33, 5803:38, 5803:42, 5803:47, 5804:6, 5804:10, 5804:16, 5804:21, 5804:26, 5804:31, 5804:38, 5804:43, 5805:2, 5805:6, 5806:3, 5806:23, 5806:30, 5807:13, 5807:47, 5808:37, 5809:3, 5809:43, 5810:14, 5811:8, 5812:7, 5812:38, 5813:43, 5814:28, 5815:20, 5817:2, 5818:11, 5819:16, 5819:24, 5819:39, 5820:21, 5821:10, 5821:19, 5821:43, 5822:18, 5823:11, 5824:21, 5824:44, 5827:1, 5827:24, 5829:23, 5830:31, 5830:37, 5832:29, 5834:8, 5836:47, 5837:5, 5838:37, 5839:2, 5839:18, 5839:43, 5840:9, 5840:15, 5840:38, 5841:16, 5842:4, 5842:15, 5844:14, 5844:23, 5844:27, 5846:12, 5847:47, 5848:21, 5849:17, 5851:6, 5854:19, 5856:4, 5858:7, 5859:10, 5861:45
- mystery** [1] - 5769:10
-
- N**
-
- name** [10] - 5764:21, 5764:23, 5764:30, 5802:12, 5803:4, 5803:42, 5804:17, 5804:33, 5850:24, 5854:41
- Narrabri** [1] - 5839:24
- narrative** [1] - 5831:5
- narrow** [1] - 5782:25
- Nation** [1] - 5818:22
- nations** [1] - 5823:45
- nature** [3] - 5769:3, 5818:13, 5828:29
- nausea** [1] - 5776:11
- Navy** [1] - 5843:8
- NDIS** [3] - 5813:21, 5813:27, 5852:21
- near** [4] - 5809:18, 5811:40, 5823:4, 5839:24
- nearest** [1] - 5827:34
- necessaries** [1] - 5808:28
- necessarily** [10] - 5782:25, 5792:8, 5813:22, 5816:14, 5836:23, 5836:26, 5845:19, 5857:15, 5861:41, 5862:25
- necessary** [2] - 5802:47, 5814:23
- necessity** [3] - 5813:9, 5814:19
- need** [106] - 5768:28, 5769:8, 5771:13, 5775:4, 5776:46, 5777:17, 5779:3, 5779:36, 5783:28, 5783:37, 5783:47, 5784:24, 5784:40, 5786:19, 5788:42, 5789:18, 5789:39, 5791:31, 5791:42, 5795:22, 5795:26, 5795:44, 5796:32, 5797:2, 5797:19, 5797:33, 5799:33, 5799:34, 5799:43, 5800:3, 5801:44, 5807:31, 5807:34, 5808:5, 5808:29, 5811:23, 5811:35, 5811:36, 5811:44, 5812:4, 5812:23, 5813:13, 5814:2, 5814:19, 5814:42, 5814:43, 5814:46, 5815:1, 5815:6, 5815:8, 5815:11, 5815:14, 5815:17, 5816:46, 5817:17, 5818:28, 5819:5, 5819:6, 5821:8, 5821:39, 5822:42, 5822:43, 5823:2, 5823:16, 5823:35, 5823:38, 5824:4, 5824:11, 5824:12, 5825:14, 5826:1, 5826:26, 5826:41, 5827:40, 5828:45, 5829:19, 5830:11, 5830:12, 5830:23, 5830:24, 5832:23, 5836:5, 5836:38, 5837:9, 5840:4, 5840:31, 5841:28, 5843:29, 5844:39, 5844:46, 5845:19, 5846:1, 5846:19, 5849:15, 5850:45, 5850:46, 5851:39, 5855:18, 5855:31, 5860:16, 5860:20, 5862:1, 5862:36
- needed** [5] - 5792:32, 5826:36, 5832:40, 5853:29, 5856:36
- needing** [4] - 5807:35, 5827:13, 5837:45, 5840:33
- needs** [30] - 5769:2, 5771:9, 5783:10, 5785:28, 5786:20, 5786:22, 5787:12, 5797:12, 5797:18, 5798:10, 5798:39, 5799:34, 5811:16, 5811:17, 5813:15, 5816:45, 5821:13, 5823:6, 5824:9, 5824:24, 5826:30, 5831:8, 5834:1, 5835:20, 5840:35, 5846:43, 5849:12, 5852:37, 5861:3, 5862:29
- negative** [1] - 5823:7
- negotiated** [3] - 5799:35, 5835:46, 5839:34
- negotiation** [1] - 5858:20
- nephrologist** [1] - 5825:11
- nephrologists** [1] - 5823:23
- net** [2] - 5838:12, 5847:15
- Netherlands** [1] - 5823:46
- network** [2] - 5791:45, 5828:5
- Network** [1] - 5858:16
- networked** [1] - 5827:3
- networks** [6] - 5827:20, 5827:25, 5828:8, 5836:23, 5851:42, 5858:15
- neurological** [1] - 5827:39
- neurologist** [1] - 5827:38
- neurologists** [1] - 5831:46
- never** [5] - 5816:15, 5816:18, 5828:11, 5842:36, 5852:43

- New** [99] - 5763:19, 5764:35, 5767:2, 5768:43, 5769:25, 5769:29, 5769:40, 5769:43, 5769:46, 5770:17, 5770:25, 5770:34, 5770:39, 5771:41, 5771:47, 5772:2, 5772:16, 5773:3, 5773:27, 5773:33, 5773:41, 5778:16, 5779:11, 5779:12, 5779:18, 5780:8, 5781:27, 5782:23, 5782:32, 5782:39, 5782:43, 5784:1, 5785:24, 5786:45, 5787:10, 5787:22, 5787:28, 5788:27, 5788:31, 5790:19, 5791:26, 5791:45, 5793:27, 5793:29, 5793:37, 5794:39, 5795:8, 5796:18, 5797:6, 5797:18, 5797:24, 5797:30, 5797:32, 5798:12, 5798:35, 5800:30, 5801:32, 5802:19, 5803:47, 5804:39, 5806:6, 5808:43, 5809:1, 5809:41, 5812:10, 5818:24, 5819:37, 5820:38, 5820:45, 5820:46, 5821:31, 5821:32, 5823:46, 5824:25, 5824:34, 5824:37, 5824:44, 5831:21, 5832:44, 5835:4, 5836:19, 5837:42, 5838:8, 5838:13, 5838:29, 5839:6, 5839:24, 5840:4, 5841:41, 5843:15, 5847:9, 5849:4, 5851:33, 5856:2, 5856:21, 5860:9, 5861:17, 5862:34
- new** [17] - 5770:43, 5771:28, 5771:30, 5771:31, 5771:34, 5775:38, 5776:7, 5783:12, 5784:19, 5807:4, 5808:4, 5810:10, 5810:38, 5837:38, 5840:40, 5852:11
- Newcastle** [1] - 5862:33
- next** [19] - 5764:12, 5775:27, 5775:35, 5776:29, 5776:47, 5788:9, 5788:42, 5796:9, 5812:2, 5818:42, 5819:1, 5827:36, 5830:12, 5833:17, 5851:12, 5851:23, 5851:32, 5856:46
- NHRA** [1] - 5835:45
- nice** [4] - 5778:30, 5828:12, 5848:13, 5853:43
- nicest** [2] - 5814:37, 5829:14
- niche** [1] - 5853:44
- night** [6] - 5817:31, 5830:22, 5830:27, 5847:31, 5851:28, 5855:14
- no** [1] - 5771:33
- no-one** [4] - 5784:23, 5810:32, 5816:31, 5853:19
- no-one's** [1] - 5830:16
- nominal** [1] - 5839:15
- non** [6] - 5817:39, 5818:29, 5828:24, 5843:20, 5858:15, 5861:36
- non-admitted** [1] - 5843:20
- non-clinician** [1] - 5817:39
- non-government** [1] - 5858:15
- non-GP** [1] - 5828:24
- non-urgent** [1] - 5818:29
- non-viable** [1] - 5861:36
- none** [3] - 5823:36, 5847:47, 5853:40
- noon** [1] - 5763:22
- normalisation** [1] - 5807:44
- north** [1] - 5842:29
- note** [4] - 5831:7, 5831:43, 5840:26, 5861:45
- notes** [2] - 5828:16, 5833:16
- nothing** [5] - 5766:4, 5767:15, 5792:5, 5836:36, 5852:10
- notice** [1] - 5818:22
- novels** [1] - 5829:35
- nowadays** [2] - 5792:24, 5796:24
- NSW** [23] - 5763:36, 5794:45, 5800:31, 5801:40, 5803:10, 5813:27, 5831:19, 5832:17, 5834:24, 5834:29, 5836:7, 5836:26, 5836:38, 5837:14, 5838:9, 5838:10, 5838:11, 5839:36, 5845:29, 5847:9, 5856:28, 5859:1, 5860:44
- nuanced** [1] - 5847:33
- number** [39] - 5765:30, 5769:17, 5769:40, 5769:42, 5769:43, 5770:12, 5773:34, 5785:15, 5786:6, 5789:25, 5789:47, 5790:3, 5790:13, 5790:34, 5793:19, 5793:26, 5806:11, 5806:19, 5808:26, 5811:25, 5819:20, 5819:25, 5819:43, 5819:44, 5821:23, 5821:35, 5826:1, 5827:9, 5828:32, 5829:17, 5843:3, 5843:32, 5847:16, 5849:5, 5849:7, 5849:10, 5849:28, 5849:42, 5853:4
- numbers** [8] - 5812:25, 5813:23, 5819:14, 5827:18, 5840:20, 5842:20, 5842:21, 5855:43
- nurse** [15] - 5766:22, 5767:46, 5768:31, 5774:20, 5776:2, 5784:24, 5809:35, 5813:10, 5830:20, 5836:3, 5843:25, 5843:39, 5844:36, 5847:21
- nurse-led** [1] - 5809:35
- nurses** [10] - 5768:4, 5771:31, 5774:47, 5775:4, 5790:44, 5824:31, 5832:38, 5834:4, 5841:4, 5844:4
- nursing** [3] - 5806:42, 5811:28, 5843:4
- O**
- o'clock** [4] - 5817:30, 5830:26, 5847:31, 5863:11
- oath** [2] - 5764:14, 5801:46
- obligation** [3] - 5837:14, 5837:32, 5839:8
- obligations** [1] - 5813:32
- observation** [3] - 5796:40, 5817:40, 5829:25
- obstetrics** [1] - 5805:2
- obtained** [4] - 5778:27, 5792:44, 5794:5, 5851:13
- obvious** [4] - 5775:10, 5799:45, 5856:8, 5856:26
- obviously** [10] - 5768:33, 5769:13, 5775:23, 5779:24, 5785:5, 5789:38, 5792:3, 5799:27, 5807:28, 5833:25
- occasions** [1] - 5822:27
- occupancy** [2] - 5839:38, 5839:40
- occupied** [2] - 5819:26, 5861:46
- occur** [8] - 5767:41, 5784:17, 5784:18, 5785:1, 5795:44, 5795:46, 5828:35
- occurring** [5] - 5769:25, 5770:4, 5770:5, 5783:32, 5796:18
- occurs** [1] - 5767:28
- Ochre** [1] - 5850:25
- OCTOBER** [1] - 5863:15
- October** [2] - 5763:22, 5803:20
- odd** [1] - 5822:27
- OECD** [1] - 5824:16
- OF** [1] - 5863:14
- offer** [10] - 5779:23, 5794:31, 5795:12, 5797:22, 5798:35, 5822:14, 5822:15, 5822:16, 5822:19, 5822:21
- offered** [2] - 5822:1, 5842:6
- offering** [1] - 5859:34
- offers** [2] - 5770:40, 5821:26
- office** [3] - 5804:44, 5807:34, 5817:10
- officer** [4] - 5837:13, 5837:21, 5860:18, 5861:28
- officers** [1] - 5857:5
- often** [34] - 5768:28, 5771:27, 5775:10, 5777:21, 5777:30, 5781:42, 5781:43, 5783:16, 5787:24, 5787:44, 5791:32, 5794:6, 5811:19, 5814:2, 5814:40, 5814:42, 5815:2, 5821:40, 5823:14, 5823:33, 5825:3, 5831:14, 5835:10, 5842:1, 5842:37, 5845:17, 5846:27, 5847:30, 5847:31, 5848:18, 5850:18, 5854:14, 5854:28, 5861:12
- old** [1] - 5776:8
- on-call** [1] - 5808:21
- on-the-ground** [1] - 5780:1
- once** [13] - 5772:34, 5774:37, 5785:26, 5786:11, 5786:13, 5787:47, 5788:3, 5808:8, 5811:11, 5811:15, 5815:38, 5821:36, 5830:10
- oncology** [9] - 5779:11, 5779:15, 5780:23, 5780:25, 5791:30, 5791:31, 5793:11, 5794:21, 5798:2
- one** [110] - 5767:40, 5768:23, 5769:2, 5770:27, 5771:39, 5771:40, 5771:41, 5771:42, 5773:39, 5774:23, 5776:22, 5777:9, 5781:14, 5781:20, 5782:35, 5782:45, 5783:1, 5783:36, 5784:23, 5784:41, 5784:42, 5785:27, 5785:28, 5787:9, 5787:11, 5787:34, 5787:42, 5787:43, 5788:1, 5788:39, 5796:4, 5798:41, 5801:37,

