Special Commission of Inquiry

into Healthcare Funding

Before: The Commissioner,
Mr Richard Beasley SC

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

Friday, 18 October 2024 at 11.30am

(Day 058)

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 with
Ms Emily Aitken for NSW Health

THE COMMISSIONER: Good morning.

MR MUSTON: This morning we've got in person Dr Michelle McRae, and on the screen, Dr Natalie Rainger.

<MICHELLE YVONNE McRAE, affirmed: [11.31am]

<NATALIE SHERIDAN RAINGER, affirmed:

MR MUSTON: I might start with you, Dr McRae, could you state your full name for the record,

DR McRAE: Michelle Yvonne McRae.

MR MUSTON: You are a dermatologist practising from Pinnacle Dermatology in the New South Wales town of Orange?

DR McRAE: Yes.

MR MUSTON: You are also a clinical lecturer for the University of Sydney?

DR McRAE: Yes.

MR MUSTON: And you are currently the senior director of training for the Australasian College of Dermatologists.

DR McRAE: Yes.

MR MUSTON: You've prepared a statement to assist the Inquiry with its work dated 17 July 2024

DR McRAE: Correct.

MR MUSTON: Have you had an opportunity to review that statement again before giving your evidence today?

DR McRAE: Yes.

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

DR McRAE: Yes.

MR MUSTON: Thank you.

That's behind tab H7.8, Commissioner.

THE COMMISSIONER: Yes.

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

DR RAINGER: Natalie Sheridan Rainger.

MR MUSTON: I'm going to struggle to pronounce this. I should have practised before. You are a consultant otolaryngologist?

DR RAINGER: Otolaryngologist, yes.

MR MUSTON: And head and neck surgeon practising in Orange?

DR RAINGER: Correct.

MR MUSTON: You have prepared a statement to assist the Inquiry with its work dated 28 July 2024?

DR RAINGER: Yes.

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

DR RAINGER: I have.

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

DR RAINGER: Actually since that statement, my position has changed. I'm no longer the supervisor of training. I've moved to head of department. That's the only thing.

MR MUSTON: So you formerly held the role of training supervisor within the Australasian Society of Otolaryngology Head and Neck Surgery?

DR RAINGER: Yes, correct.

MR MUSTON: You no longer hold that role; you are now in the head of department role?

DR RAINGER: Yes, and you can't concurrently hold both, so I've stepped down from my supervisor of training, but

I still am the surgical supervisor for the medical students at the University of Sydney on the Orange campus still.

MR MUSTON: Thank you.

Commissioner, that statement is behind tab L9.

THE COMMISSIONER: Yes, I have that one.

MR MUSTON: While we're on your statement, Dr Rainger, could I ask you to turn to paragraph 14?

DR RAINGER: So the one starting, "In my experience"?

MR MUSTON: "In my experience", yes. You tell us about some of the challenges that you perceive that would arise if you weren't visiting satellite hospitals as a specialist, or a specialist ceased visiting satellite hospitals, and you point to the risk of GPs becoming deskilled and leaving communities.

Could I ask you, first of all, to explain what you mean by satellite hospitals and the work that is being done, and then why that has the capacity to produce the result of deskilling and a downturn in the population of GPs in these communities?

DR RAINGER: Sure. So the Western area health district is a very large district spread across a long area. We provide the ENT service from Blue Mountains right through to Bourke and Broken Hill, which is covered by Adelaide, so many areas that are still remote to us, as well. As part of that service, we do both consulting and peripheral operating at smaller hospitals within the LHD.

For example, I travel to Cowra once a month where I do an operating list, which is staffed by the GPs in that town. So they are what we call GP anaesthetists. They will provide the anaesthesia for the operation as well as the follow-up and post-op care for these patients. That, in turn, keeps them upskilled in emergency airway management and skills like intubating paediatric patients, which they may have to do in emergency settings on their own out in those communities.

MR MUSTON: So I gather that if they weren't performing those procedures out in those satellite hospitals, the

skills that they have as anaesthetists would be lost or would fade.

DR RAINGER: Yes, unless you're doing something routinely, if you're not doing a difficult procedure routinely, it's even harder to do it in an emergency, high-stress-filled situation, where a child might be dying in front of you. So being able to do it in a routine, elective setting, keeps them upskilled. If you don't use those skills, you lose them. These little communities rely very heavily on sometimes what is their sole practitioner, and I strongly believe if communities don't have medical services, then you have a drift of population moving away from those small communities.

MR MUSTON: And what is it about the ability to use those skills and keep them up to date that, in your view, that is keeping GPs working in some of these communities? Perhaps to put it another way. Why is it that if they weren't able to use these skills in the satellite hospitals that they are located near, GPs would be leaving these communities?

DR RAINGER: A GP's work is extremely onerous and their role with face-to-face consulting with patients is a huge amount of what they do, but they also provide a 24/7 on-call service to that area, so they need to be able to manage the emergency things that come in after hours to stabilise patients enough to transfer them to a tertiary centre.

So I can imagine that is quite daunting and, you know, a hugely arduous task, but by giving themselves skills across lots of different areas, like obstetrics and ENT and scopes and procedural skills, it just further bolsters their confidence in their ability to look after their community.

MR MUSTON: Dr McRae, I see you are nodding. That accords with your view and experience of practising in a rural area?

DR McRAE: Absolutely. Throughout my training from medical student through to now, having exposure as a medical student to those small clinics and visiting with the surgeons and observing those GPs assisting in those various areas, particularly in theatre as GP anaesthetists and O&G, provides ongoing community support when they

really need it.

DR RAINGER: I think as well, also, it's not just the GPs, that then entails a whole theatre workforce being employed that day, and so it gives back to the community as well, local jobs for local people.

MR MUSTON: Is there an extent to which the ability for that whole workforce to participate in procedures and the like keeps the job interesting and attracts them to keep doing it in circumstances where, if they were just, say, doing other work that one might associate with a small country facility, it would be harder to attract staff to do the more run of the mill day-to-day work?

DR RAINGER: Absolutely. Look, I can't speak for the GPs individually, but myself as a surgeon, I know that I really look forward to my procedural days. The face-to-face consulting days can be a long grind, so I think people, when they learn skills, like to keep using them and be useful. Part of what we do, I guess.

MR MUSTON: In terms of the role that you have, or your practice as a VMO, you have told us in your statement that if a position had been available to you as a staff specialist, you would happily have taken it. Can I ask, would that, at least in your experience, be a relatively rare thing, for a surgeon to be a staff specialist within the public system in New South Wales?

DR RAINGER: There's a mix. There certainly are staff specialists, especially in the bigger tertiary centres in Sydney. I can really only attest to Orange and our workforce out here. Our surgeons are all VMOs, I think, 100 per cent. We have staff specialists among the physicians, but I think all of our surgeons are VMOs.

MR MUSTON: When you were first commencing your practice out there, what was it that made being a staff specialist, if that were able to have been accommodated, attractive from your perspective?

DR RAINGER: I think back then I probably didn't have a very good understanding of how the business side of public health works, so I was probably very naive, and I was interested in exploring whatever options were available to us. But I certainly liked the idea of being

able to provide a public service to a rural community. I think that's so important. I feel like our patients out here deserve the same level of care as someone, you know, in a city centre would receive. So I guess that's still an ongoing journey. You know, as part of that we still don't have our public clinics up and running, and if we had been able to take that staff specialist role from the beginning, that may have been an easier journey.

I don't know if I would necessarily go down that path now, but I think the funding to develop the public service would have been easier from a staff specialist's viewpoint rather than a VMO.

MR MUSTON: Dr McRae, I imagine that a staff specialist position as a dermatologist within a town like Orange was not something that you saw as a realistic way of practising in a town like that?

DR McRAE: It's extraordinarily unlikely, given that there are only a couple in New South Wales, in Sydney. It's very unusual for a dermatologist to have a staff specialist role, because it's a very different approach to other specialties such as surgery or physicians, which are considered as necessary in a hospital, and I would argue that some hospitals don't see dermatology as a specialty that is necessary, so we're lucky to have a seat at the table, let alone have a full-time staff specialist position.

THE COMMISSIONER: Why wouldn't hospitals see having a dermatologist as necessary?

DR McRAE: I have, for the last 10 years, tried to obtain a VMO paid position at the hospital. We did have a clinic running when I first went back as a fourth-year registrar and I was offered a position that they were going to advertise for. The advertisement was never put through, and that money was then - when I asked, "Why wasn't the ad put up", "They gave the funding to ED", was what we were told. Dermatology --

THE COMMISSIONER: So it can't be because skin conditions can't be very serious?

DR McRAE: It's not because skin conditions aren't very serious, it's because we're not seen as making the hospital

any money. In our clinic, our billings, we were told, did not make enough money to cover our costs. The problem was that the person doing the billings, who was an admin officer, had incorrectly done billings and only had earned $75 for the clinic, for example, in one clinic, and hadn't resubmitted the billings to Medicare, in error.

So this is NSW Health policy now to bill to Medicare for patients seen in the outpatients clinics, and we do bill the same item numbers for procedures. However, dermatologists don't do procedures under anaesthetic very often, so we don't use a theatre and we don't have anaesthetic item numbers. So our item numbers are limited from a billing capacity and so, because of that, we were told we cost too much to have a clinic.

THE COMMISSIONER: Despite the obvious benefits to population health having dermatology services?

DR McRAE: Despite this. So there was an example of a patient needing to be transferred to Sydney because they had a blistering skin condition - and I've been an HMO for a number of years providing my services on a daily basis on call. Westmead refused to take the patient because they said, "You've got a dermatologist in the area", however, I was not a VMO with the hospital so did not have admitting rights. That would have saved several thousand in transfer fees to a Sydney hospital, but they would rather transfer a sick patient than have someone who was local look after them.

MR MUSTON: Can I just ask you about your evidence that there is one dermatologist in each of Albury, Griffith, Wagga Wagga and Tamworth?

DR McRAE: Full time.

THE COMMISSIONER: Based on the populations of those regions, how many ideally should there be?

DR McRAE: There should be one per 50,000 people. We cover an area --

THE COMMISSIONER: How many more should that be? You can take that on notice, but --

DR McRAE: I cover an area of about - theoretically, my

local health district is 280,000 to 290,000 people. That is not including the greater Far West area.

THE COMMISSIONER: So there should be five or six of you?

DR McRAE: And I have also patients travelling out of area, because they cannot access, from the north - Blue Mountains have no dermatologist and Nepean has only private. Also from Southern New South Wales I receive from Hay and Griffith, as well as Canberra and Young and north to Coonamble, Walgett, Broken Hill, Mudgee and then to Nepean. So we would cover an area definitely over 350,000 people.

THE COMMISSIONER: Can I also ask you just to explain to me - in paragraph 9 you've talked about the very long wait list you have, which is driven by the fact that you can't divide yourself into two or three or four, and to explain to me how you manage the triaging and the more urgent appointments.

Can I give you an example?

DR McRAE: Yes.

THE COMMISSIONER: The people here know I like to talk about my own health conditions, but six or seven years ago I had something cut out of my forehead, which was I think a squamous cell carcinoma. Then about six weeks ago I had a spot on my cheek that my GP thought looked suspicious, so referred me to a dermatologist, and when I rang, I couldn't see that dermatologist until December. So I made the appointment but rang the GP back and said, "Are you worried about", and he said, "Yes, that's too along, even for a" - he didn't know what it was. It might have been, he thought, psoriasis but it looked suspicious. So I was able to see a different dermatologist very quickly, who took a biopsy. It turns out to be - they said it was a sunspot.

DR McRAE: Actinic keratosis

THE COMMISSIONER: Yes. He zapped it with liquid nitrogen, and a few other spots. But say there's someone with a similar concerning spot like that, is that something that ought to be seen urgently and how do you manage that in relation to your referrals, given there's only one of you for so many people?

DR McRAE: The first thing is it's difficult for GPs to know everything, and they've got a very broad job to do, and it's very, very variable --

THE COMMISSIONER: I've had a lot of psoriasis burnt off with liquid nitrogen, which I don't blame my GP for because he is excellent otherwise.

DR McRAE: I have a lot of respect - my father-in-law is a GP in Orange and has been since 1980. I have a lot of respect for the rural GPs locally. I would say half of them have my phone number, whether that's a good or a bad thing, including out to Forbes, Parkes, Cowra and Dubbo. So I've already been contacted this morning by two GPs.

So I guess, one, we, or I, manage this by triaging every week, if not daily. We will ask patients or GPs to send us a photo of the lesion first, and if it's not a good photo, then they come in and we book them as an urgent in what I call my "nursing list". We do it as an urgent consult, so it's not a full review but obviously when patients come and they're covered in spots on their whole head, I'm not looking at one spot, I'm looking at a lot of things.