- 5803:19, 5805:19, 5805:31, 5806:3, 5806:37, 5807:5, 5807:37, 5808:6, 5808:8, 5810:6, 5810:32, 5810:33, 5811:9, 5811:20, 5812:5, 5812:23, 5812:28, 5812:30, 5812:31, 5814:1, 5814:22, 5814:41, 5814:42, 5815:1, 5815:43, 5816:15, 5816:31, 5820:43, 5820:45, 5823:37, 5824:5, 5824:33, 5825:2, 5825:21, 5826:32, 5827:11, 5828:7, 5830:32, 5832:34, 5833:5, 5833:12, 5834:13, 5837:3, 5840:16, 5840:41, 5840:42, 5841:27, 5841:35, 5842:4, 5842:30, 5847:18, 5850:15, 5851:11, 5851:30, 5852:1, 5852:8, 5852:10, 5853:2, 5853:3, 5853:19, 5854:21, 5855:31, 5856:19, 5857:36, 5857:39, 5858:12, 5859:23, 5859:24, 5861:2, 5861:33, 5862:45
- one's** [1] - 5830:16
- one-year** [1] - 5785:28
- ones** [3] - 5801:45, 5822:40
- ongoing** [2] - 5815:5, 5830:10
- online** [1] - 5815:2
- open** [5] - 5791:17, 5792:22, 5800:25, 5839:29, 5839:40
- operated** [1] - 5787:33
- operating** [2] - 5773:36, 5793:3
- operational** [1] - 5816:45
- opportunistic** [2] - 5815:24, 5817:16
- opportunities** [4] - 5798:34, 5859:46, 5860:17, 5860:22
- opportunity** [6] - 5765:10, 5803:28, 5815:23, 5815:28, 5815:35, 5817:15
- opposed** [4] - 5787:43, 5806:10, 5832:34, 5843:31
- opposite** [1] - 5813:28
- optimal** [1] - 5836:17
- option** [4] - 5842:38, 5856:22, 5857:9, 5858:42
- options** [2] - 5850:31, 5855:42
- order** [15] - 5813:30, 5834:42, 5835:16, 5838:43, 5839:10, 5839:32, 5839:34, 5841:8, 5845:44, 5856:39, 5857:18, 5857:23, 5858:30, 5858:42
- orders** [2] - 5766:22, 5776:46
- ordinarily** [1] - 5776:22
- organisations** [1] - 5858:16
- organised** [1] - 5858:21
- original** [3] - 5822:30, 5830:35, 5856:9
- originally** [1] - 5806:13
- originated** [1] - 5784:34
- otherwise** [21] - 5780:19, 5781:33, 5807:7, 5813:11, 5813:20, 5815:28, 5825:18, 5830:14, 5831:4, 5833:31, 5836:43, 5838:22, 5843:22, 5844:5, 5844:9, 5847:11, 5847:30, 5849:41, 5857:7, 5858:1, 5858:26
- ought** [1] - 5769:37
- outcome** [1] - 5825:41
- outcomes** [6] - 5775:26, 5793:1, 5823:30, 5824:19, 5833:39, 5847:32
- outer** [5] - 5820:15, 5820:18, 5821:30, 5822:46, 5856:2
- outline** [1] - 5861:8
- outlined** [1] - 5838:18
- outpatient** [2] - 5766:7, 5850:17
- output** [2] - 5790:7, 5790:8
- outreach** [3] - 5779:38, 5792:33, 5812:29
- outset** [1] - 5780:13
- outside** [9] - 5779:34, 5781:25, 5809:27, 5822:27, 5833:24, 5841:8, 5844:2, 5844:41, 5861:9
- outskirts** [1] - 5859:26
- overall** [5] - 5810:1, 5823:23, 5823:29, 5850:2, 5850:22
- overdose** [1] - 5767:8
- overlay** [1] - 5840:42
- overnight** [2] - 5819:11, 5855:46
- overseas** [6] - 5810:9, 5841:29, 5841:45, 5843:8, 5851:30, 5852:27
- oversubscribed** [3] - 5820:2, 5820:4, 5827:35
- oversupply** [1] - 5822:8
- overtime** [1] - 5807:9
- overview** [1] - 5858:19
- overworked** [1] - 5812:29
- own** [17] - 5774:10, 5785:33, 5786:43, 5794:32, 5795:4, 5796:7, 5796:11, 5810:23, 5811:30, 5817:25, 5835:17, 5847:26, 5847:43, 5855:20, 5855:21, 5860:32
-
- P**
-
- pace** [1] - 5799:29
- pack** [1] - 5824:16
- Package** [1] - 5837:34
- paediatric** [1] - 5833:14
- paediatricians** [1] - 5833:15
- paediatrics** [1] - 5825:23
- page** [9] - 5765:29, 5770:23, 5772:25, 5773:29, 5775:18, 5786:27, 5795:7, 5795:10, 5795:12
- paid** [8] - 5795:47, 5796:23, 5798:31, 5799:18, 5824:40, 5830:16, 5846:28
- pain** [2] - 5767:21, 5776:11
- painkillers** [1] - 5769:6
- palace** [1] - 5816:43
- pandemic** [1] - 5849:8
- panel** [8] - 5764:3, 5801:27, 5809:4, 5811:25, 5814:29, 5830:32, 5848:31, 5855:40
- paper** [3] - 5830:41, 5831:3, 5852:12
- paperwork** [4] - 5852:5, 5852:15, 5852:21, 5852:24
- parent** [1] - 5840:22
- parents** [1] - 5816:26
- part** [37] - 5765:24, 5765:44, 5774:9, 5777:25, 5781:27, 5781:34, 5788:12, 5791:13, 5796:29, 5806:21, 5806:24, 5806:31, 5807:19, 5808:41, 5812:5, 5812:9, 5812:31, 5813:11, 5813:46, 5814:21, 5816:21, 5816:26, 5816:30, 5821:30, 5822:30, 5824:1, 5824:22, 5825:3, 5832:36, 5832:46, 5850:34, 5855:4, 5855:5, 5855:10, 5856:28, 5856:38, 5860:30
- part-time** [1] - 5796:29
- participate** [1] - 5773:9
- particular** [16] - 5766:8, 5778:28, 5778:32, 5793:4, 5793:45, 5799:23, 5805:27, 5820:26, 5821:12, 5823:14, 5824:18, 5830:44, 5842:5, 5853:21, 5859:13, 5859:14
- particularly** [9] - 5775:2, 5792:8, 5805:25, 5809:4, 5809:7, 5818:21, 5820:14, 5829:12, 5834:28
- partnered** [1] - 5772:26
- partnership** [2] - 5777:18, 5777:41
- parts** [3] - 5779:18, 5794:8, 5814:24
- party** [2] - 5782:24, 5782:27
- pass** [2] - 5819:22, 5859:32
- passing** [1] - 5793:27
- past** [2] - 5819:44, 5830:10
- patches** [1] - 5818:13
- patchy** [2] - 5818:13, 5827:15
- path** [2] - 5795:17, 5806:24
- pathway** [4] - 5785:13, 5821:29, 5851:32, 5854:6
- pathways** [4] - 5799:40, 5806:16, 5814:18, 5833:43
- patient** [82] - 5766:2, 5766:21, 5766:28, 5766:39, 5766:44, 5767:3, 5767:5, 5767:7, 5767:9, 5767:16, 5767:19, 5767:30, 5767:35, 5768:13, 5768:17, 5769:3, 5769:5, 5769:10, 5769:15, 5769:25, 5772:11, 5772:40, 5774:23, 5774:24, 5775:29, 5775:36, 5776:17, 5776:23, 5776:29, 5776:30, 5776:47, 5777:5, 5777:20, 5777:28, 5779:17, 5780:24, 5780:28, 5781:13, 5781:42, 5781:44, 5781:45, 5782:29, 5783:4, 5783:10, 5783:38, 5783:43, 5784:3, 5784:8, 5784:26, 5793:24, 5794:14, 5798:37, 5799:7, 5799:8, 5799:10, 5799:14, 5808:35, 5813:15, 5815:17, 5815:29, 5816:14, 5816:45, 5817:29, 5817:34, 5825:14, 5825:44, 5826:3, 5830:9, 5830:14, 5832:39, 5842:38, 5843:20, 5843:45, 5844:10, 5847:23, 5848:32, 5848:35, 5848:36, 5848:37, 5850:17, 5852:23, 5855:29

patient's [8] - 5767:15, 5772:13, 5776:25, 5780:31, 5782:28, 5783:3, 5813:12, 5817:35
patients [78] - 5765:36, 5768:17, 5768:23, 5768:35, 5768:41, 5769:19, 5769:20, 5769:28, 5769:36, 5773:42, 5774:8, 5777:1, 5779:5, 5779:9, 5779:19, 5779:23, 5779:33, 5779:47, 5780:11, 5781:7, 5781:19, 5781:31, 5782:8, 5782:37, 5783:16, 5785:3, 5786:4, 5786:8, 5789:42, 5792:4, 5793:7, 5794:15, 5795:33, 5795:40, 5797:34, 5799:9, 5799:42, 5800:7, 5807:33, 5808:20, 5808:30, 5811:31, 5814:2, 5814:37, 5817:27, 5818:8, 5818:27, 5825:4, 5826:41, 5827:11, 5827:22, 5827:30, 5827:43, 5827:47, 5828:3, 5828:20, 5828:26, 5830:7, 5831:13, 5832:21, 5833:37, 5835:37, 5839:12, 5839:15, 5839:19, 5842:22, 5842:30, 5844:45, 5847:26, 5847:28, 5847:34, 5847:43, 5848:41, 5850:11, 5852:6, 5854:6, 5854:14, 5862:28
patterns [1] - 5808:3
pause [1] - 5819:39
pausing [4] - 5766:6, 5780:33, 5824:44, 5832:29
pay [11] - 5771:25, 5786:42, 5796:15, 5796:30, 5796:46, 5797:23, 5851:26, 5854:31, 5862:28
paying [3] - 5796:33, 5839:32, 5857:4
PBS [2] - 5782:24, 5782:36
peers [1] - 5793:39
Penm [10] - 5764:13, 5764:14, 5764:30, 5764:33, 5764:43, 5764:47, 5774:40, 5785:19, 5789:15, 5796:10
PENM [33] - 5764:18, 5764:33, 5764:38, 5764:45, 5765:8, 5765:15, 5765:22, 5771:22, 5772:25, 5772:34, 5774:43, 5777:8, 5778:18, 5780:41, 5780:46, 5781:16, 5782:14, 5785:26, 5786:17, 5787:9, 5787:24, 5787:30, 5787:39, 5788:37, 5789:5, 5789:33, 5794:27, 5795:1, 5795:12, 5796:42, 5798:41, 5799:37, 5801:19
Penm's [1] - 5778:37
people [69] - 5765:46, 5771:23, 5779:44, 5785:40, 5785:46, 5786:7, 5788:15, 5788:19, 5788:22, 5793:26, 5798:47, 5799:43, 5806:5, 5806:20, 5807:9, 5807:25, 5807:43, 5808:26, 5808:42, 5809:7, 5809:33, 5810:38, 5811:12, 5811:33, 5811:35, 5811:41, 5812:18, 5812:23, 5812:35, 5814:7, 5814:11, 5815:31, 5815:44, 5816:8, 5816:18, 5816:27, 5816:30, 5817:23, 5818:46, 5819:1, 5822:25, 5823:14, 5824:6, 5824:38, 5825:16, 5828:41, 5828:47, 5829:12, 5831:34, 5833:26, 5833:39, 5838:2, 5838:4, 5839:40, 5843:33, 5843:36, 5846:6, 5847:3, 5848:7, 5848:15, 5848:17, 5849:7, 5850:5, 5850:31, 5850:45, 5850:47, 5854:42, 5861:21
people's [1] - 5827:18
per [34] - 5772:40, 5772:41, 5785:37, 5786:29, 5786:31, 5786:32, 5786:35, 5786:40, 5786:42, 5786:47, 5787:13, 5790:22, 5818:27, 5818:29, 5822:42, 5830:45, 5830:47, 5831:35, 5835:33, 5839:37, 5839:40, 5842:23, 5846:5, 5849:26, 5849:30, 5850:23, 5850:27, 5852:33, 5852:35, 5852:37, 5852:38, 5861:2
perceived [1] - 5809:32
perform [2] - 5816:37, 5835:17
performed [1] - 5774:29
performing [3] - 5768:34, 5795:30, 5823:47
performs [1] - 5824:15
perhaps [17] - 5778:34, 5779:46, 5785:19, 5789:12, 5793:29, 5798:6, 5809:32, 5823:16, 5831:4, 5834:41, 5836:1, 5837:41, 5842:9, 5845:10, 5845:19, 5845:47, 5861:40
period [5] - 5782:23, 5783:4, 5788:44, 5806:15, 5839:41
permission [1] - 5852:17
permit [1] - 5800:47
perpetuated [1] - 5854:33
person [21] - 5780:14, 5801:28, 5817:8, 5817:14, 5820:25, 5823:33, 5823:38, 5824:4, 5824:5, 5825:36, 5826:29, 5827:5, 5830:45, 5830:47, 5832:35, 5833:46, 5833:47, 5847:38, 5847:39, 5853:18, 5858:41
person's [1] - 5833:10
person-based [1] - 5833:46
personal [1] - 5837:28
personally [1] - 5847:44
perspective [20] - 5766:38, 5777:21, 5787:36, 5788:47, 5814:33, 5817:40, 5827:25, 5832:17, 5834:24, 5836:7, 5837:14, 5843:27, 5845:7, 5851:6, 5859:18, 5859:19, 5859:45, 5860:45, 5861:42, 5863:6
perspectives [1] - 5805:30
PGPPP [2] - 5853:1, 5854:11
pharma [1] - 5797:28
pharmaceutical [3] - 5781:28, 5782:34, 5783:45
Pharmaceutical [1] - 5781:29
pharmacies [1] - 5768:21
pharmacist [73] - 5765:33, 5766:9, 5766:14, 5766:24, 5766:27, 5767:13, 5767:42, 5768:7, 5768:45, 5770:19, 5772:13, 5772:14, 5772:22, 5772:26, 5772:34, 5772:35, 5774:7, 5774:30, 5775:16, 5776:12, 5776:21, 5776:37, 5777:15, 5777:42, 5778:14, 5778:16, 5778:26, 5778:31, 5778:43, 5779:2, 5779:12, 5779:13, 5779:14, 5779:24, 5780:18, 5780:19, 5780:21, 5780:24, 5780:33, 5780:36, 5781:8, 5784:7, 5784:22, 5784:24, 5785:22, 5788:34, 5788:35, 5791:22, 5791:31, 5791:45, 5792:7, 5792:14, 5792:41, 5793:2, 5793:12, 5793:13, 5793:36, 5793:42, 5793:46, 5794:2, 5794:5, 5794:24, 5794:28, 5796:5, 5796:15, 5796:21, 5797:45, 5798:6, 5800:8
pharmacist's [4] - 5775:33, 5781:13, 5786:41, 5793:43
pharmacists [77] - 5765:35, 5765:45, 5765:46, 5766:17, 5766:30, 5766:37, 5766:43, 5767:26, 5767:44, 5768:38, 5769:34, 5769:37, 5769:40, 5769:42, 5769:47, 5770:2, 5770:7, 5771:14, 5772:28, 5772:30, 5773:35, 5774:25, 5774:34, 5774:45, 5777:9, 5778:24, 5778:26, 5779:8, 5779:10, 5779:30, 5779:31, 5780:18, 5782:4, 5783:47, 5784:37, 5785:10, 5787:16, 5789:2, 5789:8, 5789:38, 5789:39, 5789:41, 5790:14, 5791:24, 5791:28, 5791:36, 5792:14, 5792:17, 5792:23, 5792:43, 5792:47, 5793:8, 5793:21, 5793:35, 5794:3, 5794:39, 5795:5, 5796:11, 5797:12, 5797:13, 5797:18, 5797:20, 5797:29, 5797:33, 5797:36, 5797:47, 5798:1, 5798:5, 5798:6, 5798:22, 5798:36, 5799:7, 5799:32, 5799:39, 5800:5, 5800:43, 5824:32
Pharmacy [5] - 5764:4, 5764:26, 5764:36, 5780:9, 5798:12
pharmacy [63] - 5764:40, 5768:23, 5768:34, 5768:43, 5769:47, 5770:35, 5770:36, 5770:39, 5770:46, 5771:2, 5771:3, 5771:8, 5771:13, 5771:32, 5771:33, 5772:5, 5772:47, 5773:47, 5774:2, 5774:14, 5774:44, 5775:18, 5775:28, 5776:1,

5777:25, 5777:38,
 5777:44, 5779:45,
 5780:10, 5781:23,
 5784:29, 5784:36,
 5784:38, 5785:15,
 5785:23, 5785:26,
 5785:30, 5786:37,
 5788:31, 5789:27,
 5789:36, 5789:44,
 5790:5, 5790:8,
 5790:18, 5790:22,
 5790:25, 5790:37,
 5791:20, 5791:40,
 5792:3, 5792:5,
 5792:19, 5792:38,
 5792:40, 5794:44,
 5796:21, 5796:34,
 5796:37, 5796:39,
 5797:7, 5797:32
PhD [2] - 5798:16,
 5851:18
phenomenal [3] -
 5810:7, 5831:22,
 5839:46
PHN [3] - 5861:25,
 5861:27
PHNs [1] - 5860:2
phone [5] - 5825:28,
 5825:36, 5827:18,
 5830:20, 5831:47
physically [1] -
 5830:15
physician [3] -
 5781:23, 5827:36,
 5830:3
physio [4] - 5812:28,
 5812:30, 5813:13,
 5814:10
physiologist [2] -
 5812:22, 5833:4
physiologists [2] -
 5811:39, 5812:26
physiology [1] -
 5814:10
physios [2] - 5812:31,
 5813:19
physiotherapist [2] -
 5812:19, 5812:20
pick [3] - 5773:45,
 5849:28, 5852:36
picked [1] - 5799:16
piece [4] - 5814:17,
 5815:46, 5852:12,
 5852:15
piggyback [1] -
 5857:37
pillar [1] - 5791:14
pilot [2] - 5833:13,
 5861:12
pilots [5] - 5832:7,
 5834:13, 5835:46,
 5836:1, 5861:12
pipeline [5] - 5785:13,
 5786:39, 5787:3,
 5790:12, 5790:14
pivotal [2] - 5832:17,
 5834:25
place [17] - 5788:6,
 5806:19, 5810:14,
 5810:15, 5810:42,
 5824:27, 5833:2,
 5838:12, 5845:17,
 5845:31, 5847:41,
 5850:46, 5858:8,
 5861:3, 5862:19,
 5862:21, 5862:23
place-based [1] -
 5858:8
placed [1] - 5785:19
placement [5] -
 5795:46, 5796:27,
 5796:34, 5796:37,
 5821:36
placements [14] -
 5790:34, 5792:39,
 5794:45, 5795:47,
 5796:22, 5796:23,
 5796:25, 5796:28,
 5820:33, 5821:7,
 5845:9, 5853:13,
 5860:22, 5860:27
places [18] - 5788:21,
 5796:47, 5818:42,
 5818:45, 5819:2,
 5819:7, 5819:17,
 5819:20, 5819:31,
 5819:36, 5819:47,
 5822:11, 5835:24,
 5842:27, 5849:22,
 5855:3, 5856:44
plan [6] - 5814:6,
 5825:29, 5825:34,
 5825:35, 5833:2,
 5851:22
planning [3] - 5806:9,
 5858:44, 5861:3
plans [1] - 5851:12
play [6] - 5785:21,
 5841:2, 5856:28,
 5856:37, 5856:38,
 5857:41
player [1] - 5824:3
playing [1] - 5844:34
plenty [1] - 5827:21
plus [3] - 5823:37,
 5843:25
pneumonia [1] -
 5847:36
pneumonias [1] -
 5846:22
pockets [1] - 5818:20
point [41] - 5766:34,
 5767:7, 5771:19,
 5771:35, 5775:8,
 5775:17, 5780:38,
 5781:14, 5783:3,
 5783:4, 5785:13,
 5785:24, 5790:12,
 5791:18, 5794:33,
 5796:45, 5797:37,
 5825:29, 5828:29,
 5829:40, 5833:39,
 5834:32, 5834:34,
 5835:39, 5837:19,
 5837:26, 5840:1,
 5840:47, 5841:25,
 5845:15, 5845:45,
 5851:44, 5851:47,
 5855:33, 5856:20,
 5856:28, 5857:38,
 5857:40, 5858:13,
 5858:40, 5861:19
points [2] - 5829:27,
 5831:25
policy [3] - 5764:25,
 5782:44, 5838:1
political [1] - 5840:42
pool [5] - 5770:44,
 5790:36, 5816:26,
 5835:47, 5861:8
poor [1] - 5768:19
population [10] -
 5809:25, 5811:18,
 5817:13, 5820:18,
 5824:25, 5824:33,
 5827:32, 5840:7,
 5849:12, 5851:4
populations [2] -
 5822:47, 5851:11
portacath [5] -
 5843:45, 5843:46,
 5843:47, 5844:8
portion [1] - 5806:39
position [13] -
 5773:46, 5782:44,
 5788:1, 5790:46,
 5793:44, 5793:45,
 5794:2, 5796:15,
 5809:16, 5822:1,
 5849:31, 5856:5,
 5857:8
positions [18] -
 5771:24, 5785:15,
 5785:23, 5786:10,
 5786:29, 5788:26,
 5788:31, 5788:33,
 5789:25, 5790:13,
 5791:28, 5793:42,
 5798:20, 5799:13,
 5835:45, 5855:12,
 5855:18, 5856:47
positive [3] - 5785:46,
 5789:6, 5813:38
possible [9] -
 5771:12, 5774:18,
 5779:17, 5783:36,
 5784:41, 5796:43,
 5797:36, 5799:8,
 5822:25
possibly [1] - 5856:37
post [3] - 5807:4,
 5817:10, 5856:9
postgraduate [1] -
 5853:11
postings [1] - 5841:5
potential [11] -
 5767:40, 5772:19,
 5772:21, 5775:25,
 5785:11, 5794:43,
 5797:5, 5805:28,
 5819:25, 5840:21,
 5841:40
potentially [7] -
 5772:21, 5783:38,
 5791:13, 5792:4,
 5800:46, 5810:24,
 5832:37
pour [1] - 5854:35
poverty [1] - 5796:28
PPMC [4] - 5772:32,
 5773:1, 5773:39,
 5778:18
practical [3] -
 5768:12, 5799:20,
 5822:18
Practice [1] - 5820:31
practice [163] -
 5766:16, 5768:25,
 5770:15, 5780:46,
 5785:43, 5805:40,
 5806:10, 5806:39,
 5806:43, 5806:44,
 5806:47, 5807:14,
 5807:32, 5808:25,
 5808:27, 5808:41,
 5809:17, 5809:26,
 5810:20, 5810:30,
 5812:5, 5813:4,
 5813:21, 5816:17,
 5817:21, 5818:7,
 5818:9, 5819:31,
 5820:3, 5822:34,
 5822:37, 5822:42,
 5824:2, 5824:5,
 5824:40, 5824:41,
 5825:4, 5825:26,
 5826:6, 5826:28,
 5827:26, 5828:21,
 5828:26, 5828:30,
 5828:44, 5829:2,
 5829:3, 5829:5,
 5829:6, 5829:9,
 5829:18, 5829:24,
 5829:29, 5829:31,
 5829:36, 5829:37,
 5830:20, 5831:6,
 5831:9, 5831:19,
 5831:22, 5832:9,
 5832:22, 5832:37,
 5832:42, 5835:10,
 5835:11, 5835:18,
 5836:3, 5836:10,
 5836:12, 5837:22,
 5837:35, 5837:39,
 5837:41, 5838:3,
 5838:5, 5838:18,
 5838:20, 5838:21,
 5838:30, 5838:31,
 5838:34, 5838:35,
 5839:25, 5840:2,
 5841:6, 5842:29,
 5842:31, 5842:34,
 5843:9, 5843:12,
 5843:24, 5843:26,
 5843:37, 5844:6,
 5844:41, 5845:25,
 5845:46, 5846:9,
 5846:15, 5846:17,
 5846:18, 5846:19,
 5846:25, 5846:33,
 5846:35, 5846:41,
 5846:45, 5847:2,
 5847:4, 5847:19,
 5847:33, 5848:8,
 5848:14, 5848:22,
 5848:33, 5848:40,
 5849:14, 5849:27,
 5849:38, 5850:3,
 5850:9, 5850:23,
 5850:26, 5850:32,
 5850:42, 5851:8,
 5851:18, 5852:39,
 5852:43, 5852:46,
 5853:2, 5853:13,
 5853:33, 5853:35,
 5853:41, 5854:22,
 5854:26, 5854:29,
 5854:35, 5854:40,
 5854:45, 5855:2,
 5855:5, 5855:7,
 5855:25, 5855:27,
 5855:33, 5855:40,
 5855:43, 5856:19,
 5856:32, 5856:40,
 5857:10, 5857:21,
 5858:5, 5860:19,
 5860:23, 5861:37
practice's [2] -
 5814:26, 5837:25
practices [15] -
 5789:12, 5810:37,

5819:26, 5819:31,
5819:32, 5819:34,
5821:1, 5833:15,
5835:35, 5843:16,
5845:18, 5845:19,
5847:10, 5857:17,
5860:27
practise [2] - 5785:29,
5823:15
practising [5] -
5804:12, 5804:44,
5806:12, 5811:21,
5823:9
practitioner [19] -
5801:29, 5802:16,
5804:11, 5808:1,
5813:11, 5814:32,
5818:9, 5826:26,
5832:37, 5832:45,
5832:46, 5833:21,
5835:29, 5836:3,
5837:12, 5838:9,
5839:34, 5847:45,
5861:38
practitioners [12] -
5779:7, 5793:39,
5806:11, 5806:33,
5807:42, 5823:15,
5823:22, 5841:1,
5843:32, 5844:42,
5849:5, 5857:34
Practitioners [4] -
5801:33, 5801:36,
5804:2, 5804:22
pre [1] - 5827:2
pre-existing [1] -
5827:2
precipitate [1] -
5768:9
predispose [1] -
5826:17
prefer [6] - 5800:20,
5822:22, 5827:10,
5847:25, 5847:44,
5859:20
preferable [1] -
5844:32
preferences [2] -
5787:41, 5789:20
preferred [1] -
5842:38
prepared [6] - 5764:6,
5765:2, 5793:21,
5802:21, 5803:14,
5808:14
prescribe [1] -
5782:35
prescribed [7] -
5767:31, 5767:33,
5767:34, 5767:38,
5769:6, 5775:38,
5781:37
prescribers [1] -
5768:24
prescribes [1] -
5766:8
prescribing [12] -
5766:20, 5766:24,
5768:2, 5770:5,
5774:13, 5776:13,
5776:34, 5776:36,
5776:39, 5777:4,
5780:31, 5814:20
prescription [4] -
5766:9, 5766:28,
5770:10, 5774:15
prescriptions [1] -
5774:3
present [10] - 5763:33,
5769:39, 5784:42,
5826:15, 5836:29,
5838:2, 5844:28,
5844:32, 5844:43,
5844:44
presentation [6] -
5769:4, 5811:4,
5825:40, 5828:21,
5843:20, 5846:9
presentations [11] -
5785:2, 5785:7,
5815:41, 5839:37,
5839:44, 5840:6,
5840:18, 5842:7,
5846:4, 5846:6,
5847:19
presented [4] -
5790:20, 5808:38,
5844:5, 5844:39
presenting [2] -
5838:4, 5839:15
presents [1] - 5809:40
preserve [1] - 5856:32
preserved [1] -
5837:12
preserving [1] -
5837:24
president [4] -
5801:29, 5801:39,
5802:17, 5804:38
pressure [7] -
5767:20, 5778:46,
5789:35, 5839:26,
5839:28, 5840:3,
5845:38
pressures [1] -
5780:35
presumably [6] -
5776:15, 5778:26,
5784:43, 5786:15,
5789:26, 5792:35
pretty [4] - 5843:8,
5853:47, 5856:24,
5857:16
prevent [2] - 5784:5,
5784:20
preventative [1] -
5817:36
prevented [2] -
5805:18, 5827:12
preventing [2] -
5770:4
previous [4] -
5819:12, 5832:43,
5848:30, 5856:15
previously [6] -
5800:44, 5803:2,
5807:3, 5829:40,
5852:47, 5853:7
provocational [2] -
5853:13, 5860:18
prices [1] - 5857:5
pricing [1] - 5858:31
primarily [1] - 5812:47
primary [78] - 5781:22,
5783:9, 5805:27,
5805:42, 5806:5,
5806:9, 5806:21,
5806:23, 5806:26,
5806:38, 5806:41,
5806:44, 5807:2,
5807:14, 5808:39,
5809:6, 5809:14,
5809:27, 5809:36,
5810:2, 5811:14,
5811:29, 5812:13,
5812:24, 5812:34,
5812:40, 5812:45,
5813:44, 5813:47,
5814:3, 5814:4,
5816:40, 5817:7,
5817:16, 5818:14,
5824:24, 5824:30,
5832:14, 5834:20,
5834:30, 5836:2,
5836:16, 5836:23,
5836:40, 5837:26,
5837:35, 5838:5,
5838:11, 5838:13,
5838:17, 5838:19,
5838:34, 5839:12,
5839:15, 5839:20,
5839:43, 5840:17,
5841:18, 5845:11,
5845:18, 5845:30,
5845:37, 5845:44,
5845:46, 5846:8,
5848:3, 5848:44,
5853:11, 5854:36,
5856:34, 5857:10,
5858:5, 5858:15,
5859:15, 5861:42
primary/secondary
[1] - 5828:24
principle [2] -
5773:36, 5833:9
priorities [1] - 5788:37
prioritise [4] - 5775:5,
5787:42, 5788:12,
5788:21
prioritised [1] -
5855:12
priority [6] - 5777:33,
5777:39, 5782:6,
5782:7, 5855:18,
5862:19
private [25] - 5784:4,
5784:8, 5784:10,
5813:21, 5825:8,
5827:31, 5831:22,
5835:11, 5835:17,
5835:36, 5836:9,
5837:22, 5837:35,
5837:41, 5838:2,
5838:3, 5838:30,
5838:34, 5841:19,
5856:32, 5856:34,
5856:40, 5857:10,
5857:17, 5857:21
problem [12] -
5775:10, 5780:37,
5795:25, 5809:4,
5819:10, 5822:39,
5824:23, 5824:42,
5824:47, 5842:16,
5842:17, 5862:26
problematic [2] -
5810:37, 5815:30
problems [7] -
5775:11, 5775:15,
5787:17, 5797:14,
5811:27, 5815:32,
5842:5
procedure [2] -
5776:47, 5824:12
proceedings [1] -
5831:33
process [19] -
5766:25, 5768:47,
5769:35, 5775:23,
5787:33, 5787:36,
5787:40, 5789:1,
5789:19, 5791:11,
5791:40, 5792:35,
5805:9, 5805:31,
5814:23, 5814:30,
5815:3, 5845:28,
5846:3
processes [1] -
5812:19
produce [2] - 5775:25,
5854:5
producing [1] -
5781:44
product [2] - 5766:11,
5833:29
profession [2] -
5778:19, 5854:30
professional [7] -
5774:11, 5778:35,
5785:45, 5789:44,
5792:19, 5793:44,
5829:36
professionals [9] -
5790:18, 5791:20,
5808:40, 5809:35,
5810:24, 5812:12,
5812:17, 5813:39,
5834:5
professions [1] -
5854:16
proficient [1] -
5827:47
profile [3] - 5767:5,
5839:14
profiles [1] - 5769:15
program [20] - 5773:1,
5773:7, 5791:25,
5792:30, 5793:22,
5793:27, 5794:7,
5800:5, 5811:42,
5819:44, 5820:4,
5820:35, 5821:30,
5825:24, 5833:20,
5833:23, 5841:41,
5849:31, 5853:14,
5857:30
Program [1] - 5820:31
programs [18] -
5786:18, 5791:23,
5791:30, 5792:14,
5792:20, 5792:26,
5793:7, 5793:15,
5793:43, 5794:40,
5799:31, 5799:44,
5800:1, 5825:22,
5850:10, 5850:12,
5854:11, 5860:38
progress [1] - 5786:20
progressing [2] -
5773:7, 5780:6
progression [4] -
5785:22, 5797:23,
5797:40, 5797:41
progressive [1] -
5827:38
project [2] - 5849:1,
5849:4
projection [1] -
5821:12
projections [1] -