So I guess I have skates on every day. But we do try and fit in all urgents as requested. So I'm currently working five days a week seeing patients.

THE COMMISSIONER: I imagine managing that is difficult. You are already have an enormous wait list.

DR McRAE: I have extremely good staff and I have increased capacity, probably a little bit to my own detriment, in terms of accepting and taking on the accreditation of training a registrar, and I've also sponsored an IMG this year as well.

THE COMMISSIONER: But going back, if we can go back to your original point about dermatologists not making money --

DR McRAE: For the hospital.

THE COMMISSIONER: Yes, for the hospital. I'm right, aren't I, that that's absolutely purely a decision that is

made on the basis of financial matters, not because --

DR McRAE: Not because of demand.

THE COMMISSIONER: -- patients can't present with conditions of the skin that are life threatening; correct?

DR McRAE: That's correct. So dermatology conditions can be life threatening; many drug reactions are life threatening, and that's not within melanoma and all the skin cancers --

THE COMMISSIONER: And not just life threatening but needing urgent medical attention?

DR McRAE: Needing urgent attention. I do receive multiple email consults and phone consults from the hospital each week, that I'm keeping a tally of, that I provide advice regarding dermatological management on the wards.

THE COMMISSIONER: Tell me if I'm wrong, you'll know much better than me, but Australia as a country has relatively high rates of skin cancers that are very serious; correct?

DR McRAE: That's correct.

THE COMMISSIONER: Yes.

DR McRAE: And are underestimated.

THE COMMISSIONER: Yes. That's enough about me.

MR MUSTON: You've told us about the waiting lists and I think also about the way in which you approach charging patients, both at one end of the spectrum bulk billed, and at the other end charged as a private patient. What's the decision-making process within your practice around where someone sits on that spectrum?

DR McRAE: I have a similar arrangement with Natalie, longstanding, any Aboriginal Medical Service patient is bulk billed. Given that I'm from the area - I will clarify, I was born and grew up in Narromine, which is west of Dubbo, and went to school in Orange and lived in Blayney, which is the size of Narromine, 3,500 people - I understand the area and where people live and where they

come from. That's not to make judgment on their background, but I do understand grossly the socioeconomic problems within different areas, and half my family still lives in Narromine and Dubbo.

My staff are long-term staff, in terms of we don't lose staff, we treat them very well, we pay them well, and they own the business with us in terms of they also understand the patients and understand the area. So when it comes to patients, I did an audit a couple of years ago and 60 per cent of my follow-up patients were not full charge or full billed, meaning they were not billed at the standard follow-up rate, which is quite high.

I did that out of curiosity more than anything, and that was just to see, I guess, where we might be sitting compared to other areas. I was actually looking at it from a research point of view with a junior doctor, however, I'm not sure if that's something we want to publish to other doctors, because it may turn them off.

But the way we do determine it is I have a four-tier billing system that is actually stipulated in terms of amounts, from full fee, pension, concession and bulk bill, and if patients ask or the GP asks for them to be looked after, then we do; if a patient asks on the day, then we also do; or if they speak to the staff and indicate that they wouldn't be able to have a biopsy because they can only afford the consult fee, then we also still look after them, because they need the biopsy.

MR MUSTON: Given the 12-month waiting list and the relatively high proportion of your patients who are sitting in that towards the bulk billing end of the spectrum, would it be an oversimplification to say that there would be sufficient demand in your region for a public dermatology clinic?

DR McRAE: Absolutely. There was a public dermatology clinic for a number of years, fortnightly, until we lost that support. I actually set up a public dermatology clinic, because I felt there was a need, through the Aboriginal Medical Service a number of years ago, and ran that for two and a half years, and it was a very enjoyable clinic. What actually led to me closing it was the logistics of referrals if I needed to do a procedure in my rooms. So if I saw the patient on that day in the

Aboriginal Medical Service and then needed to do a specialised procedure on them, I had to then take them back to my rooms. To get a referral from the GP for a different site is involved, and that was actually the biggest logistical issue.

So I still look after all those patients in my rooms, however, I would agree that culturally it's not what they would consider a culturally safe space compared to the Aboriginal Medical Service, and I'm actually in the process, through another initiative with the college, of setting up another Aboriginal Medical Service public clinic in Orange next year.

MR MUSTON: There's obviously a funding component that's required to set up a public clinic in dermatology, but there's also presumably a workforce requirement, in that you can only spread yourself so thin, and in order to run a public clinic in addition to your own practice with a 12-month waiting list, from the sounds of things, would require at least one more dermatologist, if not more?

DR McRAE: We're in the process of obtaining what we call supervisory capacity, to improve supervision. I am currently attending Canberra one day a month running a specialised paediatric dermatology clinic in Canberra. However, I have resigned from next year so that I can set up an Orange/Dubbo/Western New South Wales training program, and I have filled my spot in Canberra, and probably too well, I filled it with a few people, and I need to obtain supervision for our area. So I have some capacity, because I do try and provide a public service somewhere, even though my rooms do, in kind, provide a public service as well. But this is also a training service. So I am constantly training, on a daily basis, to try and improve long-term capacity.

MR MUSTON: Long-term capacity in terms of training dermatologists or training local general practitioners up to a level where they know the point at which they can deal with something in-house and the point at which they should be handing it over to you; is that --

DR McRAE: Training dermatology registrars with the intention of them coming back to the area, predominantly. So we have several in the program, as current New South Wales director of training, that are associated with the

area and would like to return to the area, we hope, in time. That also involves an international medical graduate from Argentina, and with this training program that's to involve Orange and Dubbo, we do have several rural trainees on the program in New South Wales at the moment, and it is a Catch-22, it's getting enough trainees, but it's also positions of supervision for those.

MR MUSTON: I might come back to the training in a moment.

Could I ask you, Dr Rainger, in relation to the public clinic that you tell us about in your statement. Putting aside, just for the moment, the benefits of a public clinic in terms of your being able to provide registrar training in Orange, was there - presumably there was - sufficient public demand on the clinic that you are seeking to set up to justify it in terms of delivering on the medical needs of the population?

DR RAINGER: Absolutely, and like Michelle, we have an especially vulnerable group of patients out here that require ENT support, such as children, Indigenous children with hearing and ear problems. So similar to Michelle, I run probably even more - so a significant proportion of our patients are bulk billed. As Michelle said, anyone - the GP asks, or anyone that asks on the day, anyone the staff identify as being vulnerable, all AMS patients, are bulk billed, anyone you know, which in a small country town adds up to quite a few, so it leaves very few that you do bill.

I also personally have never billed for a procedure. So all my procedures, which are probably 75 per cent of the patients I see, have a procedure here in the rooms, like Michelle - a biopsy or an ear cleaning or a scope to look to see if they have a throat cancer - and I have never, ever billed for a procedure. That's all bulk billing, so a huge need.

MR MUSTON: So in terms of your attempts to get the public clinic up and rolling, how does the public need for that service feature in the discussions that you have with people within the LHD?

DR RAINGER: I don't think there's any argument that there's a public need. I think we are in the same position as Michelle, in that ENT is a sub-specialty. The

sub-specialties don't tend to make the public hospitals much money. You know, the cost for doing a tonsil and a grommet is a couple of hundred dollars on MBS, whereas a cataract or a joint replacement makes the hospital money. Plus our patients, there's a high proportion of paediatric patients, so it's workload intensive in that you might do, you know, 10 small children in a day, but that requires taking 10 paediatric beds overnight and then that leaves nothing for, you know, anyone else who might need paeds in the hospital.

So a lot of it purely comes back to funding. Rather than a lack of support, it's the direction of how funding is siphoned.

MR MUSTON: Can I come to the on-call burden that you tell us about in your statement. You told us of a period in 2021 when you were doing one-to-one on call, and more recently, a still significantly higher level of on call than metropolitan colleagues. It seems obvious, but perhaps you could tell us what needs to be done in order to alleviate that burden.

DR RAINGER: I think I mentioned in my statement about critical mass. So we've been enviable in that we've recently been able to recruit two junior consultants, who were our registrars 10 years ago and we got on to the training program, again, both from rural backgrounds. We're very lucky in that one of them is a head and neck cancer surgeon, and so he has now returned out here to help set up a head and neck cancer service through the west. But again, it can't go forward without funding. He has no lists and no funding for extra theatre time, so all of these are very slow projects. But I think once you get to critical mass, you're more likely to be able to induce others to come back and join you. No-one's going to move to an area where they're going to be one-on-one on call. I think that's madness.

MR MUSTON: In terms of that on call burden, are registrars able to ease that - that is to say, if you had registrars on a training pathway in Orange and its surrounds, is that a way in which that on-call burden might be able to be eased?

DR RAINGER: Yes, absolutely. Since we were able to acquire our accredited registrar two years ago - I've been

out here as a consultant for 12 years, and in that 12 years it's been me first on call every time. You go in for every small nosebleed, every airway emergency. We cover dental as well after hours, all the dental emergencies, the facial traumas, and having a registrar definitely eases that burden, because you now have a second set of hands.

MR MUSTON: In terms of the training of registrars now that you do have the ability to employ them out there, or they are being employed out there, how much of their training is actually happening in Orange as opposed to other parts of the state and, in particular, metropolitan parts of the state?

DR RAINGER: So the ENT program is traditionally a five-year training program based across Australasia, so you will be attached to a state and every six months you move to a different position. For example, New South Wales also covers Canberra and used to cover Darwin. So our position has been ratified as what we call a SET-1 position, so it's suitable for a first year trainee, so they are able to spend six to 12 months out here.

We have expressed our preference that they stay for 12, because then they are more likely to put roots down and develop a sense of, you know, home with the community. But at this stage the college has only ratified a six-month position, again which is really difficult when you're a young person, moving around, maybe moving family with you, you have a mortgage elsewhere, you have to pay for accommodation and still meet that. It's really arduous, I think.

MR MUSTON: Dr McRae, you tell us about your college's practice that, ideally, a supervisor should not continue in that role with a particular trainee for more than six months.

DR McRAE: That's actually something that I suggested a little while ago, because we did have some rural training or registrars who were being sent to rural sites for a year, and there was one supervisor and one registrar. In the event that there are any concerns from either side, it makes it very difficult to implement change or for them to actually approach ways in which to rectify any concerns.

Currently, as the director of training and being the

chair of the rural and regional committee for the college, I understood quite acutely how that was affecting the rural registrars and their experience in some places, because we are very busy. So I'm currently supervising, full time, two registrars, and I'm very busy, but I'm also very conscious of making sure that they're appropriately supervised and appropriately given time to do certain tasks or travel to things, whereas I think in some sites, supervision standards can vary sometimes, or travel.

We had one registrar travelling between two sites that was more than an hour each way. They were travelling late after a clinic on one evening to get to the next day's clinic and there were safety concerns about travel. So we have taken things like that on board very quickly to make sure that, from an OH&S and safety point of view - the problem is because of outside of Sydney and Newcastle, there are no public clinics. All funded positions are Commonwealth STP funded, which means there's very little actual hospital supervision, they're all private supervision, and you have to have, for accreditation, certain standards, and I suggested that six months.

Now, that does limit people staying in an area and developing access, but if you've had contact with one supervisor for a whole year, it does also limit some of your exposures. So currently, going back to the question about implementing ways to deal with waiting lists, one of the things I have done is brought in a plastic surgeon to do my surgery for me every month. He does two days. He sees up to 30 patients in two days doing my surgeries as if it was me. We do all the post-op care with my nurses and all the pre- and post-op work. But plastic surgeons in our accreditation with college are allowed to supervise and train trainees in surgery, so he actually counts as another supervisor. So there are ways that we can implement access to training by thinking outside the box.

MR MUSTON: Which has the capacity to give a registrar an ability to rotate through a town like Orange more than six months?

DR McRAE: More than six months, yes. I am in the process of getting another supervisor to hopefully back-fill me in my practice so I can do the Aboriginal Medical Service clinic and things like that. Yes.

DR RAINGER: I should probably clarify, actually, we were in the same position as Michelle, with just purely one supervisor. I agree, six months is a good safeguard. We are keen on a longer period because we're in the enviable position of having, you know, four supervisors, at the moment, that the trainee is exposed to. And in the hospital setting, our trainees also get exposure to the other disciplines, so they might be able to do, you know, work with the general surgeons as well. So it's not so much of that one-on-one situation.