5849:6	5780:16, 5784:7,	5806:20	5783:16, 5791:44,	5852:46
proliferate [1] -	5784:37, 5787:5,	pushing [1] - 5816:4	5791:46, 5805:7,	re-engaging [1] -
5779:40	5794:44, 5797:34,	put [22] - 5769:5,	5807:1, 5807:3,	5852:46
prominent [1] -	5799:8, 5800:7,	5770:2, 5773:7,	5807:40, 5809:27,	re-open [1] - 5839:29
5850:14	5810:43, 5835:11,	5773:8, 5774:23,	5809:40, 5831:14,	re-present [1] -
promotes [1] -	5835:25, 5835:27,	5779:12, 5784:19,	5835:10, 5837:10,	5784:42
5854:15	5835:28, 5838:13,	5793:12, 5800:46,	5837:20, 5837:47,	re-presentation [1] -
prongs [1] - 5796:3	5841:18, 5847:4,	5813:35, 5819:8,	5838:22, 5841:13,	5828:21
pronounced [1] -	5856:29	5822:18, 5823:44,	5843:7, 5845:1,	reach [1] - 5840:31
5783:24	provision [1] -	5828:39, 5830:1,	5845:17, 5846:5,	reached [1] - 5821:47
proof [1] - 5859:41	5848:41	5833:1, 5841:17,	5849:23, 5849:45,	reaches [1] - 5774:14
prop [1] - 5861:36	provisioned [2] -	5858:37, 5858:46,	5858:29	reaching [2] -
propensity [2] -	5775:28, 5779:45	5859:28, 5861:7,		5798:22, 5798:32
5769:22, 5776:9	psychiatric [1] -	5861:40		reaction [2] - 5767:41,
proper [3] - 5832:36,	5777:15	puts [1] - 5788:34	R	5769:22
5845:32, 5859:6	psychiatrist [10] -	putting [11] - 5773:4,	RACGP [8] - 5804:29,	reactive [2] - 5766:14,
propose [1] - 5785:14	5825:28, 5825:32,	5778:1, 5779:14,	5818:40, 5819:46,	5775:13
proposition [2] -	5825:33, 5825:43,	5783:1, 5787:34,	5820:29, 5820:34,	reacts [1] - 5767:35
5797:12, 5832:30	5826:35, 5826:37,	5787:41, 5787:44,	5821:5, 5855:44,	read [1] - 5809:39
pros [1] - 5814:32	5826:45, 5827:2,	5816:39, 5831:15,	5857:20	reading [2] - 5800:33,
prospect [1] - 5859:13	5827:8, 5829:45	5845:17, 5859:28	Rachel [6] - 5801:38,	5808:29
proud [1] - 5800:6	psychiatrists [1] -		5804:36, 5814:15,	readmission [1] -
proves [1] - 5767:43	5831:45	Q	5817:41, 5847:7,	5783:40
provide [43] - 5766:31,	psychiatry [8] -	qualifications [1] -	5856:36	ready [3] - 5779:37,
5767:27, 5769:14,	5778:39, 5778:40,	5799:20	RACHEL [1] - 5802:7	5793:21, 5819:6
5769:24, 5770:1,	5778:42, 5779:11,	qualified [1] - 5790:24	raise [2] - 5800:19,	real [8] - 5779:25,
5770:6, 5770:47,	5779:15, 5794:22,	qualitative [1] -	5800:22	5809:31, 5826:20,
5772:5, 5772:15,	5826:27, 5829:42	5781:5	raised [4] - 5800:44,	5832:12, 5834:17,
5773:34, 5773:43,	public [28] - 5765:33,	quality [11] - 5776:39,	5812:39, 5814:28,	5842:16, 5842:17,
5774:25, 5774:27,	5784:4, 5811:40,	5777:3, 5779:16,	5827:24	5848:3
5775:9, 5777:9,	5812:26, 5812:28,	5780:14, 5790:10,	ramping [4] - 5773:2,	realise [1] - 5855:19
5779:9, 5779:37,	5813:22, 5814:12,	5792:39, 5817:38,	5773:16, 5773:28,	realistic [2] - 5790:1,
5790:8, 5791:29,	5816:15, 5825:8,	5840:47, 5855:42,	5800:31	5859:13
5792:27, 5792:38,	5825:11, 5825:32,	5860:4, 5860:19	range [5] - 5787:22,	realistically [1] -
5793:23, 5795:19,	5825:33, 5827:14,	Quality [3] - 5782:14,	5788:39, 5805:11,	5830:13
5796:44, 5797:1,	5827:33, 5829:36,	5782:16, 5797:27	5820:32, 5822:5	reality [2] - 5783:32,
5797:2, 5798:44,	5831:21, 5837:46,	quantities [2] -	rate [2] - 5792:19,	5783:34
5800:4, 5822:32,	5839:6, 5840:3,	5781:29, 5782:36	5846:9	really [92] - 5767:47,
5827:8, 5836:1,	5841:19, 5849:40,	Queensland [5] -	rate-limiting [1] -	5768:7, 5772:46,
5836:28, 5837:13,	5850:2, 5850:25,	5769:41, 5770:26,	5792:19	5773:2, 5774:9,
5837:45, 5839:11,	5850:26, 5850:28,	5771:40, 5771:46,	rates [5] - 5823:47,	5775:39, 5776:38,
5841:37, 5846:47,	5854:3, 5856:21	5850:14	5824:40, 5839:10,	5777:18, 5777:26,
5848:13, 5848:14,	public's [1] - 5849:46	questions [11] -	5862:10, 5862:14	5777:27, 5777:38,
5850:43, 5857:33,	public/private [1] -	5770:23, 5800:12,	rather [16] - 5807:19,	5777:39, 5777:40,
5859:14	5854:27	5800:17, 5805:11,	5808:8, 5812:18,	5778:20, 5778:39,
provided [11] -	pudding [1] - 5859:42	5805:15, 5805:17,	5814:41, 5815:2,	5778:41, 5783:43,
5765:41, 5765:42,	pull [1] - 5831:34	5805:19, 5805:30,	5824:11, 5825:31,	5783:45, 5784:4,
5766:30, 5771:45,	pulls [1] - 5806:20	5805:32, 5861:47,	5830:20, 5830:28,	5784:35, 5786:9,
5771:46, 5779:39,	purely [5] - 5796:39,	5862:47	5833:47, 5838:35,	5787:2, 5788:12,
5780:20, 5781:1,	5817:14, 5822:5,	quick [1] - 5838:40	5842:43, 5843:21,	5788:13, 5790:47,
5786:15, 5839:9,	5837:26, 5837:34	quicker [2] - 5775:15,	5848:11, 5850:47,	5791:36, 5793:16,
5848:43	purpose [1] - 5835:7	5775:25	5851:19	5794:9, 5794:14,
providers [1] -	purposes [3] -	quickly [9] - 5771:22,	ratio [1] - 5771:40	5794:16, 5795:2,
5857:22	5805:26, 5844:29,	5794:16, 5797:22,	ratios [5] - 5770:22,	5797:17, 5797:30,
provides [2] -	5858:1	5801:46, 5802:11,	5771:36, 5771:44,	5797:32, 5798:4,
5786:40, 5794:27	pursue [2] - 5778:26,	5807:47, 5821:43,	5771:47, 5772:2	5798:33, 5798:39,
providing [23] -	5779:24	5838:42, 5856:26	RDN [2] - 5858:38,	5798:42, 5798:45,
5766:18, 5770:3,	pursuing [1] - 5799:2	quite [26] - 5768:29,	5858:41	5799:7, 5799:43,
5770:47, 5771:11,	push [1] - 5846:41	5769:8, 5781:9,	re [4] - 5784:42,	5807:32, 5809:31,
5779:16, 5780:10,	pushes [2] - 5806:19,		5828:21, 5839:29,	5809:34, 5809:47,

5812:34, 5814:9,
5815:10, 5815:38,
5816:30, 5817:7,
5818:40, 5822:20,
5823:6, 5824:39,
5825:26, 5826:27,
5826:43, 5827:32,
5827:45, 5828:17,
5829:15, 5829:19,
5829:28, 5829:33,
5829:34, 5829:43,
5831:8, 5832:7,
5832:15, 5833:23,
5834:21, 5836:44,
5838:29, 5844:1,
5849:6, 5849:44,
5850:35, 5850:39,
5852:6, 5852:35,
5854:35, 5855:6,
5855:21, 5859:41,
5860:25, 5861:14,
5862:33
realm [1] - 5830:47
rearrange [1] -
5771:18
rearranged [1] -
5771:19
reason [6] - 5766:47,
5769:3, 5818:28,
5818:29, 5823:32,
5853:40
reasonable [3] -
5807:39, 5808:25,
5810:43
reasons [13] -
5769:33, 5770:27,
5781:20, 5810:26,
5810:27, 5822:5,
5823:35, 5840:29,
5840:30, 5847:18,
5859:29, 5862:5,
5862:35
rebate [1] - 5830:15
Rebekah [3] -
5801:31, 5803:45,
5819:45
REBEKAH [1] -
5802:9
rebuild [1] - 5836:45
Rec [1] - 5780:18
receive [4] - 5766:9,
5770:10, 5774:8,
5820:22
received [3] - 5793:14,
5820:22, 5833:19
receives [1] - 5820:25
receiving [3] -
5775:31, 5793:7,
5814:30
recent [1] - 5803:19
recently [3] - 5802:35,
5851:21, 5861:8
recognise [10] -
5776:34, 5786:21,
5797:19, 5799:3,
5800:4, 5824:4,
5825:1, 5836:33,
5843:18, 5857:40
recognised [6] -
5798:13, 5798:14,
5798:17, 5799:39,
5799:41, 5799:46
recognises [3] -
5800:9, 5834:2,
5843:6
recognising [1] -
5827:9
recognition [7] -
5770:46, 5798:9,
5798:11, 5799:19,
5799:25, 5799:38,
5800:5
recommendation [3] -
5773:4, 5773:14,
5849:33
reconciliation [19] -
5766:36, 5766:42,
5767:14, 5767:28,
5767:43, 5767:45,
5768:1, 5768:3,
5768:8, 5768:47,
5769:9, 5772:35,
5772:37, 5774:27,
5774:35, 5775:24,
5775:30, 5789:29,
5789:43
reconciliation" [1] -
5768:12
Record [1] - 5768:20
record [9] - 5764:21,
5764:31, 5802:12,
5803:5, 5803:43,
5804:17, 5804:34,
5830:41, 5836:22
records [1] - 5768:22
recovering [1] -
5783:19
recruiting [2] -
5790:32, 5791:15
recruitment [7] -
5786:37, 5787:33,
5787:36, 5787:39,
5789:1, 5800:43,
5806:16
red [6] - 5851:25,
5851:27, 5852:2,
5852:3, 5852:5,
5852:23
reduce [5] - 5781:2,
5814:5, 5839:44,
5851:26, 5851:27
reduced [2] - 5772:39,
5772:40
reduces [1] - 5840:17
reducing [2] - 5793:1,
5828:21
reduction [1] - 5781:4
refer [3] - 5768:11,
5786:28, 5815:7
reference [2] -
5778:30, 5795:44
referenced [1] -
5830:39
referral [11] - 5813:6,
5814:17, 5814:22,
5814:32, 5814:36,
5815:22, 5815:27,
5817:8, 5817:9,
5817:28, 5854:7
referrals [3] - 5814:17,
5817:24, 5831:44
referred [3] - 5813:13,
5844:40, 5858:9
referring [2] -
5787:27, 5833:12
reflected [2] -
5798:11, 5811:4
reflections [1] -
5817:41
reform [3] - 5781:28,
5782:34, 5783:45
reformed [2] -
5797:13, 5798:39
regard [1] - 5780:34
regarding [1] -
5833:20
regards [11] -
5829:40, 5835:2,
5836:2, 5836:25,
5838:19, 5839:7,
5850:32, 5856:30,
5856:38, 5857:14,
5858:45
region [4] - 5788:15,
5810:42, 5843:31,
5860:38
regional [48] -
5766:36, 5771:42,
5771:45, 5779:22,
5779:31, 5779:46,
5784:2, 5788:17,
5792:9, 5792:15,
5801:30, 5803:10,
5805:24, 5808:2,
5808:47, 5809:5,
5809:8, 5809:40,
5810:3, 5810:19,
5812:10, 5813:4,
5813:41, 5815:17,
5818:12, 5830:46,
5831:10, 5831:14,
5831:19, 5832:12,
5832:15, 5832:21,
5832:27, 5834:6,
5834:21, 5834:28,
5835:4, 5835:34,
5837:41, 5840:2,
5845:6, 5845:15,
5845:42, 5845:47,
5846:5, 5856:1,
5857:31, 5858:5
regional/rural [1] -
5788:22
regions [5] - 5821:2,
5821:31, 5823:2,
5856:35, 5858:3
register [1] - 5849:9
registerable [1] -
5785:27
registered [2] -
5774:37, 5794:28
registrar [14] -
5778:41, 5791:22,
5791:28, 5792:14,
5798:13, 5799:31,
5818:42, 5820:27,
5820:32, 5853:36,
5855:21, 5857:1,
5857:7
registrars [13] -
5808:13, 5819:8,
5819:33, 5819:36,
5819:43, 5819:47,
5820:23, 5820:40,
5821:1, 5821:29,
5821:40, 5859:46,
5860:11
regular [7] - 5766:46,
5768:45, 5794:28,
5816:18, 5843:37,
5850:5, 5850:8
regularly [2] - 5816:4,
5817:24
regulatory [1] -
5861:10
reintroduced [1] -
5854:12
reinvest [2] - 5835:19,
5838:17
reinvested [2] -
5836:15, 5838:25
reinvestment [2] -
5835:19, 5838:23
reiterating [2] -
5832:13, 5834:19
reject [1] - 5832:30
rejected [3] - 5788:2,
5788:3
rejection [1] - 5788:7
related [6] - 5767:1,
5769:16, 5781:17,
5783:45, 5784:34,
5830:43
relates [1] - 5844:29
relation [9] - 5768:35,
5768:47, 5769:37,
5771:43, 5774:28,
5779:42, 5793:41,
5841:17, 5851:47
relational [1] - 5832:1
relationship [5] -
5817:34, 5818:3,
5825:42, 5833:8,
5850:6
relationships [3] -
5833:34, 5858:14,
5858:36
relatively [7] -
5774:29, 5793:26,
5812:42, 5815:29,
5816:47, 5823:45,
5840:41
released [2] - 5818:22,
5848:34
relevant [2] - 5821:6,
5862:4
reliable [1] - 5851:41
reliance [4] - 5832:16,
5832:20, 5834:23,
5856:35
reliant [1] - 5812:18
relief [1] - 5781:9
relies [3] - 5813:6,
5818:8, 5861:5
relieve [1] - 5789:35
relocate [1] - 5820:42
relocating [1] -
5820:41
relocation [1] -
5860:13
rely [4] - 5767:46,
5835:9, 5836:27,
5858:20
relying [1] - 5835:8
remain [5] - 5816:23,
5816:25, 5816:26,
5816:27, 5840:22
remaining [1] - 5818:8
remember [7] -
5781:47, 5816:13,
5817:27, 5822:46,
5831:26, 5849:2,
5849:21
remembering [1] -
5818:3
remote [21] - 5779:39,
5779:47, 5784:2,
5792:33, 5820:15,
5830:46, 5831:10,
5831:14, 5831:20,

5832:15, 5833:27,
5834:22, 5834:29,
5845:6, 5845:15,
5856:15, 5859:46,
5860:4, 5860:14,
5860:23, 5860:28
Remote [1] - 5849:36
remotely [4] - 5792:4,
5792:5, 5792:6,
5792:23
removes [1] - 5829:8
removing [1] -
5828:47
remunerate [1] -
5836:15
remuneration [5] -
5834:41, 5835:2,
5846:26, 5857:14,
5859:3
renal [8] - 5772:13,
5775:45, 5776:30,
5777:28, 5827:36,
5828:33, 5830:2,
5830:3
rent [1] - 5796:30
repeat [1] - 5818:1
replace [3] - 5807:36,
5808:6, 5849:10
replacement [1] -
5811:44
replacing [1] - 5808:9
replicated [1] -
5829:46
report [4] - 5773:4,
5784:13, 5784:33,
5795:7
reporting [1] -
5790:21
representations [1] -
5782:41
requested [1] -
5839:33
requests [1] - 5771:27
require [8] - 5768:33,
5768:38, 5776:12,
5776:27, 5776:31,
5792:37, 5846:39,
5846:40
required [7] - 5766:1,
5788:32, 5790:37,
5795:43, 5814:31,
5851:35, 5852:11
requirement [1] -
5808:21
requirements [2] -
5773:40, 5790:29
requires [9] - 5766:43,
5777:4, 5779:7,
5782:45, 5786:13,
5792:34, 5794:24,
5814:11, 5850:2
requisite [2] - 5771:1,
5784:28
rerouted [1] - 5857:46
research [1] - 5831:36
resident [11] -
5786:18, 5791:22,
5792:13, 5793:42,
5793:44, 5794:2,
5794:5, 5798:13,
5799:30, 5855:20
residents [3] -
5791:28, 5852:42,
5855:11
resistant [1] - 5775:40
resource [1] - 5837:25
resourced [1] -
5781:12
resources [6] -
5773:1, 5790:4,
5832:47, 5843:3,
5843:11, 5850:20
respect [2] - 5769:36,
5780:44
respectful [1] -
5854:16
respiratory [1] -
5828:2
respond [1] - 5771:9
responding [1] -
5768:14
response [6] -
5771:14, 5773:28,
5774:3, 5781:39,
5800:31, 5833:46
responsibility [7] -
5796:8, 5798:24,
5832:14, 5834:20,
5836:27, 5857:41,
5857:42
rest [3] - 5806:40,
5849:40, 5854:10
restored [1] - 5809:26
restructuring [1] -
5771:26
result [3] - 5799:18,
5811:12, 5821:44
resulted [1] - 5820:7
results [3] - 5787:2,
5787:6, 5855:32
retain [3] - 5798:36,
5813:37, 5858:3
retained [2] - 5857:31,
5857:33
retaining [1] - 5797:36
retention [3] -
5785:47, 5794:34,
5859:41
retire [2] - 5851:12,
5851:23
retired [1] - 5838:14
retires [1] - 5811:19
retiring [3] - 5851:12,
5851:20, 5852:1
retraining [2] -
5790:28, 5790:37
return [1] - 5860:13
returned [2] - 5813:27,
5849:9
reverse [1] - 5848:26
review [11] - 5765:10,
5766:19, 5767:9,
5769:24, 5769:28,
5776:12, 5776:31,
5789:9, 5789:43,
5802:30, 5803:28
reviewed [2] -
5798:21, 5802:35
reviewing [1] -
5766:15
reviews [1] - 5815:6
reward [1] - 5771:25
rewarding [1] -
5786:20
rhetorical [2] -
5783:35, 5784:41
rheumatologist [1] -
5815:7
Richard [2] - 5763:14,
5763:35
rightfully [1] - 5852:32
rightly [4] - 5778:42,
5791:2, 5800:5,
5837:10
rights [1] - 5809:22
rigorous [1] - 5769:8
rigour [1] - 5769:2
ring [1] - 5822:47
ringing [1] - 5824:14
rise [1] - 5849:6
risk [15] - 5769:14,
5769:15, 5769:27,
5769:28, 5781:17,
5782:5, 5816:1,
5816:9, 5816:35,
5832:10, 5834:14,
5841:14, 5841:21,
5844:2, 5845:24
risk-based [2] -
5769:15, 5769:27
risks [2] - 5771:47,
5782:22
road [2] - 5840:33,
5841:12
robustness [1] -
5798:9
role [22] - 5765:32,
5766:37, 5774:8,
5775:27, 5775:33,
5776:15, 5781:14,
5785:21, 5795:17,
5804:6, 5804:11,
5804:26, 5804:28,
5812:33, 5817:35,
5832:42, 5832:43,
5844:33, 5848:6,
5848:7, 5850:3,
5860:31
roles [2] - 5794:36,
5836:3
roll [2] - 5828:10,
5837:39
rolled [1] - 5780:7
rolls [1] - 5858:44
room [1] - 5826:37
rooms [2] - 5816:19,
5816:46
Ross [1] - 5763:27
rotating [1] - 5841:8
rotation [5] - 5794:19,
5794:21, 5821:31,
5821:38, 5855:15
rotations [4] - 5794:6,
5794:7, 5853:1,
5860:21
rough [1] - 5857:13
round [1] - 5832:38
route [1] - 5766:3
routine [1] - 5810:41
Roxon [1] - 5849:23
Royal [5] - 5801:32,
5804:1, 5804:21,
5836:9, 5843:7
rubbing [1] - 5837:9
run [3] - 5816:41,
5851:3, 5862:13
running [5] - 5783:21,
5809:20, 5832:5,
5833:18, 5840:32
runs [2] - 5815:32,
5833:24
rural [48] - 5779:22,
5779:31, 5784:1,
5792:9, 5792:15,
5801:30, 5803:9,
5807:23, 5807:25,
5808:1, 5808:47,
5809:5, 5809:8,
5810:3, 5810:6,
5810:19, 5815:17,
5818:12, 5820:3,
5820:15, 5827:25,
5828:7, 5830:46,
5831:10, 5831:14,
5831:19, 5832:15,
5834:21, 5834:28,
5835:34, 5838:28,
5841:28, 5841:47,
5845:6, 5845:15,
5846:14, 5849:36,
5854:22, 5854:47,
5855:1, 5855:6,
5855:24, 5856:1,
5856:13, 5856:15,
5860:23, 5860:28
Rural [5] - 5801:39,
5804:38, 5837:33,
5849:36, 5858:16
rurally [1] - 5827:46
Ryde [1] - 5797:28

S

safe [11] - 5766:21,
5766:28, 5774:13,
5777:3, 5784:26,
5795:40, 5846:23,
5847:37, 5847:40,
5851:42, 5860:4
safer [3] - 5780:42,
5790:9, 5793:23
safest [1] - 5779:16
Safety [2] - 5782:17,
5797:26
safety [4] - 5777:39,
5783:4, 5840:47,
5861:20
sailing [1] - 5857:12
salariéd [12] -
5835:25, 5835:28,
5835:44, 5836:10,
5838:31, 5857:8,
5859:15, 5859:28,
5861:17, 5861:28,
5861:40, 5861:42
salaries [1] - 5787:35
salary [4] - 5786:41,
5798:23, 5836:2,
5838:25
salariying [1] -
5836:25
sat [1] - 5844:9
satellite [3] - 5811:10,
5811:13, 5811:20
satisfied [2] -
5765:17, 5803:33
save [1] - 5832:33
saves [1] - 5775:11
saving [3] - 5840:6,
5840:19, 5842:37
savings [2] - 5775:19,
5840:15
saw [4] - 5809:43,
5813:26, 5815:26,
5828:15
SC [4] - 5763:14,
5763:26, 5763:35
scale [3] - 5839:8,
5840:31, 5861:4
scales [1] - 5797:23

scenario [6] - 5818:26, 5818:30, 5818:33, 5819:14, 5823:19, 5825:11, 5825:31, 5825:32, 5827:13, 5829:3, 5830:7, 5830:31, 5836:26, 5836:28, 5838:38, 5842:20, 5842:30, 5843:12, 5843:33, 5844:30, 5844:31, 5844:33, 5846:9, 5846:17, 5847:13, 5847:26, 5849:12, 5849:40, 5850:12, 5850:15, 5852:36, 5854:14, 5855:11, 5861:35
scheduling [2] - 5832:13, 5834:18
Scheme [1] - 5781:29
scheme [3] - 5835:18, 5853:19, 5856:6
schemes [2] - 5806:17, 5835:23
school [3] - 5849:27, 5852:34, 5854:34
scope [6] - 5779:45, 5792:6, 5832:40, 5844:41, 5844:42, 5847:32
Scott [2] - 5763:38, 5804:19
SCOTT [1] - 5802:1
screen [1] - 5801:35
screening [1] - 5817:17
script [1] - 5784:45
season [1] - 5788:33
seats [1] - 5819:6
second [8] - 5788:38, 5800:42, 5822:3, 5826:34, 5828:29, 5849:35, 5851:13, 5851:30
secretary [3] - 5801:30, 5803:9, 5828:15
section [1] - 5835:15
sector [1] - 5770:34
sectors [1] - 5770:33
see [82] - 5765:46, 5775:3, 5775:5, 5781:32, 5783:10, 5783:25, 5783:30, 5784:45, 5785:35, 5785:43, 5786:7, 5787:24, 5787:32, 5787:35, 5787:47, 5788:21, 5791:11, 5795:1, 5795:3, 5795:16, 5795:17, 5797:7, 5805:25, 5805:37, 5807:25, 5807:33, 5808:12, 5808:19, 5808:26, 5808:27, 5809:18, 5812:2, 5813:2, 5814:2, 5814:6, 5814:20, 5814:21, 5815:8, 5815:18, 5815:42, 5816:15, 5816:29, 5816:46, 5816:47, 5817:25, 5818:26, 5818:30, 5818:33, 5819:14, 5823:19, 5825:11, 5825:31, 5825:32, 5827:13, 5829:3, 5830:7, 5830:31, 5836:26, 5836:28, 5838:38, 5842:20, 5842:30, 5843:12, 5843:33, 5844:30, 5844:31, 5844:33, 5846:9, 5846:17, 5847:13, 5847:26, 5849:12, 5849:40, 5850:12, 5850:15, 5852:36, 5854:14, 5855:11, 5861:35
seeing [18] - 5785:2, 5806:17, 5809:1, 5811:47, 5812:41, 5813:29, 5815:7, 5816:34, 5817:23, 5817:27, 5817:29, 5818:47, 5827:11, 5827:12, 5839:14, 5842:22, 5853:34
seek [2] - 5835:15, 5856:38
seem [6] - 5771:36, 5783:36, 5790:12, 5828:11, 5833:38, 5849:21
sees [3] - 5777:25, 5816:31, 5817:13
SEIFA [2] - 5822:37, 5822:40
selected [2] - 5845:23, 5845:24
selection [1] - 5775:45
self [1] - 5814:38
self-diagnosing [1] - 5814:38
send [3] - 5815:12, 5846:33, 5854:7
sending [3] - 5806:20, 5828:19, 5855:30
Seng [1] - 5842:46
Senior [1] - 5763:26
senior [3] - 5797:44, 5797:45, 5853:34
sense [8] - 5768:12, 5787:12, 5799:17, 5799:20, 5805:17, 5818:37, 5844:28, 5848:3
sensible [1] - 5789:3
sensitivity [1] - 5775:44
separate [2] - 5833:20, 5842:33
September [1] - 5765:2
serendipitous [1] - 5827:6
series [1] - 5805:11
serious [1] - 5825:41
seriously [4] - 5771:3, 5771:6, 5786:39, 5787:3
serve [2] - 5822:47, 5824:33
served [1] - 5843:7
serves [1] - 5804:45
service [44] - 5766:29, 5768:45, 5769:29, 5771:28, 5772:29, 5772:41, 5773:12, 5774:6, 5774:26, 5780:8, 5784:7, 5784:38, 5786:41, 5787:15, 5792:27, 5794:38, 5798:45, 5813:16, 5813:22, 5837:13, 5837:46, 5839:8, 5839:43, 5840:46, 5842:24, 5843:30, 5845:11, 5845:12, 5845:32, 5845:34, 5846:26, 5846:28, 5846:42, 5847:1, 5848:41, 5848:43, 5850:17, 5850:18, 5857:34, 5859:4, 5860:3, 5860:11, 5860:36, 5862:36
Service [2] - 5780:9, 5836:9
service-based [1] - 5843:30
serviced [1] - 5820:46
services [44] - 5765:41, 5766:19, 5769:14, 5770:1, 5770:3, 5770:6, 5770:47, 5771:34, 5771:44, 5772:5, 5779:23, 5779:34, 5779:37, 5779:39, 5780:10, 5780:14, 5780:16, 5780:18, 5780:23, 5792:23, 5793:7, 5810:2, 5811:41, 5812:43, 5814:5, 5824:3, 5835:7, 5838:14, 5841:22, 5841:37, 5842:24, 5842:42, 5843:5, 5844:20, 5844:21, 5845:14, 5845:31, 5846:8, 5847:11, 5849:14, 5850:22, 5850:26, 5850:36
services' [1] - 5845:8
serving [1] - 5811:18
session [1] - 5805:27
set [5] - 5765:30, 5779:27, 5837:40, 5840:46, 5846:27
setting [28] - 5765:33, 5766:16, 5766:37, 5770:37, 5770:38, 5776:26, 5776:35, 5777:2, 5777:6, 5779:26, 5785:11, 5790:20, 5790:25, 5790:27, 5790:29, 5790:37, 5790:39, 5806:44, 5807:14, 5808:2, 5809:27, 5831:22, 5838:21, 5838:33, 5839:19, 5839:20, 5860:20
settings [6] - 5779:47, 5792:16, 5809:5, 5809:8, 5818:12, 5848:45
settle [1] - 5783:27
Settlement [1] - 5837:34
seven [6] - 5781:31, 5783:26, 5783:29, 5783:30, 5784:13, 5833:30
sexy [2] - 5829:12, 5854:30
shape [1] - 5795:2
shared [1] - 5850:10
Shetty [1] - 5842:45
shift [5] - 5805:40, 5818:26, 5818:31, 5841:13, 5855:14
shifting [1] - 5807:40
shoots [1] - 5817:8
short [4] - 5781:33, 5790:30, 5799:32, 5818:22
short-staffed [1] - 5790:30
shortage [4] - 5770:33, 5780:15, 5821:11, 5845:10
shortages [4] - 5783:25, 5785:6, 5807:7, 5831:4
shortfall [2] - 5838:43, 5839:5
shortfalls [1] - 5829:21
show [3] - 5772:38, 5799:40, 5826:23
showed [1] - 5830:45
showing [2] - 5774:44, 5843:21
shown [1] - 5781:2
shows [3] - 5775:1, 5794:37, 5799:37
sick [8] - 5825:4, 5825:6, 5826:6, 5826:7, 5827:30, 5827:44, 5852:44
sicker [1] - 5827:47
side [10] - 5774:23, 5776:10, 5777:16, 5781:38, 5783:1, 5787:34, 5831:29, 5836:40, 5862:21, 5862:22
sifting [1] - 5789:18
sign [2] - 5814:11, 5852:11
signals [1] - 5799:11
signatories [1] - 5782:33
significant [13] - 5768:29, 5790:28, 5790:37, 5806:11, 5807:3, 5815:11, 5823:40, 5824:9, 5839:9, 5839:26, 5839:28, 5839:33, 5857:16
significantly [3] - 5778:34, 5823:29, 5851:36
silo [1] - 5842:33
similar [4] - 5809:28, 5859:34, 5861:18, 5862:34
similarly [4] - 5814:15, 5831:12, 5842:30, 5859:37
simple [2] - 5816:43, 5816:47
simply [2] - 5770:7, 5780:20
single [13] - 5769:24, 5813:15, 5835:27, 5836:11, 5838:28, 5842:44, 5853:4, 5856:13, 5856:29, 5856:44, 5859:33, 5859:37
sit [5] - 5802:36, 5812:43, 5824:16, 5824:17, 5843:33
site [3] - 5792:17, 5837:15, 5843:33