MR MUSTON: Recognising the challenges associated with only one supervisor, do you agree, Dr McRae, with Dr Rainger's observation a moment ago that the longer you can keep someone, say a registrar, in a community, the greater that chance that they will join the local football team, become enmeshed with the community in a way that might mean that they see it as a longer-term prospect than a six-month stop on their training journey?

DR McRAE: The longer they stay, the more likely to develop networks and contacts which embeds them more in the community. The problem from a dermatology training point of view with the STP funding - and this is for multiple STP positions - is that without a public clinic, we're actually not developing our peer contacts of other specialties within the hospital, and we don't have access to the support of training positions in the hospital, such as accommodation support and things like that.

So when a trainee in dermatology moves to somewhere in Orange, there is some rural loading for STP, however, accessing it from the hospitals can be quite difficult sometimes. They're not part of that general registrar cohort in the hospital and it's a bit of an exclusion from emotional and peer support. I've been trying to promote that as a need, actually, for the registrars that are coming out, that we need to have them included within grand rounds and things. We do present grand rounds once or twice a year and --

DR RAINGER: I think that's vitally important. One of the main reasons we stay out here doing what we do is the camaraderie. If you're not able to gain access to that, as Michelle said, why would you stay?

DR McRAE: They will see everything in my rooms, because

my rooms is basically like a public hospital clinic. So the public hospital clinic isn't necessarily there because, fortunately, I am able to provide that service. My husband is very understanding, he is an economist and he helps manage medicine before business, or patients before business.

However, having a public hospital clinic provides multiple things, and that is the multidisciplinary approach. I actually do some work with Sam Roberts, who Nat was alluding to, who's the head and neck oncology surgeon who is ENT trained. Just prior, before he came back, we set up an MDT in head and neck cancer for the area, and there is a meeting now every fortnight for that.

So we had a discussion a couple of years ago over dinner in the pub, how to set up this MDT with the local surgeon, or surgeons, before Sam came back, knowing that Sam was returning, because we needed to be able to have these discussions, just as you would have in any large hospital, to discuss these complicated cases. Unfortunately, if you're not on the ward sometimes as a registrar getting pulled in to these things, you miss a lot of those opportunities.

I have a haematologist working in my rooms two days a week as well, who is based in the hospital, and we share a lot of patients. We see a lot of lymphomas, skin lymphomas, in our area for various reasons, so they do get access to a lot of things like that as well, because I am trying to provide support to other specialties outside the hospital within our rooms.

MR MUSTON: You tell us in your statement, Dr McRae, about a dermatology registrar that you are currently supervising, through an affiliation with Concord hospital.

DR McRAE: Yes.

MR MUSTON: Can I ask you, how did that come about?

DR McRAE: That's part of an STP position that I applied for the year prior, and was allocated by the college. Currently through the New South Wales rural task force, we've been trying to work out a way to kill two birds with one stone, essentially - improve support to rural areas and rural training sites for registrars, but also help some of

the Sydney hospitals prove need. So my goal, as part of director of rural and regional chair, is to also help support all areas outside of Sydney, but also Western Sydney, so Liverpool, Campbelltown and Nepean. We have no hospital service in Nepean Hospital, so the west-most service is Westmead and then Liverpool. Because of that, there is a massive shortfall in multiple areas.

Currently we've worked an arrangement to utilise STPs with hospitals that would benefit from showing demand, and one of those hospitals was Concord hospital, because they had one registrar. Another one was Sydney Children's Hospital, and they're linked with Byron Bay in a similar fashion.

MR MUSTON: Dr Rainger, you tell us about the registrar who began working with your team in early 2023. Again, just at a logistical level, how did that come about? Who arranged or how did it come to pass that that particular registrar came to be working with you - was it the college, the system or some work done by you locally?

DR RAINGER: Like Michelle, a very long-term process. I first applied for the STP funding in 2017 and was successful, but at that stage we didn't have enough consultants here to meet the college guidelines for supervision. We have to have a minimum of three ENT surgeons to have an accredited trainee. So multiple attempts across the years, finally successful in 2023, and we had been lucky enough to have this candidate as an unaccredited registrar the year before, and so she had had 12 months in Orange, and therefore when she got on to the training program from our site, was very keen to have the opportunity to come back.

But I think something that's often overlooked is there's great evidence on people having a rural background and spending rural time in terms of their long-term rural commitment, but another emerging area of evidence is how important the partners are. So there's no point in us impressing on trainees if their partners can't come and can't find a job. So we went to great lengths to seduce her partner at the time, introduce him to the local cricket club and help him find a job, and I think that's part of it as well. You're really looking at moving a family, not just a person.

MR MUSTON: In that sense - and we've heard quite a bit of evidence around this already - is that one of the real challenges presented by the fact that vocational training can often be quite metro-centric, in circumstances where those years when you're doing your internship and your vocational training tend to coincide with those years when you're meeting people and starting a family and laying down roots in a community?

DR RAINGER: Yes absolutely. So the age of medical students is significantly older than it used to be. So, you know, med students used to finish in their early 20s and now they're not finishing until late 25s, early 30s, and by that stage of your life, most people have a mortgage and anchors.

MR MUSTON: Could I ask you, Dr Rainger, just quickly: you've told us that you sent a letter to Dr Chant in order to try and get the training position, or the public clinic that enabled you to get the training position, going. What had brought you to the point where you felt you needed to do that?

DR RAINGER: Just a recognition that although the local health district is supportive, their hands are tied. If they don't have funding, they don't have funding. So just trying to think outside the box of other ways that I might be able to get funding to start the clinic. We are quite an equipment-heavy specialty, so it costs a lot to set up a public clinic with the standard of care equipment needed. It's not like an orthopaedic surgeon who might be able to walk in with a tendon hammer and not need anything else.

We need scopes to be able to view internally, we need microscopes to be able to look at eardrums and oral cavities and things like that. So I always knew it would be hard, because it would be a huge cost for the hospital without much monetary return. So although it's a really valuable service and the community are on board, if they don't have the money, they don't have the money.

We're kind of back around to that now in terms of developing - trying to develop a head and neck cancer service. Same thing, the LHD are very willing, but, you know, there's a lack of anaesthetists, there's a lack of nursing staff, which leads to no theatre time, which leads to - at the moment, Sam, my colleague, is having to take

the majority of his cancer patients down to Sydney to Lifehouse to operate on them, which then, you know, that transfer adds to the cost. It could be done cheaper with better benefit to the community locally, but you need that injection of funding to start it up.

MR MUSTON: Just working through that process with the head and neck cancer clinic, presumably, again, you perceive there to be a public demand within your area for such a clinic?

DR RAINGER: Yes. We're absolutely able to display that public demand, and when you look at the data of whether you have - you know, you need to be able to do a minimum number of cases each year to be considered a head and neck cancer service, and I think within the first six months of Sam starting he was more than able to double that number within a small period.

MR MUSTON: Are you aware of the discussions that have been had within the local health district about setting that up and what might be required in order to set that service up?

DR RAINGER: We've definitely been involved in discussions.

MR MUSTON: With whom?

DR RAINGER: Both the LHD and then also Greater Western area health, so with the CEO of the district who is located in Dubbo. We've also had face-to-face meetings with him. We've also had support from outside organisations such as ASOHNS, which is the Australasian college of otolaryngology, as well as support from the AMA. So that's an ongoing process.

MR MUSTON: And has it been suggested to you by any of the people who you have been engaging with that a service of that type is not needed locally?

DR RAINGER: Absolutely.

MR MUSTON: Sorry?

DR RAINGER: Yes. So again on initial presentation of our brief, that was definitely what was told to us. But with

opportunity to speak longer with the CEOs and be able to present the case basis, I think we're slowly winning people around. I think that's not necessarily people's belief that it's not needed. I think that public health generally has a tendency to say no to anything at first because it costs money, and then there's a development pathway you have to go through to be able to justify the need and the benefit to the area.

So I don't think it's necessarily unfair, I just think that it's the way our health system works, which we are so lucky to be able to have a healthcare system that provides free health care to everyone in Australia no matter what. So in some ways, we're incredibly fortunate.

MR MUSTON: In relation to the accreditation that you have out there, it was, I think you tell us at the end of your statement, a 12-month provisional accreditation with a proposed review in August of this year. Has that review been conducted?

DR RAINGER: It hasn't. So it's upcoming within the next sort of four to six weeks, and at this stage we won't meet the criteria for the accreditation to continue because the public clinic is still not up and running. Although the equipment is there and the space is there, we're still waiting on bureaucratic approvals.

MR MUSTON: Can I ask, Dr McRae, you tell us about, and have told us today a little bit about, the proposal to increase the training capacity in Western New South Wales for dermatologists. Having regard to the relatively limited number of dermatologist supervisors on the ground in Western New South Wales, could you just talk us through how that might work, particularly in light of the proposal that such trainees would spend most of their time training locally?

DR McRAE: So with the support of the college, we have been allocated funding through the "Flexible Approaches to Training in Expanded Settings", which is Commonwealth Government funding. It's not for funding of training positions, it's actually for supervisory or other research capacity and things like that, and this is for supervisory capacity for Western New South Wales. So we've put together and approved a project, and the collaborators are University of Sydney, the Orange Aboriginal Medical

Service, myself, and the local health district and the local - there's one more - training provider, Western New South Wales training.

We're in the process of, next year, Orange will be the first site for a registrar. It will utilise the STP funding that I already have, but it is to establish more supervision and to establish initially a public clinic at the hospital, as well as a public clinic at the Aboriginal Medical Service. Then the goal is for the second year to establish a position in Dubbo under supervision of visiting dermatologists.

Now, there are already some visiting dermatologists to Dubbo, privately and to the hospital. There's one attending eight times a year to Dubbo hospital, and we have fly-in/fly-out to Broken Hill as well.

We also have funding available through New South Wales Rural Doctors Network for outreach clinics to certain areas that haven't yet been utilised, that we're hoping to utilise as part of this training pathway, given the proximity of Parkes to Dubbo and the funding that's already available for Bourke and Broken Hill, and utilise our contacts with Sydney Uni in conjunction with that, given that the students also go to those areas. So we're hoping that we will be able to establish enough supervision for the first three years to be able to support three or four years' training in those areas.

From an accreditation point of view, we actually are exposed to enough in the vast majority of areas to do training rurally. As I said, we can utilise the visiting plastic surgeons for surgical training, even though we do train, ourselves, in plastic surgical repairs of the skin, and we have radiation oncology. I currently run a clinic with pathology services, private pathology - they do it pro bono every fortnight. So the registrars are exposed to all the necessary requirements for accreditation. So we have very good training in our area because of the number of cases and the demand. We purely need supervision.

MR MUSTON: So three potential benefits of that: the first would be having registrars training and practising out in these regional areas will increase the extent to which public demand for dermatology services can be met day-to-day.

DR McRAE: Yes.

MR MUSTON: Secondly, by providing training pathways for dermatologists, you increase the number of practising dermatologists, which can only be good from the sounds of things.

DR McRAE: Yes.

MR MUSTON: The third thing is if we can create a situation where the majority of a registrar's training time is spent in a particular region, the chances of that registrar, if you pick the right person, sticking in the regions, can only be enhanced.

DR McRAE: I already have a registrar starting next year, because I'm involved in with college selection and allocations, so I allocate the 42 registrars to 36.5 positions throughout New South Wales. They are keen to go to Orange/Dubbo for their training. So even though it wasn't as part of the application process, we are trying to help with selection in terms of ensuring that people who would like to work out of Sydney have some ability in terms of selection, because often in selection programs, those that have most access to dermatology - because there is very little dermatology in the university training or in your hospitals - Nat and I both trained in Orange and there was little dermatology exposure, and I would take RDOs to go to the dermatology clinic and that's how I had my dermatology exposure. But there was little - otherwise, there was no dermatology exposure. Whereas in Sydney, you take unaccredited training jobs to get into the program.

I'm very fortunate, my college is very open to trying to rectify these workforce shortages, however, the biggest thing, as Natalie said, is funding. The college doesn't control the funding or the places. We allocate the people to the places, and if there is no funding in a hospital for a position, we can't allocate someone there. So STP make up about a third of our funded positions in New South Wales, and that's Commonwealth funded and that has its own regulations and limitations.

MR MUSTON: So whilst you have a lot of, from the sounds of things, collaborators and people contributing bits to make this training pathway work, would it be right to say

that you and your colleagues at the college have largely been responsible for stitching all of those bits together in a way that makes it work?

DR McRAE: Yes. I'm very fortunate. Until about six years ago, there wasn't a college staff member that assisted with workforce in this way, and as part of the 2020-2023 plan of the college, rural workforce was the goal. I've been quite aggressive in helping push rural workforce concerns and focus at the college throughout not just New South Wales but Australia, and not just Western New South Wales.