sites [3] - 5792:25, 5839:5, 5861:12
sitting [2] - 5826:14, 5851:27
situ [1] - 5860:40
situation [4] - 5780:32, 5780:33, 5786:28, 5825:39
situations [1] - 5846:32
six [13] - 5767:25, 5788:44, 5794:6, 5794:12, 5794:13, 5804:28, 5807:36, 5810:40, 5821:36, 5825:12, 5852:14, 5862:40
six-minute [1] - 5862:40
six-month [3] - 5788:44, 5794:6, 5821:36
skill [9] - 5778:27, 5778:32, 5779:25, 5779:27, 5793:4, 5799:42, 5841:7, 5846:27, 5856:47
skilled [1] - 5780:2
skills [27] - 5778:24, 5778:25, 5778:30, 5779:4, 5779:8, 5779:15, 5785:43, 5786:19, 5786:21, 5791:10, 5792:44, 5793:3, 5794:4, 5794:10, 5794:16, 5797:1, 5797:20, 5798:10, 5799:40, 5805:2, 5826:33, 5827:46, 5842:2, 5857:23, 5860:29
skin [1] - 5833:30
skin's [1] - 5844:1
skipped [1] - 5777:34
sleep [1] - 5830:22
slightly [4] - 5779:26, 5806:12, 5841:27, 5863:5
slipping [1] - 5827:29
Sloane [10] - 5801:30, 5803:4, 5803:7, 5812:39, 5825:15, 5834:11, 5836:34, 5840:43, 5844:15, 5856:4
SLOANE [36] - 5802:5, 5803:7, 5803:12, 5803:17, 5803:22, 5803:26, 5803:31, 5803:36, 5805:46, 5806:37, 5808:47, 5809:11, 5811:3, 5812:47, 5814:15, 5830:34, 5830:39, 5832:7, 5834:34, 5834:41, 5834:47, 5836:21, 5837:3, 5837:7, 5838:16, 5839:4, 5839:22, 5839:46, 5840:45, 5844:36, 5845:27, 5845:40, 5847:7, 5856:8, 5858:12, 5860:43
Sloane's [1] - 5849:39
small [22] - 5785:36, 5793:26, 5811:10, 5811:12, 5816:41, 5835:34, 5837:25, 5839:5, 5839:11, 5839:23, 5840:23, 5840:28, 5840:40, 5840:41, 5841:29, 5841:34, 5841:38, 5857:18, 5858:25, 5858:37, 5861:11, 5861:37
smaller [9] - 5779:22, 5788:16, 5792:8, 5813:29, 5813:31, 5824:38, 5835:6, 5837:41, 5838:31
smart [1] - 5826:27
smooth [1] - 5857:12
snaffled [1] - 5854:43
so-and-so [1] - 5828:14
social [6] - 5813:26, 5814:20, 5822:41, 5823:11, 5823:13, 5842:35
socially [1] - 5816:25
society [1] - 5816:21
sociodemographic [1] - 5822:36
socioeconomic [3] - 5822:33, 5823:7, 5862:27
sold [1] - 5809:18
sole [1] - 5784:24
solution [4] - 5842:5, 5842:15, 5855:46, 5855:47
solutions [3] - 5785:9, 5805:28, 5842:4
solve [2] - 5775:10, 5797:14
solving [1] - 5811:27
someone [50] - 5771:19, 5784:18, 5789:11, 5796:46, 5811:42, 5812:35, 5814:30, 5814:33, 5815:27, 5815:28, 5822:19, 5825:13, 5825:14, 5825:29, 5826:5, 5826:23, 5826:26, 5826:40, 5827:12, 5827:17, 5827:36, 5827:38, 5828:38, 5830:21, 5833:7, 5833:31, 5833:45, 5835:30, 5836:28, 5837:33, 5840:21, 5840:32, 5842:36, 5842:47, 5843:7, 5843:13, 5843:42, 5844:4, 5844:11, 5845:3, 5846:29, 5846:32, 5847:41, 5853:7, 5853:37, 5853:47, 5854:8, 5854:31, 5855:19, 5859:20
sometimes [8] - 5767:42, 5781:43, 5795:6, 5829:11, 5835:36, 5837:19, 5837:22, 5847:18
somewhat [3] - 5840:43, 5841:26, 5843:34
somewhere [10] - 5786:31, 5825:15, 5830:47, 5841:41, 5842:23, 5843:23, 5847:14, 5849:29, 5850:27, 5854:8
soon [1] - 5833:40
sooner [3] - 5826:1, 5833:38, 5836:43
sorry [18] - 5771:6, 5771:15, 5772:32, 5779:13, 5782:12, 5790:46, 5791:26, 5793:38, 5796:21, 5806:20, 5809:12, 5814:15, 5830:34, 5837:3, 5839:29, 5844:17, 5854:42, 5860:10
sort [9] - 5799:12, 5809:12, 5818:12, 5831:12, 5837:31, 5857:27, 5857:32, 5857:44, 5861:3
sorted [2] - 5775:15, 5783:20
sought [1] - 5813:44
sound [3] - 5790:15, 5790:17, 5833:9
sounds [3] - 5808:37, 5824:22, 5848:23
sources [2] - 5768:20, 5768:27
South [89] - 5763:19, 5764:35, 5767:2, 5768:43, 5769:25, 5769:29, 5769:40, 5769:43, 5769:46, 5770:17, 5770:25, 5770:34, 5770:39, 5771:41, 5771:47, 5772:2, 5772:16, 5773:3, 5773:27, 5773:33, 5773:41, 5778:16, 5779:11, 5779:12, 5779:18, 5780:8, 5781:27, 5782:23, 5782:32, 5782:39, 5782:43, 5784:1, 5785:24, 5786:45, 5787:10, 5787:22, 5787:28, 5788:27, 5788:31, 5790:19, 5791:26, 5791:45, 5793:27, 5793:29, 5793:37, 5794:39, 5795:8, 5796:18, 5797:6, 5797:18, 5797:24, 5797:30, 5797:32, 5798:35, 5800:30, 5801:32, 5802:19, 5803:47, 5804:39, 5806:6, 5808:43, 5809:1, 5809:41, 5812:10, 5818:24, 5819:37, 5820:38, 5820:46, 5821:32, 5824:25, 5824:34, 5831:21, 5832:44, 5835:4, 5836:19, 5837:42, 5838:8, 5838:13, 5838:29, 5839:6, 5840:4, 5841:41, 5843:15, 5847:9, 5849:4, 5856:2, 5856:21, 5860:9, 5861:17
southern [1] - 5804:12
space [2] - 5782:8, 5856:37
sparse [3] - 5791:44, 5791:46, 5827:35
speaking [4] - 5769:41, 5771:18, 5826:37, 5845:6
speaks [1] - 5775:17
SPECIAL [1] - 5863:14
Special [1] - 5763:7
special [2] - 5829:33, 5850:13
specialisation [6] - 5779:4, 5798:46, 5829:24, 5829:30, 5831:31, 5831:40
specialise [6] - 5779:10, 5794:24, 5797:20, 5829:6, 5849:44, 5856:18
specialised [1] - 5786:19
specialising [1] - 5829:3
specialist [22] - 5779:33, 5794:20, 5814:18, 5814:21, 5814:24, 5814:31, 5815:12, 5816:19, 5819:13, 5823:36, 5825:8, 5827:31, 5828:5, 5828:8, 5828:24, 5828:25, 5832:33, 5832:34, 5835:8, 5835:9, 5851:31
specialists [7] - 5768:25, 5778:38, 5827:40, 5828:9, 5831:45, 5832:26, 5854:13
specialties [4] - 5829:47, 5830:4, 5855:28
specialty [11] - 5823:27, 5823:28, 5824:33, 5825:9, 5828:17, 5829:46, 5832:25, 5832:45, 5854:24, 5855:27
specific [1] - 5860:47
specifically [5] - 5806:39, 5836:25, 5842:43, 5845:2, 5860:12
spectrum [2] - 5769:1, 5825:44
speed [1] - 5828:9
spend [9] - 5781:7, 5790:41, 5790:43, 5830:45, 5836:38, 5841:45, 5850:24, 5850:28, 5862:37
spending [5] - 5790:43, 5824:17, 5848:37, 5851:3
spends [1] - 5848:18
spent [4] - 5775:18, 5775:24, 5801:14,

5842:41
split [1] - 5835:11
splitting [1] - 5806:8
spoken [5] - 5806:42, 5810:6, 5826:40, 5848:31, 5853:23
spot [2] - 5809:13, 5858:38
spots [1] - 5847:8
sprawl [1] - 5820:17
spread [1] - 5830:43
springboarded [1] - 5857:32
stability [1] - 5835:28
stable [4] - 5777:2, 5777:5, 5815:6
staff [4] - 5772:38, 5813:37, 5849:42, 5859:2
staffed [3] - 5768:39, 5790:30, 5797:35
staffing [3] - 5772:42, 5797:6, 5797:9
stages [1] - 5856:17
stagger [1] - 5848:10
stand [3] - 5833:20, 5853:9, 5862:14
stand-alone [1] - 5833:20
standard [2] - 5793:16, 5853:2
standards [2] - 5766:17, 5774:11
standing [1] - 5822:36
stands [1] - 5824:25
start [9] - 5788:38, 5794:3, 5805:36, 5824:12, 5831:33, 5842:30, 5848:11, 5849:5, 5856:46
started [1] - 5856:43
starter [1] - 5858:10
starting [9] - 5764:12, 5764:20, 5778:35, 5787:36, 5818:26, 5818:30, 5818:33, 5819:14, 5856:46
starts [2] - 5774:27, 5857:42
state [22] - 5764:20, 5764:30, 5771:10, 5779:6, 5780:13, 5786:29, 5797:24, 5797:30, 5802:11, 5803:4, 5803:42, 5804:16, 5804:33, 5838:43, 5845:15, 5850:7, 5856:12, 5856:45, 5857:39, 5858:13, 5859:7, 5859:17
state's [1] - 5856:5
statement [23] - 5764:6, 5765:2, 5765:29, 5773:23, 5778:23, 5778:31, 5786:27, 5791:8, 5792:45, 5795:43, 5800:36, 5800:46, 5802:21, 5802:26, 5803:19, 5813:36, 5825:21, 5830:40, 5832:4, 5833:13, 5835:44, 5838:18, 5861:9
statements [1] - 5803:14
states [14] - 5770:16, 5771:37, 5772:1, 5772:14, 5772:28, 5778:13, 5781:6, 5781:30, 5787:1, 5790:42, 5793:29, 5793:39, 5794:41, 5796:14
statin [1] - 5828:40
Statistics [1] - 5849:3
statistics [1] - 5810:1
status [3] - 5773:6, 5776:26, 5777:2
stay [12] - 5767:22, 5772:39, 5821:37, 5821:40, 5829:31, 5829:38, 5830:26, 5849:7, 5856:35, 5857:32, 5859:30, 5860:41
steep [1] - 5794:9
step [5] - 5792:19, 5795:1, 5799:10, 5812:2, 5818:39
stepped [2] - 5793:22, 5800:4
stick [1] - 5833:29
sticking [1] - 5844:8
still [27] - 5767:15, 5773:38, 5784:34, 5789:39, 5790:28, 5793:30, 5793:34, 5810:35, 5812:25, 5814:2, 5814:5, 5814:6, 5814:8, 5814:11, 5815:21, 5819:11, 5823:47, 5836:14, 5836:19, 5837:14, 5838:10, 5847:30, 5851:34, 5851:35, 5852:27, 5856:10, 5857:8
stitches [1] - 5769:5
stood [3] - 5809:19, 5843:32, 5853:8
stop [3] - 5767:24, 5851:44, 5858:46
stops [1] - 5857:42
story [3] - 5784:2, 5813:28, 5818:1
strain [1] - 5790:4
strands [1] - 5778:25
strategies [1] - 5807:30
strategy [2] - 5785:47, 5839:35
stratify [1] - 5816:38
stream [1] - 5820:26
streamline [1] - 5815:3
streamlined [1] - 5814:39
Street [1] - 5763:18
strength [1] - 5790:14
strengths [1] - 5775:2
strict [1] - 5805:17
stroke [9] - 5783:18, 5784:6, 5784:12, 5784:14, 5784:19, 5784:20, 5794:23, 5815:10, 5816:11
strong [1] - 5811:32
strongly [1] - 5798:21
structure [2] - 5771:25, 5799:27
structured [1] - 5794:28
struggling [2] - 5787:14, 5809:34
student [7] - 5785:26, 5785:31, 5787:37, 5794:44, 5796:22, 5796:37, 5860:22
students [35] - 5770:36, 5770:39, 5774:36, 5774:40, 5774:44, 5785:34, 5785:37, 5786:10, 5787:45, 5788:9, 5788:47, 5789:5, 5789:17, 5791:2, 5792:40, 5795:1, 5795:6, 5795:13, 5795:16, 5795:19, 5795:30, 5795:34, 5795:47, 5796:6, 5796:17, 5796:24, 5796:28, 5796:34, 5796:43, 5797:7, 5797:33, 5852:32, 5852:33, 5852:38
study [3] - 5788:8, 5815:46, 5830:45
stuff [5] - 5777:43, 5843:9, 5846:45, 5857:37, 5861:13
style [2] - 5843:9, 5861:28
styles [1] - 5816:36
sub [16] - 5814:31, 5823:27, 5823:28, 5823:36, 5825:9, 5829:3, 5829:6, 5829:24, 5829:30, 5831:31, 5831:40, 5832:45, 5849:9
sub-register [1] - 5849:9
sub-specialisation [4] - 5829:24, 5829:30, 5831:31, 5831:40
sub-specialise [1] - 5829:6
sub-specialising [1] - 5829:3
sub-specialist [1] - 5814:31
sub-specialty [4] - 5823:27, 5823:28, 5825:9, 5832:45
sub-sub-specialist [1] - 5823:36
sub-sub-specialty [1] - 5823:28
subject [1] - 5767:2
submission [2] - 5770:40, 5833:20
subscribed [1] - 5849:32
subscription [1] - 5849:32
subsidised [1] - 5838:25
substantial [2] - 5806:32, 5807:1
substitute [3] - 5845:37, 5845:41, 5848:3
subtle [1] - 5844:23
suburb [2] - 5830:43, 5830:44
suburbs [2] - 5804:12, 5832:11
success [5] - 5848:24, 5858:9, 5859:39, 5859:42, 5861:5
successes [2] - 5856:27, 5859:33
successful [10] - 5809:20, 5832:7, 5835:23, 5835:35, 5838:22, 5853:24, 5856:6, 5857:28, 5858:2, 5862:13
successfully [1] - 5858:41
succession [1] - 5858:44
suddenly [1] - 5854:41
suffer [1] - 5788:17
suffers [2] - 5823:6, 5854:29
sufficient [6] - 5768:33, 5785:12, 5786:14, 5793:38, 5795:45, 5811:17
sufficiently [2] - 5782:28, 5802:35
suggest [1] - 5848:1
suggested [3] - 5793:36, 5795:42, 5795:46
suggests [1] - 5767:44
suicidality [1] - 5826:17
suit [2] - 5813:40, 5831:16
suitable [3] - 5790:23, 5820:2, 5822:1
suitably [1] - 5790:23
summarised [1] - 5809:46
summation [1] - 5823:19
superhero [1] - 5831:16
supervise [1] - 5819:33
supervised [2] - 5785:29, 5789:39
supervision [7] - 5789:41, 5789:46, 5855:5, 5859:46, 5860:4, 5860:5, 5860:14
supervisors [2] - 5797:3, 5819:6
supplementary [1] - 5800:46
supply [11] - 5765:36, 5765:44, 5766:27, 5770:8, 5770:9, 5770:19, 5772:23, 5774:7, 5798:29, 5820:8
supplying [1] - 5774:11
support [18] - 5782:46, 5784:35, 5786:14, 5787:5, 5794:37, 5797:37,