However, I've decided it's time to focus on the area in which I am located because there is a need, and hopefully, what the goal is, this funding model or training model actually can be rolled out not just to other dermatology models but other training situations such as rheumatology or other situations where there is not hospital-based training necessarily, but training which requires STP funding and things.

We still have another position we need to apply for next year for Dubbo, because we're already aware that Dubbo doesn't have funding for a registrar, so that still will need to happen to make this work as well.

MR MUSTON: So I gather that you, like Dr Rainger, have been engaging with the local health district in terms of trying to work out what can be done.

DR McRAE: Yes.

MR MUSTON: But is there a contact or a point of contact within the ministry, wearing your college hat - more statewide rather than your central west hat - that you engage with to try and work out in a more strategic way how these problems might be addressed through training pathways?

DR McRAE: No, but I wish there was, and that comes actually to a comment, one of the aspects the college, I think, has given in their submission about statewide governance. We're dealing with every hospital at an LHD level and every LHD has different priorities, and even within the LHD, Orange and Dubbo are very different - and I understand that, having lived in both and the demands

from different areas. So in my role as director training, I understand the difference between even the hospitals within Sydney and their funding issues.

We have two hospitals in Sydney at the moment. One has huge demand but enough registrars, and they've done a great job at building their department, and another hospital that actually services a larger population has one registrar, and they're on conditional registration because there is not enough training, and also the demand - it's a terrible situation. But the feedback is they need a clinical restructure, not another registrar, and this comes down to funding purely.

So bringing together the numbers and looking at where registrars are located, you know, we also need good and safe training places, and having another registrar at least in that hospital is needed to take the pressure off having a single registrar, and also just for the benefit of the department.

So I think a statewide governance - and I've thought about this a lot, my background is as an engineer and I would like to think I try and find solutions, not complain but find a solution - is to actually look at the need first across hospitals and see where we actually need those training positions and public clinics, because at the moment I see the hospitals as similar to a council, and each council has their own priorities and you get a huge variation, depending on what local area you live in.

MR MUSTON: We might take that up with some of the colleges this afternoon.

DR RAINGER: Could I make a comment about what you asked about the health ministry. We're probably a little bit further down this pathway than Michelle and so we have had engagement with the ministry. Starting, but initially purely by chance, I happened to have an ENT colleague who knew Kerry Chant, who was able to put the brief in front of her one night having dinner with her, and that's how we got our start for the clinic. So that was luck rather than being able to facilitate it through the channels out here.

MR MUSTON: Just asking you to pause there, whilst it's obviously an excellent outcome for the people of your region, I gather you would agree that that's not the way

that these decisions should ideally be made within a wider system.

DR RAINGER: No. And I agree with Michelle. Since then, we've been able to meet with Ryan Park, the Minister for Health. So our next step now, we had a planning meeting with ASOHNS yesterday and we're going to attempt to meet with Susan Pearce, the secretary for health, to see if again we can set up statewide governance.

But we have been told in feedback from the Minister for Health that one of our difficulties of funding is that we're a safe seat. He said that, "If you're a safe seat, then you're less likely to have money reallocated your way." I don't know how - I mean, that's above my pay grade, but as Michelle said, you know, the local councils are like the hospital board and they're all heavily invested in it, but you do need that statewide governance, I think, to make it equal.

MR MUSTON: Again, it's a matter I think we're proposing to pick up this afternoon with the colleges, including your college, Dr Rainger, but the idea of a centralised body within the ministry that has access to workforce data and a slightly broader picture of needs mapping than is available within an individual LHD or at an individual facility should, would you agree, be involved in broad decision-making about the allocation of resources, particularly to the extent that those resources are meeting need and providing training opportunities?

DR RAINGER: When I speak to my Sydney counterparts, who are supervisors of training and then might be looking at adding an extra registrar to their hospital or, you know, growing their services, it seems to be a mere formality compared to the years and years of work we put in to get one position. You know, they just say, "Oh, RPA needs another position, so there you go." I'm sure it's not that easy, but it certainly doesn't take the same amount of time as to grow a service from the ground up out here.

MR MUSTON: Quickly, Dr McRae, you make a point in your statement and you have told us today about some of the challenges associated with the cost of doing a rural placement or rural term as part of your vocational training. One can readily understand how that might work if you're spending six months in a country town and then

having to return to the metro area where you've laid down your roots and maybe want to keep a house or something like that being very expensive, but is the problem as acute in the case of - if it were possible to run longer periods of training rurally?

DR McRAE: It's less acute in terms of people are more likely to take on a lease longer, and the problem is that across the state, and Australia, the housing shortage - leasing is less than 1 per cent in Orange at the moment. So looking for a six-month lease is impossible, and even getting a 12-month lease, you are often having to ring on behalf of the doctor to try and find them an appropriate place. I have used contacts to get registrars accommodation.

The problem is, if they're not out there for an extended period, then they usually have either a lease or a mortgage or family in Sydney as well. So there are other considerations, and that's what I have said to the registrars I'm allocating, that I don't do logistics, but I am considerate of their backgrounds, and I do take great consideration into that, knowing that I had two children during my training and I understand school and all those things. So I am very considerate of all those things. However, we do need to find ways.

I actually have part of a research project that is run across three states at the moment. It is a melanoma research project on a 3D body scanner that my husband and I felt that the area required, after it fell through at the hospital twice, for various reasons, and we took it on in our practice, through Sydney University. It requires a melanographer to run it, which can be a nurse or a doctor. However, I have doctors applying for the melanography role who are interested in dermatology, because it is seen as a research role.

Next year, our melanographer is going to live in - we have a farm and they're going to live in the farmhouse, and we're providing that to them, because they won't be able to find accommodation with their dogs. Then I've been in contact with the hospital - you know, again, like Nat said, finding partners work - to help to look for him applying for jobs through the hospital as well, so that this person can work in the research role, which is important for the whole area, because it's a melanoma research project, and

it has further benefits because now I'm involved in more outcomes from this study that are quite major. They just won one of the Eureka prizes recently for this work.

So if we can get them out there, staying for longer than a year, they're more likely to find those costs less daunting, I think, and more likely to leave those costs behind in Sydney or whatever metropolitan area they're in.

MR MUSTON: Would you broadly agree with that, Dr Rainger, in terms of your experience to the extent you have experience of dealing with the logistics or assisting registrars dealing with logistics of moving to Orange or its surrounds?

DR RAINGER: Yes, absolutely, and having had personal experience of that myself, going through the ENT training program, you know, moving every six months for five years across Australia and, you know, meanwhile my husband's back in Orange on the farm - it's definitely challenging. So, yes, I agree with Michelle.

MR MUSTON: Dr Rainger, you have told us in your statement that you see benefit in effectively centres of excellence or centres where specialist services within regions congregate. Could you just expand a little bit on what you see as the utility of that approach?

DR RAINGER: We are very fortunate within Orange itself to have a lot of specialists that live and reside here, compared to our hospitals on either side in Dubbo and Bathurst who have a much higher what we call FIFO, so fly-in/fly-out, locum requirement. I think part of that is testament to having had a rural medical school branch out here, of Sydney University. We have a large cohort of people, such as Michelle and myself, who went through Sydney University but were able to do rural placements out here as med students, and then went on to be junior doctors here, and then were supported by the hospital to get on to their specialist training programs.

Being able to offer such a similar standard of care as to what you would find in your city counterparts makes the whole area more attractive to anyone, whether you are coming for mining or engineering or schooling, then you're able to have that medical excellence to back it up.

MR MUSTON: Perhaps for immediate purposes, does the array of specialists who might serendipitously live in Orange make it a more attractive place for another specialist, even one in a different area, to come and live and set up practice, do you think?

DR RAINGER: Absolutely. As Michelle said, the contacts you make with your peers and the camaraderie is so important - the fact that we all know each other well and work together and are able to walk past someone in the corridor and say, "Oh, I've got this patient you might be able to help me with" - so it's the small-town advantage of knowing each other but still with that, you know, bigger town advantage of that higher level of care.

DR McRAE: I would just like to back Natalie up with that, in that the majority of our cohort that were not all med students, but then interns and residents in Orange during our period, are nearly all in Orange, whether that's as a specialist or as GPs. There are many doctors who are now just retiring who we trained under, but many of those that we're working with are now of our vintage, so to speak, and it would be nice to be able to feed back into that with more that come through training in the area.

MR MUSTON: Could I ask --

DR RAINGER: It's certainly been an advantage to us in that, because we've been able to train juniors locally and recruit them locally, this is the only reason we've been able to set up the first rural training accredited ENT registrar position for Australia. So we are in a very lucky position compared to a lot of other rural areas, that don't have the ENT workforce we do.

MR MUSTON: Dr McRae, you just told us about some of the potential consequences or outcomes of rural-based training. Is there any aspect of it which is contributed to by the fact that those more senior doctors now retiring, whom you have referred to, have provided you with some sense of a career pathway locally - that is to say, perhaps even said, "If you come and work out here, I'm going to retire in 10 years and so you could be the next me", or is it personal reasons that largely draw people to a town like Orange?

DR McRAE: It's probably less of a thing in dermatology.

I don't think we look to take over. There is so much work, we don't need to inherit a practice. It's not like a Sydney practice where I think people are looking to. We do want to be able to hand over our patients, though, and make sure there's enough care, but whether they are with me or working out there, I don't mind. I just would like another three dermatologists in Orange and whether they are with me or not I don't mind. I think it's because of personality and that we had such good training, and the patients --

DR RAINGER: I think as well, compared to Sydney, the med students out here get one-on-one face time with the consultant, and that's what makes the difference. You have that increased exposure, whereas in a big city hospital, on a ward round, they would be anonymous. It's that mentorship rather than the fact of succession planning. It's that being able to see what your life could look like and having these great role models and being able to come back and institute that.

DR McRAE: And I guess picturing what our life may be like. Nat and I were very fortunate, we both got onto our respective training programs quite early, and I actually put that down to the exposures we got in our internship and residency years and the fact that there were very few limits between us and the consultant. We were essentially working directly all the time. In my actual interview for dermatology, one of the consultants said to me, "That would not happen", and I said, "It did happen", because they didn't believe that a resident would be given that amount of responsibility.

DR RAINGER: I agree. I had references from the consultants out here, from in my junior doctor years, and you could see from that that they actually knew me and that I had worked with them, and I think that makes a huge difference.

MR MUSTON: You've mentioned getting onto the training program early as being a stroke of luck. Is there any scope for rural-based training to be provided as an opportunity to get on to training places earlier than others might, with a view to incentivising people to pick up those training opportunities rurally?

DR RAINGER: There hasn't been for us up until now. As of

next year, we are hoping to institute a rural training pathway. So that will be a huge step forward. It means we will be able to alter the criteria because the job experience we provide out here is different to the metropolitan areas. So definitely we're going to be able to develop more of a rural focus.

DR McRAE: It's a little bit tricky because I've been working with the college regarding selection. Unfortunately in the past it's been very driven towards PhD exposure and research, which you can't get outside of metropolitan, which means often applicants outside of a city area don't score as well for selection, because they don't have that exposure. So we've been working on that, because it is - we've actually implemented via the rural and regional committee a scoring rubric for rural applicants, to actually help promote, because they lose points because they don't have access to the research, if they stay somewhere like Orange. They might do a project with me but that's not the same as working as a researcher in Sydney, which is why this new research project in Orange is great.

We have implemented these things because of - there's a term that has been coined about geographical narcissism, that, you know, you have to be in Sydney to get exposure, or Melbourne. It's a bit of a fallacy, but they don't realise the limitations of exposure due to distance.

MR MUSTON: Can I quickly just finish with some questions of you, Dr McRae, in relation to what you tell us in paragraphs 21 to 23 of your statement about the absence of specialist training for dermatology as part of the advanced specialist competency that GPs can acquire. Could you just explain to us what that means, first, and then what you perceive to be the consequences of that in terms of delivery of dermatological care to the community?

DR McRAE: Sorry, which number again?

MR MUSTON: Paragraph 21.

DR McRAE: So dermatology is distinct, and GPs do - it's been quoted that for GPs, 25 per cent of their presentations involve some sort of dermatology presentation. However, there is a significant variation in GPs on what exposure they've had in dermatology.

I've discussed this. I am actually part of the specialist group of the Australian Rural Doctors' Association and I'm also part of the rural medical specialists association, and I have discussed this at that level, especially at the Rural Doctors Association, that's associated with ACRRM and the rural generalist training program, that of the eight areas that you can train in as a rural generalist, dermatology is not included, which I think is a massive oversight. However, the reason it's not included is because of funding. The others are associated with hospital-based placements. So that's obstetrics and gynaecology, emergency, psychiatric, anaesthetics, things like that.

So it's assumed that dermatologists will teach themselves their dermatology through courses. The college of dermatology now has a course, a business that runs courses, but there are many courses available and they're not standardised, and so I have discussed this with various people through the RDA over time. I haven't broached it for a little while but I think that that is an area where we could focus to upskill.

In the past, GPs such as my father-in-law used to do a lot of skin cancer work and excise things, and that was part of their every-day business, it was not their sole component like a skin cancer clinic. Many of my GP colleagues that contact me from various towns are GPs that see everything and have very good insight into their limitations and when they need to ask questions, and will contact me for advice and whether they need to send someone over and things like that. There are lots that won't contact me for various reasons, and I'm more than open to chat to any of the GPs to provide advice if they need it.

It is difficult, because there is such a variety and discrepancy in training in GPs. It would be nice to have something like the rural generalist pathway take on dermatology as one of those areas of focus to improve general knowledge, but that's another training area.

They do cover a lot of things, and not all are interested in skin. Some are very interested and some aren't so interested.

Next year will be the first year that I actually have a GP coming in to work with me, who is actually interested

in potentially applying for dermatology. She's just had her second baby, so she's still deciding. She is a very good GP, currently works part time in a skin cancer clinic, but is very aware of, I guess, limitations and wants to train further. So I do see that there is a place. The GPs are so short in our area at the moment, we're not looking to get GPs to do dermatology training per se, but I think upskilling and improving the standardised knowledge is important.

THE COMMISSIONER: Just on that, about GPs being so short in your area, in the last sentence of paragraph 23, you say you often find yourself performing quasi GP work in Orange. It may be related in part to what you were just saying, but can you just expand on that for me?

DR McRAE: So we see patients from over the whole of Western New South Wales. For example, in Cobar, there has not been a permanent GP there for a number of years, and I have a patient who has psoriasis, who has cholesterol problems and can't see a GP, and so I would provide his cholesterol script and his blood tests as part of his - because in psoriasis - heart disease is a co-morbidity for psoriasis.

THE COMMISSIONER: Jeez, no-one has told me that.

DR McRAE: It is. It's a strong co-morbidity.

MR MUSTON: We'll hear of little else between now and the end of this Commission.

THE COMMISSIONER: It is alarming.

DR McRAE: It is actually chicken or egg. We don't know if heart disease increases your psoriasis risk or vice versa, and knowing that - and we actually aim for 100 per cent clearance of psoriasis to improve your heart disease risk.

THE COMMISSIONER: Okay, thank you for that.

DR McRAE: But there's been multiple things that I have diagnosed. A patient came in and they came for a skin check and they had acute diverticulitis and I was like, "You're not having a skin check today, we need to sort out your belly", or pancreatitis or thyroid disease or Ross

River virus. So we're still physicians, as such, but sometimes you can't ignore when someone's actually very sick.

THE COMMISSIONER: Thank you.

Dr Rainger, can I just ask you, in paragraph 14 of your statement - Mr Muston asked you about the risk or the reality of local GPs deskilling if specialists don't visit the satellite hospitals, and you talk about having to drive onerous distances, and often in the dark, then you say, "Operating at these sites" - I think it means - "is less efficient". What should I understand by the efficiency issue you've raised there? It is just in the last three lines of paragraph 14 where you talk about operating at these sites being "less efficient". What does that mean?

DR RAINGER: Yes, so "less efficient" - sorry, that should be clarified. That's not a reflection on the nursing staff or the team there, it's often hamstrung by the number of beds. So a small peripheral hospital has less beds, therefore, I can do less cases there. So on an all-day list in Orange I can do 10 cases, but when I go to Cowra, I can only do five overnights. Some would argue that my time would be better spent staying in Orange and getting 10 off my wait list, rather than spending the day driving two hours each way to only do five.

THE COMMISSIONER: But that would ignore the patients that need your services at that other site.

DR RAINGER: Correct.

THE COMMISSIONER: So the efficiency is simply a function of bed availability.

DR RAINGER: Correct, yes.

THE COMMISSIONER: Understood.

MR MUSTON: I rather gather from what you've told us, Dr Rainger, that even if a view were taken that it were more efficient to operate on those 10 cases in Orange and to have five of them drive from, say, Cowra to Orange because Cowra to Orange is not that far to drive, there is value, nevertheless, in continuing to operate in Cowra, because that provides opportunities for local general

practitioners that keeps them seized of their skills and also potentially keeps them delivering good general practice in the town of Cowra, where, if they didn't have that opportunity, they may not.

DR RAINGER: Absolutely. And it's also closely related - for example, when a GP anaesthetist does a list with me, they have to intubate a small child. That means stopping them breathing and placing a tube into their airway to breathe, which is all done in a controlled setting for an elective surgery. But that then impacts on, say, the obstetrics service they might deliver after hours, where they are forced to deliver a newborn and then may need to resuscitate and intubate a newborn, which is a highly more fraught procedure. So it gives them the confidence to know that they are regularly intubating small children, so should that happen in an emergency, they will be able to handle it. Otherwise it then impacts on them saying, "We're not going to provide an obstetrics service", then the community - why would they stay in that area?

MR MUSTON: Intubating a paediatric case definitely requires significant skill, as was revealed in Bega.

THE COMMISSIONER: Mr Muston had a go on a doll in a hospital. That's what he's referring to. But he did well, apparently.

MR MUSTON: The doll survived.

DR McRAE: I would just like to add to that that the extra costs that we don't consider are the costs to the families. Often we have children whose families can't afford to stay overnight and they may miss their surgery in Orange because of other financial reasons, or the car broke down. Often I'm looking after a kid whose parents can only just afford to put petrol to get 115K to us and back home again. So providing that service to those communities, you know, does help provide - because long term, that child needs to hear and speak, and if they don't have their ears done or their tonsils out, that's chronic illness, and these are the long-term costs I think that are underestimated.

MR MUSTON: That's probably a nice point to finish on, but Dr Rainger, I'll ask you this: in terms of some of those procedures that we've been talking about, the child who needs to have their tonsils done or some grommets put in,

whilst it might be seen as low value in terms of return to the health system immediately in performing that procedure, the long-term economic benefits of having a child who is able to hear throughout their schooling presumably can be immeasurable.

DR RAINGER: Absolutely. There is excellent data to suggest that if you have hearing loss in the formative years, it then directly correlates with educational achievements and criminal activity. So hearing loss can be tied directly into that.

I would like to clarify when you said "economic benefits", I think when you called this a "low-value" procedure, I think we need to clarify that that is low value in terms of revenue raising for the hospital but, life changing in terms of the --

THE COMMISSIONER: No, Mr Muston didn't mean low value in terms of health care.

DR RAINGER: I know. No, I'm just getting it on the record that it's low value revenue-wise but --

THE COMMISSIONER: We can talk about arthroscopies, if you want to, but we're talking about something different.

MR MUSTON: We're talking about high-value care which is not productive of large revenue streams.

DR RAINGER: Maybe not value monetarily, yes.

DR McRAE: Children can't advocate for themselves.

MR MUSTON: Especially if they can't hear or speak properly.

On that note, I have no further questions for these witnesses, Commissioner.

THE COMMISSIONER: Thank you.

MR CHIU: I have no questions, Commissioner.

THE COMMISSIONER: Thank you.

To both of you, we know how time constrained you are

and how busy you are, so we're very grateful for the time you have spent and the assistance you've given the Inquiry. Thank you both, and you're excused.

DR McRAE: Thank you,

<THE WITNESSES WITHDREW

THE COMMISSIONER: We will adjourn until 2 o'clock.

LUNCHEON ADJOURNMENT

THE COMMISSIONER: Good afternoon.

MR MUSTON: The afternoon's panel is large and impressive. In front of you, from your left to your right, we have Professor Boon Lim, who is the vice president of the Royal Australian College of Obstetricians and Gynaecologists; Dr Frances Page, elected member (safety and quality officer) and co-deputy chair from the New South Wales regional committee of the Australian and New Zealand College of Anaesthetists; Matthew Ingram, who we have heard from already, who's involved in the training delivered through the Australian College of Emergency Medicine; Dr McRae, who we heard from this morning; and Dr Josephine Burnand, who is the acting medical director at HETI.

Up on your screen, if we look at the top left, is Justine Harris, the chief medical workforce adviser from the Ministry of Health; Associate Professor Kerin Fielding, going clockwise, who again we have heard some evidence from before, she is the current president of the Royal Australasian College of Surgeons; and Libby Newton, the manager of education and policy at the Royal Australasian College of Physicians.

We are going to be joined a little bit later this afternoon by Professor Inam Haq and Associate Professor Kudzai Kanhutu, both of whom we have heard from before from the physicians, but they're not able to join us immediately.

THE COMMISSIONER: It is my fault for not suggesting it, but nameplates would have been a great idea.

MR MUSTON: They have all got them. I can read them from here.

THE COMMISSIONER: I'm blaming myself. Do we know who would like to take an oath or an affirmation?

MR MUSTON: I have not worked that out. I think if we go through each. Given the number, Commissioner, do we want to do two job lots, as it were?

THE COMMISSIONER: You want to do all the affirmations first?

MR MUSTON: Anyone who would like to give an affirmation, which is the non-religious version of swearing to tell the truth, if you say, "I do", at the end of what the court officer is about to say, that will cover you and then we can do, if any --

THE COMMISSIONER: I assume all three of you online can hear me? All nodding. The same applies for you. We're going to do the affirmation first. If any of you want to give an affirmation, say "I do", when it is read. Thank you.

<BOON LIM, affirmed: **[2.04pm]**

<MATTHEW JAMES INGRAM, affirmed:

<MICHELLE YVONNE McRAE, on former affirmation:

<JOSEPHINE BURNAND, affirmed:

<LIBBY NEWTON, affirmed:

<JUSTINE HARRIS, affirmed:

<FRANCES PAGE, sworn:

<KERIN FIELDING, sworn:

MR MUSTON: Just on that logistic aspect of it, when Professor Haq and Associate Professor Kanhutu, join us, given both of them have given evidence previously --

THE COMMISSIONER: Do you want them on their former oath?

MR MUSTON: It may be sufficient for you to remind them they're on their former oath so we don't need to interrupt

matters.

THE COMMISSIONER: I'm going to call that sufficient, yes. I should just say at the outset, although I might be jumping the gun because Mr Muston is probably about to say this, but whenever anyone is giving a response to a question that Mr Muston asks, if any of you feel like you would like to supplement it or give a clarification or say anything in response, please, just indicate somehow and we will get to you.

MR MUSTON: I was going to say that. The other thing I was going to say was, to the extent that during the course of this process this afternoon, any of you think it would be useful to ask one another questions, by way of clarification or to try to understand the position of your respective organisations on certain issues, do feel free to ask them.

The purpose of this afternoon is to try to exchange some ideas around how we might adjust the vocational training systems in a way that utilises the information available to the ministry and the fact that the ministry is essentially the employer of all of the registrars or a large majority of the registrars, so as to try to deal with some issues of maldistribution, looking at ways that we can open up some bottlenecks in training pathways and the like, that, with the powers available to the ministry or the resources available to the ministry, might be able to be opened up in a way that would be beneficial from the point of view of each of your respective colleges.

The sense we have got, I should say openly, from the evidence that we've heard to date, is that the process of vocational training is highly fragmented. That is not necessarily a criticism, but it seems just to have been the organic way in which vocational training has grown having regard to the fact that each of the different colleges plays the critically important role that it plays in that training pathway and in decision-making around that training pathway, that they have each evolved in subtly different ways, so that the way in which our hypothetical medical student, who we talk about sometimes in this Commission, passes through one or other of those training pathways, is a little bit unclear sometimes, at least to us.

Can I start, though, by asking - perhaps you, Dr Burnand, might be the most appropriate person to start with --

THE COMMISSIONER: Just before you do, ordinarily we would, of course, ask each witness their name and occupation and those sorts of things . We know who is here and we know what their roles are, so I am content for you to just proceed, in other words.

MR MUSTON: Before we do that, I should actually check, to the extent that I introduced them, was that something that found its way into the transcript?

COURT REPORTER: Yes.

MR MUSTON: I can ask this question to short-circuit it: did I misdescribe any of you in a significant way? If so in what way?

DR PAGE: Yes. I'm not the deputy co-chair, I'm the co-chair of the regional committee. That was a mis-transcription the last time as well.

MR MUSTON: Mis-transcribed from the same document. For that, I apologise, all the more the second time around.

DR PAGE: No problems at all.