- 5820:31, 5820:40,
5820:41, 5825:25,
5828:4, 5828:19,
5836:39, 5848:42,
5850:45, 5851:1,
5855:19, 5860:13
supported [4] -
5773:36, 5821:22,
5833:33, 5860:28
supporting [2] -
5820:47, 5860:40
supports [2] - 5812:4,
5834:1
suppose [2] - 5809:3,
5840:3
supposed [1] - 5844:1
surface [1] - 5844:1
surgeons [1] -
5823:23
surgery [1] - 5854:44
surgical [1] - 5794:13
survey [3] - 5818:23,
5850:25, 5851:21
SUSTAIN [2] -
5825:24, 5833:13
sustain [1] - 5809:36
sustainable [1] -
5810:26
Swan [1] - 5861:26
sweet [1] - 5809:13
swimmingly [1] -
5839:25
Swiss [1] - 5811:26
sworn [2] - 5764:18,
5802:1
Sydney [16] - 5763:19,
5764:41, 5774:44,
5785:33, 5796:42,
5804:12, 5817:44,
5818:15, 5818:18,
5818:21, 5823:1,
5830:44, 5842:41,
5859:25, 5859:26,
5859:27
symptom [1] -
5842:16
system [52] - 5766:39,
5771:10, 5778:14,
5789:1, 5791:4,
5795:38, 5799:21,
5806:18, 5806:21,
5811:40, 5811:47,
5812:4, 5812:18,
5812:28, 5814:8,
5816:2, 5816:14,
5816:15, 5817:37,
5819:16, 5820:10,
5820:12, 5824:1,
5824:19, 5824:24,
5824:47, 5825:2,
5827:3, 5827:45,
5831:21, 5833:36,
5834:1, 5836:38,
5837:46, 5839:6,
5840:16, 5840:19,
5841:31, 5841:36,
5841:37, 5841:46,
5843:1, 5844:34,
5847:16, 5847:25,
5848:18, 5850:6,
5851:1, 5851:41,
5854:34, 5856:21
system's [1] - 5780:38
system-wide [1] -
5824:24
systematise [1] -
5827:16
systematised [1] -
5827:16
systemic [1] - 5828:4
systems [10] -
5812:19, 5818:6,
5824:8, 5829:20,
5829:43, 5850:10,
5850:14, 5850:46,
5850:47, 5858:46
-
- T**
-
- tab** [2] - 5764:7,
5802:42
table [4] - 5770:23,
5778:33, 5823:44,
5826:14
tablets [1] - 5769:10
tabs [2] - 5803:38,
5825:41
tail [1] - 5770:6
take-away [1] - 5799:6
Tamsin [1] - 5763:28
tangential [1] -
5841:27
tape [6] - 5851:25,
5851:27, 5852:2,
5852:3, 5852:5,
5852:24
target [2] - 5849:30,
5852:37
targeted [2] - 5789:22,
5820:43
targets [1] - 5852:36
task [5] - 5766:1,
5768:35, 5769:2,
5774:28, 5778:20
tasks [4] - 5775:9,
5777:33, 5777:37,
5794:36
Tasmania [1] -
5859:33
Tasmanian [1] -
5859:34
teach [2] - 5795:4,
5796:45
teaching [9] -
5787:11, 5787:20,
5792:33, 5795:31,
5795:35, 5795:37,
5795:46, 5831:36,
5833:18
team [19] - 5806:40,
5808:41, 5811:28,
5813:12, 5813:14,
5814:25, 5830:2,
5830:19, 5830:29,
5832:22, 5832:36,
5848:41, 5848:44,
5850:35, 5857:18,
5857:37, 5859:43,
5861:29
team-based [1] -
5830:29
teams [2] - 5833:35,
5860:1
Teams [2] - 5792:24,
5792:29
tease [1] - 5805:28
technicians [1] -
5771:13
technology [1] -
5820:41
Technology [1] -
5817:44
telehealth [5] -
5779:39, 5780:7,
5780:11, 5780:17,
5792:28
Temora [1] - 5804:45
temporary [1] - 5857:5
tend [1] - 5765:46
tender [1] - 5765:24
term [4] - 5818:3,
5819:30, 5833:34,
5842:42
terms [17] - 5769:2,
5769:8, 5775:28,
5779:21, 5783:34,
5791:6, 5792:43,
5792:47, 5805:9,
5805:37, 5808:1,
5810:43, 5824:18,
5824:21, 5851:8,
5853:2, 5853:3
terrible [1] - 5814:38
terribly [1] - 5813:23
terrific [1] - 5853:19
test [3] - 5807:47,
5861:12, 5861:13
testings [1] - 5775:44
tests [2] - 5814:47,
5817:17
thankfully [1] -
5821:22
thankless [1] -
5829:11
themselves [5] -
5787:4, 5787:7,
5795:17, 5808:10,
5828:47
therapy [1] - 5767:24
therefore [3] -
5782:35, 5807:33,
5822:34
they have [42] -
5764:6, 5770:1,
5772:28, 5772:36,
5772:37, 5772:38,
5772:39, 5772:40,
5773:7, 5773:8,
5773:11, 5777:31,
5778:13, 5779:8,
5781:6, 5781:14,
5784:21, 5784:26,
5786:21, 5786:36,
5786:47, 5788:12,
5788:20, 5793:4,
5794:4, 5796:8,
5796:16, 5799:10,
5799:13, 5799:40,
5799:42, 5809:20,
5810:9, 5810:10,
5815:9, 5825:17,
5836:8, 5842:1,
5842:28, 5844:38,
5856:23, 5861:22
They've [1] - 5852:13
they've [19] - 5773:31,
5781:32, 5784:19,
5788:6, 5809:21,
5809:22, 5813:30,
5815:10, 5824:39,
5824:40, 5824:41,
5825:45, 5829:13,
5835:35, 5841:42,
5851:41, 5853:24,
5857:29
thin [5] - 5836:4,
5858:8, 5858:19,
5858:40, 5859:12
thinking [3] - 5784:23,
5811:34, 5856:18
thinks [2] - 5807:35,
5850:26
third [2] - 5809:24,
5851:14
thorough [2] -
5774:27, 5775:24
thousand [2] - 5816:3,
5819:40
thousands [1] -
5816:8
threat [1] - 5810:2
three [25] - 5783:22,
5788:4, 5789:20,
5796:16, 5807:20,
5808:6, 5808:7,
5808:10, 5818:20,
5819:11, 5825:14,
5825:47, 5827:37,
5828:15, 5831:25,
5839:37, 5839:40,
5842:41, 5851:10,
5852:8, 5852:14,
5852:16, 5855:40,
5855:47, 5857:30
thriving [1] - 5810:8
throughout [1] -
5796:35
throw [1] - 5774:40
throwing [1] - 5826:42
THURSDAY [1] -
5863:15
ticked [1] - 5830:27
ticking [1] - 5816:7
tide [1] - 5851:8
tied [1] - 5827:41
time-based [1] -
5846:29
timeline [1] - 5788:41
timely [2] - 5781:25,
5812:42
tired [1] - 5824:7
tiredness [1] - 5824:7
tirelessly [1] - 5856:36
TO [1] - 5863:15
today [9] - 5764:3,
5765:11, 5797:19,
5798:44, 5800:2,
5802:31, 5803:29,
5835:33, 5848:31
today's [1] - 5831:33
tomorrow [6] -
5810:11, 5825:36,
5830:8, 5830:12,
5830:24, 5863:12
took [1] - 5844:7
tool [1] - 5858:18
tools [1] - 5858:7
top [7] - 5785:36,
5789:20, 5806:46,
5807:29, 5824:17,
5825:43, 5832:40
topic [1] - 5852:31
topography [1] -
5845:9
total [4] - 5819:34,
5849:6, 5850:24,
5850:27
totally [2] - 5836:4,
5847:7
touch [2] - 5832:19,

- 5838:41
touched [3] - 5818:11, 5831:30, 5834:8
towards [3] - 5789:6, 5816:4, 5842:13
town [40] - 5809:47, 5810:6, 5810:14, 5810:38, 5810:42, 5811:10, 5811:13, 5811:16, 5811:18, 5811:19, 5811:21, 5812:15, 5812:22, 5812:30, 5812:31, 5835:10, 5835:15, 5836:16, 5837:23, 5837:26, 5837:36, 5837:39, 5839:23, 5839:44, 5840:2, 5840:41, 5841:19, 5857:34, 5859:23, 5859:24, 5859:25, 5859:37, 5859:47, 5861:26, 5861:39
towns [22] - 5809:12, 5809:29, 5809:32, 5809:40, 5810:31, 5810:35, 5811:5, 5812:16, 5813:4, 5813:29, 5821:37, 5836:4, 5837:8, 5837:10, 5837:38, 5838:31, 5839:11, 5841:29, 5841:34, 5858:22, 5860:8, 5860:9
track [1] - 5858:19
train [18] - 5774:36, 5790:44, 5791:2, 5791:31, 5796:8, 5796:11, 5819:2, 5819:3, 5819:5, 5819:7, 5819:11, 5820:10, 5821:30, 5822:27, 5841:36, 5855:44, 5857:10
trained [16] - 5790:19, 5793:8, 5793:38, 5806:24, 5806:32, 5810:9, 5823:4, 5830:21, 5841:29, 5841:42, 5842:32, 5851:15, 5851:30, 5851:32, 5852:27, 5862:20
trainees [1] - 5819:26
training [61] - 5777:10, 5778:24, 5778:27, 5779:22, 5779:25, 5786:18, 5790:28, 5790:44, 5791:6, 5791:9, 5791:11, 5791:13, 5791:20, 5791:23, 5791:25, 5791:29, 5792:14, 5792:20, 5792:26, 5792:44, 5793:3, 5793:14, 5793:15, 5793:38, 5793:42, 5793:47, 5794:29, 5794:31, 5799:19, 5799:30, 5799:31, 5805:2, 5806:13, 5818:41, 5819:12, 5819:17, 5819:18, 5819:30, 5819:31, 5819:32, 5819:44, 5820:12, 5820:23, 5820:32, 5820:34, 5821:30, 5821:41, 5822:11, 5822:12, 5822:13, 5848:24, 5849:22, 5853:37, 5856:17, 5856:30, 5856:47, 5857:1, 5857:22, 5859:19, 5860:38
Training [1] - 5820:31
trains [1] - 5774:40
transactional [1] - 5833:8
transferrable [1] - 5790:27
transferred [1] - 5784:3
transition [3] - 5782:23, 5782:26, 5795:24
transitions [10] - 5765:41, 5781:16, 5781:18, 5782:5, 5783:44, 5783:47, 5784:6, 5784:22, 5784:26, 5784:37
trap [1] - 5840:9
travel [1] - 5857:19
travelling [1] - 5809:15
travels [1] - 5808:3
treat [2] - 5776:10, 5777:19
treating [5] - 5776:16, 5776:23, 5816:42, 5828:41, 5839:19
treatment [5] - 5775:31, 5779:43, 5779:47, 5814:40, 5828:42
tree [1] - 5824:18
tremendous [1] - 5859:43
trend [2] - 5807:17, 5848:27
triage [3] - 5843:4, 5844:10, 5845:2
trial [2] - 5860:47, 5861:26
trick [1] - 5854:47
tricky [4] - 5833:9, 5841:12, 5858:12, 5861:38
triggered [1] - 5814:16
trips [1] - 5766:36
trouble [1] - 5855:9
true [6] - 5765:18, 5765:47, 5802:38, 5803:33, 5811:23, 5853:25
truly [1] - 5860:39
trust [1] - 5857:16
try [11] - 5779:9, 5788:37, 5791:35, 5805:28, 5816:5, 5825:22, 5833:44, 5848:26, 5851:19, 5858:16, 5861:13
trying [11] - 5769:27, 5775:20, 5788:9, 5795:39, 5805:20, 5811:42, 5815:26, 5829:20, 5840:15, 5849:1
turn [4] - 5818:26, 5819:4, 5848:23, 5851:7
turned [2] - 5769:5, 5821:24
turning [3] - 5821:15, 5842:4, 5848:32
turns [2] - 5785:42, 5847:37
twelve [1] - 5804:8
twice [2] - 5788:3, 5827:10
two [36] - 5776:47, 5777:8, 5783:36, 5787:24, 5787:42, 5789:26, 5793:10, 5794:7, 5795:14, 5796:3, 5798:5, 5801:9, 5801:46, 5803:14, 5804:29, 5807:8, 5807:36, 5807:38, 5808:6, 5808:7, 5808:10, 5809:16, 5809:19, 5810:40, 5812:30, 5818:30, 5819:11, 5825:28, 5825:34, 5825:47, 5826:36, 5827:37, 5833:14, 5842:41, 5850:8, 5859:27
two-year [1] - 5794:7
type [6] - 5779:47, 5780:3, 5798:29, 5832:40, 5839:20, 5859:20
types [4] - 5768:3, 5769:18, 5777:21, 5784:16
typical [2] - 5765:32, 5767:3
-
- U**
-
- UK** [2] - 5823:45, 5851:33
ulcers [1] - 5829:13
ultimately [1] - 5813:40
unable [3] - 5782:34, 5825:31, 5844:31
uncommon [1] - 5846:20
under [15] - 5789:41, 5810:2, 5811:47, 5816:36, 5819:36, 5820:46, 5831:9, 5832:13, 5834:15, 5834:18, 5835:16, 5835:18, 5850:4, 5855:5, 5862:14
under-appreciation [1] - 5831:9
under-serviced [1] - 5820:46
underfunded [1] - 5770:35
underneath [1] - 5811:32
understood [3] - 5773:47, 5792:45, 5834:11
undersubscribed [1] - 5819:45
undersubscription [1] - 5820:6
undertake [6] - 5766:43, 5789:40, 5792:20, 5792:25, 5821:31, 5821:36
undertaken [3] - 5769:35, 5769:37, 5791:24
undertaking [3] - 5774:34, 5796:34, 5796:37
undifferentiated [1] - 5844:45
unfilled [1] - 5819:7
unfortunately [4] - 5768:17, 5768:42, 5770:2, 5790:41
uni [1] - 5796:17
unintentional [1] - 5767:8
universities [2] - 5796:14, 5860:21
University [5] - 5764:41, 5774:44, 5785:33, 5796:43, 5817:44
university [5] - 5785:33, 5796:26, 5827:4, 5831:36, 5852:36
unless [3] - 5830:15, 5835:24, 5835:27
unnecessary [2] - 5814:23, 5815:21
unpack [2] - 5811:8, 5819:19
unpaid [1] - 5817:29
unreferred [1] - 5850:22
unsafe [1] - 5807:40
unseen [1] - 5817:7
unsustainable [1] - 5807:26
unviable [2] - 5862:30, 5862:37
unwell [5] - 5779:6, 5825:6, 5844:44, 5846:30, 5848:7
up [70] - 5767:8, 5768:21, 5769:5, 5773:45, 5774:1, 5778:14, 5783:9, 5784:8, 5790:21, 5790:31, 5795:45, 5799:16, 5799:18, 5799:29, 5806:41, 5807:6, 5808:28, 5809:19, 5809:35, 5810:20, 5811:29, 5813:30, 5814:7, 5814:26, 5816:4, 5821:28, 5823:8, 5823:20, 5825:3, 5825:5, 5825:15, 5825:35, 5825:39, 5826:23, 5828:3, 5830:8, 5831:25, 5832:4, 5832:22, 5835:41, 5836:5, 5836:36, 5837:9, 5837:40, 5838:33, 5838:38, 5840:26, 5840:33, 5840:46, 5841:5, 5841:11,