MR MUSTON: Can I start with you, Dr Burnand. Do you see opportunity for the ministry, in particular HETI as the educational pillar within the ministry, if properly resourced to do it, to play a greater role in the coordination of vocational training pathways of people who are employed on those pathways within a public health system in New South Wales?

DR BURNAND: It probably depends what you mean by "coordination". We certainly are experienced with the specialist vocational training networks that we currently have oversight of, although their funding is different and their resources are different between them. We have been able to broker, if you like, and deal with some of those obstacles to training pathways.

There's certainly an opportunity to expand not only that work within the existing vocational training pathways

that we currently oversight, but potentially additional specialist training pathways, particularly when there are workforce issues. And not only where there are workforce issues, but also potentially where there are issues of trainees along that pathway meeting particular training requirements through access to - and I think the Commission has heard quite a bit of evidence about some of those bottlenecks that occur in order to meet the college requirements for the training.

MR MUSTON: Just dealing with that, what is it that you think that an organisation like HETI might be able to bring to the bottleneck problem and how might that work?

DR BURNAND: I think it's not just HETI. Obviously this touches on workforce issues, which is clearly the responsibility of the ministry proper, but it also involves the collaboration with the LHDs and also obviously the colleges as well, particularly I think colleges operate at a federal level but they also, many of them, have branch training committees which have fellows that are familiar with their local context and the training requirements and the sort of training opportunities we can offer. That information is really important to bring to the table, if you're trying to figure out how to manage trainees through training pathways.

MR MUSTON: Do I gather from that that you see continued value in the colleges, specialists in each of their respective areas, in some areas being the appropriate body to inform decisions about what the training pathway should involve in terms of level of experience, number of procedures, whatever way various colleges want to define the means by which a training pathway is travelled - they are the body to do that?

DR BURNAND: The colleges are responsible under the national law, if you like, to set the requirements for training. You need to go through an Australian Medical Council accredited college program in order to gain specialist medical registration with the Medical Board, so that's kind of the regulatory space that we're sitting in.

MR MUSTON: Just pausing there, do you see any problem with that conceptually, in terms of the appropriate body to be making decisions about what a training pathway

involves - for example, the anaesthetists as a college are on one view the most appropriate group to be making decisions about what the anaesthetic training pathway should look like in terms of its content?

DR BURNAND: Correct. I think specialists, medical specialists and groups of medical specialists in developing curriculum - and most colleges have quite robust processes in developing their curriculum and their training requirements - are in the best position to make those calls.

That said, there is probably room to look at - again, I think this has been mentioned before in the Commission, and I know some colleges are doing this - different supervision models, as an example. So whilst the curriculum, the requirements for assessment of trainees are set by the colleges, there is probably room for looking at, given the current situation and health service changes, and the majority of colleges are in a process of renewing curriculum - it's a continuous process for colleges; it's not a set and forget. So there is room to look at different ways of doing things in the context of emerging issues or opportunities.

MR MUSTON: I might ask the colleges one after the other. Presumably, that internal process of reviewing the suitability of the criteria applied as part of the requirement to make your way through a training pathway in your college, Professor Lim, is something which is constantly under review?

PROFESSOR LIM: Yes, it is. The curriculum is currently under review as well. We've gone through the AMC accreditation recently and came up with 15 recommendations. But at the same time, the curriculum has been under review, taking into account, you know, the contemporary requirements in terms of procedural numbers and the level of competency as well. So it is a live document, it will obviously respond to the workforce concerns, workforce issues as well, and in terms of the rural/metropolitan split, obviously recognising the specific requirements in these particular areas as well.

So what we're really concerned with is, at the end of the training program, that we want to ensure that the fellow who comes out at the end of the training program,

and also the advanced proceduralists, will be well equipped to be able to provide the service that they are required to provide.

MR MUSTON: Dr Page, the anaesthetists - is it similar?

DR PAGE: Yes, I would say it is similar. The curriculum was completely rewritten in 2011, and the full mass of the current curriculum was designed so that it had much more agility than the previous curriculum, which is essentially just a very long Word document which had no agility to it whatsoever.

The structure of the new curriculum has been designed so that it's a living document that can be much more easily updated, modified, changed according to the changes in medical practice, broadly, but also so that it can encompass the opportunities that people have for learning, wherever they happen to be, so that it would enable people to learn whether they were in a rural setting or a metro setting, to accredit the experience that they get wherever they happen to get it.

In that regard I think it's quite a flexible document. But it does have some hard-line standards. There are certain requirements that have to be met, certain procedural skills, certain experience, certain volumes of practice, certain evidence, if you like, of competence that has to be achieved in order to gain fellowship.

MR MUSTON: In relation to --

THE COMMISSIONER: Sorry, can I just interrupt, this is my fault, it's not a criticism of anyone, it's my lack of understanding.

Originally, when you asked Dr Burnand, your question was:

> *Do you see opportunity for the ministry, in particular HETI ... if properly resourced ... to play a greater role in the coordination of vocational training pathways...*

Then the answer was:

It probably depends what you mean by "coordination".

Then there is - again not a criticism - no clarification about what you meant by "coordination". Then your next question was:

Just dealing with that, what is it that you think that an organisation like HETI might be able to bring to the bottleneck problem and how might that work?

The answer was, again not a criticism:

I think it's not just HETI.

There was then a whole list of other examples. I don't think I got clarity on either of those.

MR MUSTON: I'm happy to clarify both. I was going to come back to it.

THE COMMISSIONER: You are coming back to it? That's fine.

MR MUSTON: Yes. I was going to ask you first, in terms of the agility, what do you mean by a greater level of agility?

DR PAGE: I think just the way that it's written and the way that it's broken down enables us to sort of look at what the changes in practice are in medicine broadly and to sort of say, "Is it still relevant that we're asking trainees to have this amount of experience in this particular area? Is that really how we practise medicine today in comparison to five, ten, whatever years ago", and equally to bring in other experience that is actually becoming much more commonplace relevant to anaesthesia practice in 2025.

MR MUSTON: So coming back to some evidence that you gave last time you joined us around the bottlenecks around paediatrics, for example, is there agility within the existing curriculum that would enable movement around the number of paediatric procedures that a trainee has to undertake in order to get through that bottleneck?

DR PAGE: There is and that has already happened over the lifetime of the current curriculum since it was completely rewritten. But paediatrics is an interesting example because there is a huge need for a level of skill in paediatric anaesthesia across the state. There will be children presenting for tonsil and adenoid removal in smaller more rural hospitals, just as they will in big metro centres, and so the capacity of our anaesthesia workforce to deliver that sort of care. We won't be dealing with separation of conjoined twins in a small rural hospital, so we can save all of that for the big metro centres, but we do need a baseline of good quality paediatric anaesthesia care available across the state, we need a baseline of neonatal resuscitative care across the state for those ladies who deliver babies in small rural hospitals in the same way that they need it in large metro centres.

You can look at things like cardiac and neuro, which can be much more centralised because those sorts of surgeries will be unlikely to happen - a big open heart bypass surgery is not going to happen in a small regional hospital - but babies are going to continue to be delivered in those hospitals and young children are going to present for ear, nose and throat procedures, they're going to present with broken limbs that need setting, et cetera. That's why paediatrics is such a sticking point because there is a requirement for it statewide and will continue to be.

MR MUSTON: In relation to that requirement - that is, for example, the number of paediatric procedures that are required to be completed as part of the training pathway - the evidence you've given previously is that that's a bottleneck.

DR PAGE: Mmm-hmm.

MR MUSTON: Is there a process of discussion with the ministry about the way in which that bottleneck might be cleared or the way in which - or what that bottleneck might look like in terms of the number of trainees who could be pushed through, if the number of those procedures was adjusted down? For example, my memory is you said I think it was 20 procedures for children under a particular age was the requirement. Is there discussion with the ministry about whether, if it was reduced, say, to 15, what that

might look like in terms of the bottleneck?

DR PAGE: It's not only the numbers. That's not the only issue. It's actually about understanding the whole approach to paediatric patient management. If you have a child that presents for an operation, you actually have their parent with them as well. So you're actually managing two individuals in that setting, and it's about an approach to a child, so how you would engage with a child that's 10, different to one that's five, different to one that's two. The approach is not the same for children at different ages and you need to be able to get age-appropriate language and age-appropriate rapport with the child in order to be able to deliver safe, effective anaesthesia care. So there's a whole load of other learning that comes as a consequence of being in a paediatric environment where you're doing lots of paediatric cases.

You can do whatever number you choose to pluck from thin air. You can do those numbers, one, and then another one another week later and another one three weeks later, and so forth, but if you actually get that immersive experience in a paediatric environment, what you will end up with at the end of the day, even if the numbers game is the same, is a much higher quality of clinician, because they've just seen so much more, they've been involved watching other people. It's not just the ticking off of the numbers, if that makes sense.

MR MUSTON: Accepting that, and not for one moment wanting to suggest that numbers might be used as a rough metric to try to identify a slice of experience which will give you those things, I suppose my question was, in terms of determining what that slice might look like, is there a process that the college undergoes where it discusses with the ministry the impact that adjustments on that number might make on the bottleneck problem?

DR PAGE: I don't believe that there's a process for the college to determine the curriculum standards to facilitate workforce needs of the ministry. I think that's a little bit the tail wagging the dog. I think that we need to work out what the experience needs to be to provide clinicians of the quality that we want looking after the adults and kids of the state, and then work out how we get that experience for the people.

There has been some change, as I've said, with the paediatric numbers. There have been some adjustments made within the paediatric specialised study unit since the curriculum was written and there has been discussion with the Ministry of Health and with the hospitals that provide tertiary paediatric care in the state, to look at what capacity those hospitals have for additional training. It was two years ago, I think from memory, but don't quote me on that, it could have been three, when the Ministry of Health actually provided a little bit of additional funding to create one extra position at Sydney Children's Hospital and two extra positions at Westmead Children's Hospital, which, because people go to those hospitals for three or four months at a time, has actually created 10 extra paediatric slots, if you like, for 10 extra individuals to get through training.

So that's really the engagement that has happened and that extra bit of funding has gone a very long way to facilitating a lot of trainees getting through. That's, per year, 10 extra trainees getting through that paediatric component statewide, which is really important.

MR MUSTON: Understanding the evidence that you've given previously about the absence, effective absence, of unaccredited training positions within your area of specialisation - that is to say, you can be an anaesthetist registrar on a training program or not on a training program, and the work that you do in that capacity will take you progressively closer to a point at which you have completed all of the requirements, am I right in understanding that in order to get through those bottlenecks, you do effectively need to find your way onto one of the training program positions - into one of the training program positions?

DR PAGE: It is certainly a lot easier if you do. It isn't mandated. So there have been trainees, we've had two of them at our own hospital, who have done the entire of their training as independent trainees. So they've got one job and then another and then another and then another, and progressively got jobs that facilitate them completing all of the specialised units that they need to complete to get their fellowship and they've successfully got their fellowship.

But it's certainly a lot easier, because if you are on a program, on a scheme, then the rotational training program director will actually help navigate that pathway for you. It is part and parcel of their responsibility to look at where you're at in your training, what the next bits are that you need, and to ensure that they're in place for you. So rather than having to do it for yourself, it's sort of handed to you on a plate.

MR MUSTON: Would it be right to say that the majority of people who find their way through the training pathway within anaesthetics, at least at the moment, get there through that more structured path?

DR PAGE: Yes, far and away, yes, the vast majority. It's very difficult for somebody to do a fully independent pathway, because of those bottlenecks. If you've got very limited capacity to send people to places where they can do paediatrics, cardiac and neuro, then you have to save those slots for the people with whom you've made a contractual obligation to complete their training, provide them the access that they need to those training components in a four-year time frame.

MR MUSTON: And when you say "obligation", that's because those who are on the training, in the scheme positions, have a term of employment of four years, during which they will be shepherded through each of the requirements, whereas --

DR PAGE: Yes. So the contractual obligation that the LHD and the individual trainee exchange with one another is that the trainee works for the LHD for four years and within that four-year time frame, the department agrees to provide access to all of the bits that the trainee needs to complete training.

MR MUSTON: And are the majority of those scheme positions in larger metropolitan hospitals?

DR PAGE: Yes, yes.

MR MUSTON: Dr Ingram, can I ask you, in relation to the emergency medicine training program, the same question as I've asked Professor Lim and Dr Page. Insofar as you're aware, is the syllabus something which is constantly under review within the college?