5841:16, 5841:17,
5841:36, 5841:42,
5842:6, 5843:21,
5843:32, 5845:44,
5846:19, 5846:22,
5848:32, 5851:3,
5852:37, 5857:41,
5858:39, 5860:27,
5861:36
upcoming [1] -
5807:18
update [1] - 5815:11
updated [2] - 5815:23,
5852:7
urban [1] - 5820:17
urgent [35] - 5818:28,
5818:29, 5842:7,
5842:8, 5842:15,
5842:19, 5842:21,
5842:27, 5842:32,
5842:33, 5842:42,
5842:43, 5843:17,
5843:21, 5844:14,
5844:17, 5844:18,
5844:19, 5844:20,
5845:8, 5845:11,
5845:12, 5845:33,
5846:15, 5846:16,
5846:26, 5846:38,
5846:44, 5847:1,
5847:5, 5847:13,
5847:19, 5848:2,
5848:32
urges [1] - 5840:10
useful [7] - 5805:20,
5815:38, 5824:2,
5825:24, 5826:15,
5833:19, 5843:44
uses [1] - 5843:5
usual [2] - 5768:21,
5842:31
utilise [1] - 5797:4
utility [1] - 5805:32
Utopia [1] - 5853:27

V

valuable [2] - 5829:8,
5857:6
value [21] - 5766:32,
5775:9, 5777:9,
5786:21, 5787:32,
5787:35, 5788:10,
5791:11, 5792:3,
5794:38, 5795:19,
5796:44, 5797:1,
5797:2, 5798:44,
5798:45, 5814:29,
5815:21, 5817:46,
5818:1, 5859:18

value-adding [1] -
5766:32
van [4] - 5801:35,
5804:16, 5804:19,
5817:47
VAN [15] - 5802:1,
5804:19, 5804:24,
5804:28, 5808:32,
5817:33, 5819:29,
5819:43, 5820:29,
5821:17, 5821:21,
5822:3, 5822:25,
5848:29, 5859:36
variable [2] - 5776:44,
5810:14
variations [1] -
5810:45
varied [2] - 5809:11,
5859:38
variety [5] - 5768:27,
5781:6, 5781:19,
5809:40, 5810:30
various [9] - 5766:1,
5767:2, 5771:2,
5771:14, 5773:8,
5778:25, 5791:41,
5791:46, 5797:25
vary [2] - 5809:47,
5811:18
vast [1] - 5768:43
vaster [1] - 5777:11
vastly [1] - 5771:36
VCPS [1] - 5780:9
ventricle [2] -
5823:37, 5823:41
version [2] - 5807:31,
5835:26
versus [4] - 5771:42,
5775:20, 5795:14,
5840:32
vessel [1] - 5823:41
vessels [1] - 5823:37
via [8] - 5780:11,
5780:16, 5791:46,
5792:23, 5792:28,
5792:29, 5825:16,
5837:33
viable [12] - 5835:36,
5835:40, 5835:42,
5840:34, 5846:31,
5850:42, 5850:43,
5856:40, 5858:25,
5858:33, 5861:36,
5861:37
vice [1] - 5764:35
Victoria [11] -
5769:41, 5770:26,
5770:42, 5771:40,
5771:46, 5786:28,
5786:36, 5787:2,

5787:20, 5787:33,
5795:14
Victorian [4] -
5786:38, 5786:40,
5787:5, 5861:26
view [26] - 5769:36,
5777:12, 5778:43,
5780:38, 5783:3,
5783:4, 5785:13,
5785:24, 5788:47,
5790:12, 5794:33,
5822:20, 5823:20,
5835:39, 5837:26,
5840:47, 5842:10,
5844:14, 5845:15,
5855:34, 5856:28,
5857:38, 5857:40,
5858:3, 5858:13,
5858:40
viewing [1] - 5840:10
viewpoint [1] - 5779:2
views [1] - 5856:5
village [2] - 5811:13,
5811:20
virtual [7] - 5831:37,
5832:19, 5832:23,
5833:23, 5833:27,
5833:34, 5833:43
Virtual [1] - 5780:8
virtually [2] - 5832:32,
5832:35
visa [1] - 5806:16
visit [5] - 5810:41,
5815:14, 5815:22,
5837:28, 5848:35
visited [1] - 5838:12
visiting [2] - 5809:22,
5837:13
visits [3] - 5812:23,
5815:21, 5860:13
VMO [5] - 5804:44,
5809:24, 5835:11,
5836:28, 5837:34
VMOs [5] - 5811:25,
5836:39, 5841:23,
5841:38, 5841:47
void [2] - 5821:12
volume [7] - 5835:36,
5835:39, 5840:47,
5841:3, 5841:6,
5842:25, 5861:35
volumes [1] - 5858:26
vomiting [1] - 5776:11
vRGS [1] - 5831:38

W

WA [1] - 5780:7
Waa [2] - 5839:27,
5841:3

wage [3] - 5786:36,
5786:43, 5786:47
Wagga [8] - 5810:8,
5811:11, 5822:19,
5822:21, 5827:34,
5835:5
Wagga's [1] - 5842:29
wait [3] - 5784:45,
5810:44, 5825:12
waiting [3] - 5773:38,
5788:23, 5788:29
Wales [89] - 5763:19,
5764:35, 5767:3,
5768:43, 5769:26,
5769:29, 5769:40,
5769:44, 5769:47,
5770:17, 5770:25,
5770:35, 5770:39,
5771:41, 5771:47,
5772:2, 5772:16,
5773:3, 5773:27,
5773:33, 5773:41,
5778:16, 5779:11,
5779:12, 5779:18,
5780:8, 5781:27,
5782:23, 5782:32,
5782:39, 5782:43,
5784:1, 5785:24,
5786:45, 5787:10,
5787:22, 5787:28,
5788:27, 5788:31,
5790:19, 5791:26,
5791:45, 5793:27,
5793:29, 5793:37,
5794:39, 5795:8,
5796:18, 5797:6,
5797:18, 5797:24,
5797:30, 5797:32,
5798:35, 5800:30,
5801:32, 5802:19,
5803:47, 5804:39,
5806:6, 5808:43,
5809:1, 5809:41,
5812:10, 5818:24,
5819:37, 5820:38,
5820:46, 5821:32,
5824:25, 5824:34,
5831:21, 5832:44,
5835:4, 5836:19,
5837:42, 5838:8,
5838:13, 5838:29,
5839:6, 5840:4,
5841:41, 5843:15,
5847:9, 5849:4,
5856:2, 5856:21,
5860:10, 5861:17
Walid [1] - 5842:45
walk [3] - 5780:30,
5837:23, 5840:9
walked [1] - 5782:28

walking [1] - 5793:11
walks [2] - 5824:4,
5824:6
wants [5] - 5772:11,
5773:9, 5788:33,
5793:47, 5842:9
ward [22] - 5772:6,
5772:8, 5772:10,
5778:40, 5779:11,
5779:13, 5779:14,
5790:47, 5791:30,
5793:11, 5793:12,
5793:22, 5793:36,
5794:13, 5794:14,
5794:20, 5794:21,
5794:22, 5794:23,
5794:25
wards [10] - 5766:18,
5768:39, 5768:40,
5768:44, 5768:45,
5770:3, 5771:29,
5774:4, 5793:34,
5794:14
warranted [1] -
5837:29
watching [1] - 5790:4
Water [4] - 5801:35,
5804:16, 5804:19,
5817:47
WATER [15] - 5802:1,
5804:19, 5804:24,
5804:28, 5808:32,
5817:33, 5819:29,
5819:43, 5820:29,
5821:17, 5821:21,
5822:3, 5822:25,
5848:29, 5859:36
Waterhouse [1] -
5763:28
ways [5] - 5797:8,
5816:29, 5828:42,
5850:33, 5853:5
wealth [1] - 5805:29
Wednesday [1] -
5763:22
Wee [2] - 5839:27,
5841:3
week [13] - 5804:8,
5807:21, 5809:16,
5811:41, 5812:3,
5825:35, 5830:10,
5830:12, 5830:13,
5830:23, 5843:41,
5848:34
weekends [1] -
5853:38
weeks [6] - 5796:16,
5810:40, 5815:47,
5818:30, 5825:14,
5852:14

weight [1] - 5811:45	5835:44, 5861:9	workplace [1] -	5854:23, 5854:43,
welcome [1] - 5791:47	WITNESS [1] -	5790:30	5859:27, 5860:18,
Welfare [1] - 5849:4	5801:21	works [5] - 5786:45,	5860:19
well-loved [1] -	WITNESSES [1] -	5787:34, 5815:32,	yesterday [3] -
5857:33	5863:9	5856:29, 5856:32	5813:26, 5814:16,
well-organised [1] -	witnesses [3] -	world [2] - 5823:19,	5853:24
5858:21	5764:3, 5800:13,	5824:1	Yik [9] - 5764:12,
well-provisioned [2] -	5800:18	worse [3] - 5767:30,	5764:13, 5764:20,
5775:28, 5779:45	witnesses' [1] -	5776:32, 5823:30	5764:23, 5772:29,
well-resourced [1] -	5861:46	worth [7] - 5781:31,	5773:45, 5775:13,
5781:12	women's [2] - 5829:4,	5782:35, 5782:36,	5789:11, 5798:47
Wellington [1] -	5850:36	5783:26, 5788:14,	YIK [64] - 5764:16,
5810:11	won [1] - 5780:9	5837:44, 5839:22	5764:23, 5764:28,
West [1] - 5861:43	wonderful [2] -	worthwhile [1] -	5765:6, 5765:13,
Western [2] - 5821:32,	5810:9, 5812:2	5863:6	5765:20, 5765:35,
5842:41	wooden [1] - 5826:14	wow [1] - 5854:13	5766:13, 5766:42,
western [1] - 5861:17	words [2] - 5771:44,	wrap [1] - 5860:35	5767:38, 5768:16,
Westmead [1] -	5851:20	wrap-around [1] -	5768:38, 5769:13,
5787:30	work/life [1] - 5807:5	5860:35	5769:39, 5770:30,
whammy [1] - 5823:11	workaround [1] -	wrapped [1] - 5813:14	5771:8, 5772:4,
what-not [1] - 5823:23	5832:26	Wright [1] - 5817:44	5772:10, 5772:21,
whatsoever [1] -	WorkCover [1] -	write [2] - 5833:16,	5772:46, 5773:16,
5857:45	5852:8	5854:7	5773:20, 5773:25,
whereas [8] - 5807:5,	worker [1] - 5813:26	writing [2] - 5776:42,	5773:31, 5773:38,
5809:19, 5810:11,	workers [1] - 5796:9	5829:35	5774:6, 5774:33,
5816:46, 5830:46,	workforce [64] -	written [1] - 5781:45	5775:35, 5776:19,
5833:11, 5843:35,	5768:34, 5770:1,	wrote [1] - 5802:33	5776:25, 5778:1,
5848:37	5770:17, 5770:32,		5778:6, 5778:11,
whereby [3] - 5814:30,	5770:33, 5773:47,	Y	5778:37, 5779:29,
5821:47, 5827:3	5774:23, 5774:25,		5780:6, 5781:1,
whichever [1] - 5842:9	5775:6, 5779:37,	year [27] - 5770:43,	5782:16, 5782:32,
whilst [5] - 5779:24,	5779:45, 5780:2,	5785:28, 5785:34,	5783:7, 5783:15,
5789:46, 5799:16,	5780:15, 5784:29,	5787:21, 5788:9,	5783:40, 5785:1,
5808:37, 5836:14	5785:14, 5785:24,	5788:34, 5788:39,	5785:17, 5786:35,
whole [15] - 5773:22,	5786:14, 5786:39,	5788:42, 5789:2,	5787:20, 5789:15,
5787:40, 5790:43,	5787:3, 5789:27,	5789:40, 5790:39,	5789:31, 5789:38,
5815:45, 5816:36,	5789:36, 5790:1,	5790:43, 5790:45,	5790:7, 5790:17,
5823:33, 5823:38,	5790:5, 5790:36,	5794:5, 5794:7,	5791:17, 5792:11,
5824:30, 5827:32,	5790:43, 5791:8,	5818:23, 5818:42,	5792:37, 5793:6,
5832:10, 5832:11,	5791:13, 5792:2,	5819:1, 5819:19,	5793:33, 5794:2,
5854:12, 5854:33,	5792:41, 5794:33,	5819:47, 5821:23,	5796:3, 5797:17,
5855:6, 5858:31	5795:45, 5800:37,	5833:18, 5838:44,	5797:44, 5799:6,
wholeheartedly [1] -	5805:24, 5805:26,	5849:28, 5855:47,	5799:25, 5800:1,
5827:28	5805:39, 5806:9,	5856:43, 5856:46	5801:17
wide [2] - 5778:29,	5806:15, 5806:33,	year's [1] - 5818:45	young [1] - 5792:19
5824:24	5807:1, 5807:11,	yearly [1] - 5814:21	yourself [3] - 5787:17,
wider [1] - 5811:17	5807:30, 5807:34,	years [32] - 5779:40,	5794:32, 5795:3
wife [1] - 5847:38	5807:44, 5810:7,	5784:1, 5784:33,	
willing [3] - 5807:37,	5810:8, 5810:26,	5785:44, 5793:19,	Z
5808:7, 5822:12	5811:17, 5813:9,	5795:2, 5797:47,	
willingness [1] -	5824:30, 5824:40,	5798:1, 5798:2,	Zealand [6] - 5798:12,
5847:25	5829:32, 5829:38,	5798:7, 5804:29,	5823:46, 5824:37,
window [1] - 5782:25	5831:4, 5831:32,	5809:16, 5809:19,	5824:44, 5851:33
withdrawn [1] -	5837:11, 5837:18,	5810:22, 5813:21,	zero [2] - 5787:22,
5776:8	5840:22, 5845:10,	5818:5, 5819:11,	5787:24
WITHDREW [2] -	5849:8, 5849:11,	5819:44, 5820:7,	zoom [2] - 5792:24,
5801:21, 5863:9	5851:24, 5851:28,	5826:34, 5826:35,	5792:29
withheld [1] - 5776:46	5853:29	5827:10, 5827:37,	
witness [5] - 5825:21,	workload [3] - 5807:3,	5828:38, 5842:41,	
5830:39, 5833:12,	5807:25, 5848:16	5851:13, 5851:23,	