DR INGRAM: Yes, very similar answer to my colleagues, regular review and updates, and quite broad-reaching as well. While obviously medical expertise is at the core of what we do and train in, the reviews are far reaching and they look at the methods of assessment, the frequency of those assessments, location and type of placements to ensure adequate metropolitan and rural/regional exposure. So it's really a review of the entire training program, not just the hard-core medical expertise contents of the curriculum. Although that list of procedures and areas of expertise is also very much reviewed, it's quite broad and far reaching when it is reviewed.

MR MUSTON: From within the college, is consideration given through that process to the extent to which decisions about how training is delivered and the way it is delivered might impact on workforce challenges like maldistribution and - well, in particular maldistribution?

DR INGRAM: I haven't personally been involved with one of those reviews so I couldn't necessarily comment, but I would comment on some of the differences between what Dr Page has spoken about with the College of Anaesthetists and the College of Emergency Medicine, in that when you are an accredited ACEM trainee, there's a district director or a director of emergency medicine training who is responsible, in those words, for shepherding you through your requirements for experience in maybe anaesthesia or intensive care or maybe paediatrics rotations in some ways. But there is also more of a sort of free-market concept where, if a trainee would like to make a term at Westmead Children's emergency department part of their training, to meet their paediatric emergency requirements, then they can choose to do that and go and approach Westmead Children's Hospital, apply for a job, and if they're successful then that's obviously then an accredited term towards the end of their training.

So there are both components and significant flexibility within the emergency medicine training program of how you would like to complete the program, and then there's huge variability in the terms that you can do and the breadth of exposure you can get.

Again, picking up on paediatrics, as one simple example, going and working at Westmead Children's for six

months would meet the paediatric requirement, and there's an alternative where you could also do a logbook in a non-paediatric centre and you see a minimum number of children, a minimum number of acuity and that's then reviewed by the directors of training and then the college to say that that's substantial paediatric exposure to make you an appropriately qualified fellow of the college.

MR MUSTON: In terms of that training pathway, is it perhaps - well, is there scope within emergency medicine for that training pathway to be largely completed in a rural or regional setting?

DR INGRAM: Yes, except that there is a six-month mandatory component in a tertiary centre. So it certainly goes both ways, where people who mainly work in rural/regional areas do certainly benefit from exposure to tertiary centres, and quaternary centres, with different services and vice versa.

MR MUSTON: I should probably come back to you, Professor Lim, just to explore, in relation to your training pathway, where does it sit in terms of the way in which it's structured? Is it a training pathway where trainees, once on the pathway, are, to use the terms we've been using, shepherded through the various requirements by the college as part of that process, or is it more of an independent process of the type that might be available to some trainees in other colleges?

PROFESSOR LIM: The training pathway is structured. The traditional pathway is centred around what is called the ITP - integrated training program - sites, which then have rural attachments as well. So the trainee is required to spend six months in a rural setting and another six months in a regional setting as well. So they take a year out. But they will be shepherded through that pathway, in which they have links with the ITP centres.

There's also a rural training program as well, which is centred around Orange. The aim is to try to develop and encourage rural and regional fellows, who then will continue to work in the rural and regional setting as well. But the majority of the trainees go through the metropolitan pathways.

In their four years of core training, one of the years

they have to spend outside their sites, and then in the last two years, as advanced trainees, then they choose to come back - obviously could come to the ITP, but they could go to another centre and choose a special interest area that they can pursue as well.

MR MUSTON: So the rural pathway that you say has been developed in Orange, for example, is that a pathway whereby your home base, as it were, is Orange or a rural setting, and then you are shepherded out of that to do the metropolitan placements that you need to do before being shepherded back in to your rural home base to finish your training?

PROFESSOR LIM: Correct. There is a reciprocal arrangement, they spend six months in a regional or metropolitan setting as well.

THE COMMISSIONER: Sorry to interrupt. I think we've been joined by Professor Haq.

Can you hear me, Professor? Just so you know, because you gave evidence previously, we're just considering you on your former oath. Welcome.

<INAM HAQ, on former affirmation: [2.35pm]

THE COMMISSIONER: Sorry, go ahead.

MR MUSTON: Dr McRae, your training pathways are obviously subtly different given the small proportion of colleagues who work in the public hospital system, but just in terms of the way in which that pathway is structured and how decisions are made about where a trainee who is on the program goes, could you just explain how that works in the context of your college?

DR McRAE: It's similar to the other colleges in that the majority of the trainees are in NSW Health funded positions in hospitals, so they are in public hospital positions within the metropolitan Sydney hospitals. Of the 42 trainees that I will be placing this year, there will be a couple of overseas trainees, so it comes down to 36 positions in New South Wales, of which - sorry, it's in my statement - 23 are New South Wales Government funded. They're only available in Newcastle and Sydney, and there is one hospital-funded position in Canberra.

The remaining positions that make up another 13.5 positions are STP-funded positions which means they're partially hospital and partially private work based, or rural, so the rules for that are either private or rural. The majority are rural associated with a hospital in Sydney. There is one in Canberra as well. So we cover Canberra into our New South Wales allocations.

Of those we have a director of training, of which I'm the New South Wales senior director of training at the moment, and I do all the allocations for the subsequent year and have to negotiate where everyone is placed and what their previous rotations have been and what their requirements are.

I only take special preferences for out-of-Sydney sites, which is Newcastle and Canberra and any other rural associated site, of which six months may be in Sydney and six months outside of. That varies from first-year to fourth-year positions, and we need to cover requirements of public exposure, private exposure, surgical exposure and paediatric exposure.

Regarding curriculum, we are actually in the process of doing a review of the whole training model and progression, not just the curriculum but the whole work-based assessment process. The curriculum is separate in itself and is updated every few years to encompass changes in several aspects of how medicine in general changes. But the actual training is being assessed at the moment as part of AMC requirements.

Then the accreditation is a separate issue again. Every site has to meet same accreditation requirements, and that needs to be able to ensure exposure to histopathology, surgery, radiation oncology. So dermatology, most don't realise, actually covers a broad diversity of exposures, however, we don't have the same requirements of meeting a minimum number of paediatric exposures, although most hospitals - even though we have Sydney Children's and Westmead with limits to our numbers, we allow hospitals such as Royal North Shore, that has a strong paediatric component, Newcastle and Canberra, to contribute to their paediatric exposure.

MR MUSTON: In terms of the way in which a candidate is

shepherded through each of the various positions that they might have in order to acquire that experience, how does that work? Who is the shepherd?

DR McRAE: Currently, I'm the shepherd.

MR MUSTON: You've already given some evidence this morning about the way in which you've set about trying to build capability to deliver a predominantly rural-based vocational traineeship, presumably, if the various building blocks that you have been seeking to stitch together can be located, that's something that is possible?

DR McRAE: Yes. So there are more than enough cases rurally to see adequate exposure, it's just recognising and putting them together. We're looking to flip the normal model on its head, of three years rurally and one in Sydney.

The main important reason to have one year in Sydney is purely for context of tertiary referral, for your super-specialised paediatric clinics and your Mohs surgeons that only do particular work - so basically referring back to your silos that do very specialised work. There's only so many dermatologists that do particular lasers - because these are very expensive machines, so not everyone buys a machine - and that are very competent in these.

You need a year to develop your contacts with your primary referral hospital. So in the process we're looking to link Orange with Liverpool or Westmead as our primary, because they're the ones that most patients are currently referred to. Ideally Nepean, in time, would be that hospital, however, we don't even have a dermatology department there, yet, so that's another goal for the future. But from a case point of view, we have enough cases in all areas to meet our curriculum and exposure requirements.

MR MUSTON: Without needing to know what they are in specific detail, is it the case, as part of the dermatology training pathway, that there are bottlenecks, particular areas of specialist experience that constrain, at the moment, the number of people who can be pushed through the pathway, or are there other limiting factors?

DR McRAE: There is no bottleneck per se in terms of

exposure. Our primary bottleneck is obtaining NSW Health funding positions at hospitals. We allocate the trainees to what positions we have available. If a hospital only has one trainee position in a very busy department and we're unable to access funding for another position, that is a hospital funding concern, not a college concern. So we're constantly trying to obtain further funding for positions at multiple hospitals. However, as mentioned earlier this morning, it's working with individual hospitals or the LHDs that is probably the most difficult part of the process.

MR MUSTON: We might come back to how that process could be adjusted in a moment.

Associate Professor Fielding, can I ask you: in respect of the surgeons and the curriculum for study that one needs to pass through in order to become a fellow of your college, how does that work in terms of the setting of the curriculum, the identification of candidates who are on the training pathway and the way in which they are shepherded through that pathway?

ASSOC PROFESSOR FIELDING: We have nine curriculums because we have nine different specialties of surgery, so it does depend a little bit on the specialty, but if we talk about orthopaedics and general surgery to start with, because they're really the major specialties that we have workforce inequity within rural, then we can have a bit of a chat about some of the sub-specialties, if you like, but is that okay?

MR MUSTON: Yes.

ASSOC PROFESSOR FIELDING: Our training programs are basically all training generalists and they are competency-based programs. We've just achieved three years of accreditation with the AMC. We had nine of our conditions met, nine conditions are progressing well and we've got three new ones. So we're very proud of that work to get nine curriculums together. Like I said, the curriculums in orthopaedics and general surgery are competency based, so there is caseload and case mix required for that, but obviously we have gone past the numbers game.

I think our view on the workforce distribution, which

is, I gather, really the mainstay of this question, workforce - there is a condition around workforce, and it's not something that I believe many of the colleges have done well, and partly that's because you don't know what you don't know. Where there are not trainees, we don't know information about a lot of those sites, and we've been working very hard with DOHA and with the ministries to try and find sites that need to be accredited. But there is a process for accreditation for a surgical position that needs to look at the caseload and the case mix and to see whether we can place a trainee in a site.

We have a rural health equity strategy that has looked at the evidence internationally about how we start to reverse the barriers to rural training. The evidence shows that we need to train in rural, we need to have rural people applying for those programs.

We actually need rural people to be involved in the governance of those programs, so rural sites actually do need to be involved in decision-making. We need networks that are based in rural, with the hub of the network in rural, and some connection to metropolitan for some of the specialties.

Some of our training does require some attachment to a specialty area in a metropolitan centre, for two reasons: metropolitan centres are important links for rural surgeons. I'm a rural surgeon and I have very significant links with St Vincent's Hospital and Prince of Wales. That's really important because there are cases that we cannot do in rural because of what is available in our rural centres and a combination of trauma issues that need to go to neurosurgery or cardiothoracic surgery, for example, where we do not have equipment or surgeons to do that work in the country. So we really need to look at networks. I think we can do this with HETI, and I think it would be much better if we did do that with HETI, and find out what rural centres need and what they want for workforce planning and development. We certainly have many trainees in rural, but they are doing one year in rural.

We have a minimum one year of training that you have to do in orthopaedics and general surgery in rural. We now have one year of ENT surgery, six to 12 months of surgery training required for urology and plastic surgery. It's well on its way to developing rural pathways.

This is happening as we speak, and we're very keen to be involved, but the networks are what needs to be set up. There need to be links between the rural and the city so there are agreements between metropolitan centres to allow those rural trainees to come into the city. We believe that about 70 per cent of training can be done in rural, right through the whole pathway of training from medical school, internship, right through training.

A good example: we have four orthopaedic trainees in Wagga and we have eight general surgical trainees. So we're already doing the training. I've been training surgeons in Wagga my whole career for 30-plus years, and very sadly, most of them are metropolitan surgeons. The evidence shows that we need them there at the beginning of their training and we need them there at the end of their training. If they go back to the city for the end of their training, they don't come back.

These people are adults, they have families, they have children and it's difficult for them, when they settle in the city, to then relocate. So it's a whole career issue that we know the answers to and we're very happy to be involved.

MR MUSTON: Coming back to my question, in terms of identity of the person or organisation, who shepherds a surgical trainee through each of the rotations or requirements that they need to shepherd through and making decisions about where they will go as part of that pathway, who is responsible for that?

ASSOC PROFESSOR FIELDING: We are at the moment. We have statewide committees that report to a national committee, and the state committee sets up the pathways.

Dare I say, those committees are very metropolitan based. I believe that the area health services actually need to be involved in some of this decision-making and I don't think it would be difficult for them to be involved.

I think each area health service should be having its own education group, which could involve all the specialties together, looking at what they need for the future for their workforce, and they should be linked to

the city, and we would absolutely be able to supply surgeons that are supervisors of training in those sites, to be on those committees.

But at the moment, the statewide distribution of trainees is based in metropolitan and, as I'm sure you understand, metropolitan people make metropolitan decisions. That's not a criticism, but rural people actually know what they need and know what they want. I can say that because I am a rural person, and we are very keen to train in Wagga; very keen to train, I've heard, in Orange, in Lithgow, in Lismore and in Armidale, many places around the state, but we actually need a bit of support.

We're very limited in our support for supervisors of training, for admin support in rural sites. So that's partly why the metropolitan model works, because there's a little bit more FTE in the big city hospitals for people like surgeons to be doing this sort of work.

So if we have an education office in a rural hospital, a bit of admin support for the supervisors of training and they can work together.

MR MUSTON: I think, Commissioner, Associate Professor Kanhutu has just joined us.

THE COMMISSIONER: Yes. Welcome, Professor. We discussed before with Professor Haq, you are just on your former oath from the last time you gave evidence, so we're just proceeding on that basis. I can tell you can hear me, because you are nodding your head.

<KUDZAI KANHUTU, on former affirmation: [2.49pm]

MR MUSTON: Can I ask you quickly, Ms Newton - and again, please pass the question on to either Professor Haq or Associate Professor Kanhutu if more appropriate - in general terms, the training pathway for physicians, I understand there is already, as evidence has been given, some general or basic physician training which is facilitated through HETI within the ministry, at least in New South Wales; is that correct?

MS NEWTON: That's correct. So HETI has established networks of physician education. We've got a range of those within New South Wales. Predominantly they are

probably metropolitan centred. Within those, we've got network directors of physician education who have a key role in shepherding trainees in those hospitals, those networks, throughout those networks for their training pathways, and they're governed by physician councils which are attached to HETI.

The model works quite well. We are quite interested in seeing what scope there is for establishing rural networks and taking that successful model that medical schools have pioneered in having networks that have a rural or a regional hub and rotate out from there, as Kerin and some of the others on the roundtable have mentioned.

We see there is a lot of promise in building on that impetus in the workforce locally that have been nurtured through that undergraduate/postgraduate location. So if we can build on that, the key issue for us is the workforce for providing that supervision there, and so that's where we can see that there's a real role for employers, to play a role in recognising the work that goes into delivering physician education on the ground. Inam?

PROFESSOR HAQ: Thank you very much, Libby, for that. It's a great start. I think there's certainly more work we want to do in partnership with HETI to extend in basic training but also I think in advanced training. As you know, we have over 30 specialties in acute medicine or non-traditional, they call it, areas, but equally important areas such as environmental medicine and public health and rehabilitation medicine.

It's a very diverse set of colleagues that we work with, all with individually slightly differing requirements, and we recognise that rural is not one catch-all title, there is a rural in one place that's very different to a rural in another place, and we need to understand that. As Kerin says, the community knows what they want and we will and we want to listen to and engage with and really leverage off the developments of the end-to-end rural medical training programs now across the state.

The worst outcome would be that if those people train in their medical schools locally and then move metropolitan, the whole concept falls on its head. We must work together, and this is the only way we can do it. The

colleges can't do it on their own. We have to work with HETI and the ministry to ensure that this works. So creating end-to-end rural networks with the opportunity to come in to metro for specialty expertise as required I think is really important, and understanding that tertiary/quaternary interface with generalism,

Professor Kanhutu could probably talk about the work that we're engaging with on rural generalism as well. I think this is a key opportunity of time for us now, where things are in place that have not been before, ie, the end-to-end medical programs, and we want to and we are at the moment engaging in accreditation renewal so that we can recognise rural sites.

At the moment there have been some barriers to that. The level accreditation, level 1, 2 and 3 of hospitals and what can be provided there is changing and our curriculum is changing. It's now, as Kerin says, competency based. A lot of the what are called "entrustable professional activities", the assessment of professional clinical behaviours, can be delivered anywhere, not necessarily in a metropolitan centre, apart from maybe a small number.

So the foundations are in place really, now, for us to take that next leap forward and really embed proper and intentional rural training, where perhaps before it's been a little bit based on interest and opportunity, which is fine, but I think we can't carry on like that.

ASSOC PROFESSOR FIELDING: Can I just add that there are already regional training hubs set up by the federal government 10 years ago, that are attached to the local rural universities. The infrastructure is there and ready. It needs a little bit of a boost and I could see that happening with HETI or the ministry, but there is already a network beginning that needs to have some accountability from the city to add in to that. But those hubs are already there, and I forgot to mention the regional training hubs.

PROFESSOR HAQ: Absolutely right. We really need to re-energise those.

We are also learning a lot from federally funded programs in FATES. I know, Kerin, you're running a program around rural training. Us in the physicians, we've also

got a great project in rural palliative medicine and potential end-to-end programs there. Western Australia are looking at end-to-end rural training in both adults and paediatrics, so there are lessons learned and mechanisms and structures that we can transpose to a New South Wales environment and context that I think can be really important.

But Kerin has hit on the point here: in order for those trainees and those supervisors to succeed, they need support, actually on site. So the supervisors need the time, the allocated time, to do their work. We know the service pressures across the country, but the ministry, I think, has a key role in ensuring that supervisors have the time allocated in their jobs to do the role.

Happy supervisors, happy trainees, happy patients, happy communities. So that is really key. The appropriate administration and logistical support there, either in person, where we're needed, but also networked as well throughout the system, is key to that success. Just dropping trainee A into location X with no other support is not going to work.

One final point is STP positions. We must leverage the STP positions at the moment. Certainly with physicians, they are a little bit siloed and on their own. There's lots of opportunity to bring those together into communities of practice, into formal networks that we've already talked about. I know we've already given evidence at the STP review to this effect. There are opportunities there for the federal government to completely change how that system works to the benefit of all. Thank you.

ASSOC PROFESSOR FIELDING: The federal government has assured us - just early on Monday, actually, because many of us were at a rural workshop in Darwin on Monday - with STP funding that there will be some changes that will be positive for rural.

Can I just say that we've been working together with several of the colleges in the room today on rural pathways and rural training and barriers to rural training with these FATES projects, Kudzai was in Darwin with me, and we have agreed to start a rural training pathway with a regional training hub in Darwin next year. So we can do this. We just need some support.

MR MUSTON: Dr McRae?

DR McRAE: Just as a comment, we utilise our STP funding, we've brought them together to try to develop a spoke and hub model with Sydney hospitals and regional areas and link them with a tertiary hospital in Sydney essentially, in a way developing networks, which is working quite well. We're also utilising the FATES program as setting up the Orange/Dubbo training program. FATES is this "Flexible Approach to Training in Expanded Settings" model, and it's federal or Commonwealth funding. It's only for two to three years and it's to prove a concept.

So it's great to have these positions, but I see the STP funding and FATES funding as proof of concept funding. They are not long-term funding. I think this is really important for us to acknowledge generally, that a third of New South Wales positions for dermatology are currently based on STP funding and you have to apply and put in your interest and they are allocated. I think that's a really important thing to acknowledge from a government/NSW Health perspective, because some of these things are not long-term solutions, for a problem that is growing bigger.

I actually have a question for Justine or - who funds the HETI program with the physician support?

DR HARRIS: Do you want me to answer that?

DR McRAE: I'm not sure. Who is best to answer it?

MR MUSTON: Whichever of you or Dr Burnand feels best qualified to answer.

DR BURNAND: I'm comfortable to respond to that. I think some of the benefits of - you term it "training pathways", but actually it's training networks - have been well articulated by some of the other evidence this afternoon.

In the initial establishment for basic physician training, if we take that, back in 2004, training networks - although I have put this in my previous statement - were initially groups of hospitals or sites that were pulled together in order to ensure that if a trainee, an individual trainee, was allocated to that training network, they would have a pathway to meet their

college requirements. The original funding came from the ministry, and that continues for physician training.

Not all of the vocational training networks that HETI supports are funded in the same way, and there is variation, but that funding was originally through the ministry.

MR MUSTON: Dr Harris, you've got your hand up.

DR HARRIS: I just wanted to add to what Jo was saying about the networks. When they were originally set up there were different funding mechanisms, and so the basic physician training network has the strongest workforce component, the rest are more education and training. But even with the basic physician training programs, as the positions have grown over time, the networks have broken up and they've all become more self-funded, without the centralised funding, so that has been a limitation on the ongoing growth and development of those networks.

Having vocational training networks sitting with HETI works really well, but you kind of need an ability to grow and change to meet the circumstances as they change in the state, based on evidence. That's one of the issues that happens with that, but they are very good networks.

MR MUSTON: Dr Harris, this question is probably best directed to you. We've heard some evidence on several occasions from Mr Griffiths about the sort of workforce data which is available within the ministry in terms of the mapping of immediate need for particular areas of specialisation and forecast, or projected future need, based on an array of factors including retirement of existing workforce, increased areas of need based on changing health demographics and the like.

At the moment, is that information being used in any strategic way to inform decisions about training pathways and how vocational training might work in any particular area of practice? Perhaps starting with the physicians, given there's an existing relationship, networking relationship.

DR HARRIS: It is available. It is used in some respects to look at workforce issues. I think with the physicians, because we have the network we can actually see, you know,

what the issues are. The problem that we have is we need a mechanism to respond to the issues as they come up, which is the funding and also some workforce distribution levers to be changed, because the governance of the network, when it was set up, has sort of stayed the same and it's not agile enough to respond to what's happening currently.

MR MUSTON: I understand the funding piece, but as I think you've indicated, there are the funding challenges, coupled or compounded sometimes by the workforce challenges in finding people to fill funded positions, but the workforce levers that you have available to you to try and address some of those challenges include, don't they, the training pathways which potentially can funnel trainees, at least, into particular areas and, if those pathways are successful, perhaps increase the number of permanent practitioners who practise in areas of need or perceived future need?

DR HARRIS: Yes, if the vocational training pathways, ones that are HETI governed and the ones that ideally would be sitting under there, were overlaid with the workforce plan, I think that would be the best scenario to respond to the state's needs and the community needs.

MR MUSTON: I will come to you, Professor Haq, in a minute, I see your hand up, but can I just ask you Dr Burnand, coming back to my poorly expressed question at the start, when I asked whether you thought HETI - and perhaps I'll expand it to the ministry more generally - had a role to play in the coordination of some of these training pathways, what I had in mind was a role to play in seeking to build, out of the resources available within the system, a networked pathway which enabled a prospective trainee to pass through each of the gates that they need to pass through in order to accrue the curriculum, or to satisfy curriculums set by the college on the one hand - so that's the building of the networks using the resources that are available - and, secondly, assisting to shepherd registrars who are all employees, or by and large employees of the state, through those networks; and then perhaps if I could tack on a third question, perhaps more for Dr Harris, whether there might be value in HETI and the ministry combining to do that in a way which funnels these trainees into areas of immediate and future need within their respective areas of specialisation? It's a big question.

Break it up, and if you miss any of it I'll come back and ask it again, this time.

DR BURNAND: Thank you. If I take the first component, is there a role? The answer to that would be yes. I would also say that that's precisely why the HETI vocational training networks were set up initially, to provide a mechanism for people to meet their requirements through college, through a range of different exposures in different settings and sites. You have heard from some of the colleges, for example, that they do have a requirement for a trainee to complete a certain amount of time in rural or regional locations. The network includes - I'm speaking in general terms, but the training network would include a large tertiary metropolitan hospital, a rural hospital, often an outer metropolitan hospital.

MR MUSTON: Pausing there, in building networks and having regard to the information available to HETI and the potential shepherding service that it might offer, there is an ability within HETI, is there not, to facilitate to the greatest extent possible the flipping of that, such that, consistent with Dr McRae's observation, it is possible to have a rural-based training position, where that trainee is shepherded through the six months or year of metropolitan training, to ensure that they get the full curriculum rather than what would seem to be, and I say uncritically, the default, which is a metropolitan-based training program with a six- to 12-month rotation through regional and rural areas?

DR BURNAND: Absolutely. The original intent of the training networks was to make all participating partners equal partners. Traditionally we have had a hub and spoke model and I think you have articulated that there are still - we gravitate to that. But the principles underpinning the networks are to have equal partners as part of that network. So each of those participating hospitals has a network governance committee, which includes, if I'm talking about the basic physician, the physicians, who understand the curriculum and the training requirements, but it also includes representatives of the local facilities from the hospital executive, so medical administrators and others, who work together, and that structure works in each of the training networks. It not only has some workforce considerations, but also education and training considerations, and then that reports up to

the state training council, which HETI oversights. So that's the basic governance structure.

Is there a possibility to flip to have a more rural-based program? Within that structure, I would say anything's possible with the appropriate consideration. You did ask, though, "within existing resources". I think this is one of the issues in terms of creating new pathways, particularly when we're talking about creating pathways in regional and rural locations, which may not have the existing educational infrastructure, both equipment, physical resources, but also supervisor resources that traditional training sites in the metro enjoy. So can we do it within existing resources? I would suggest that would be very challenging.

MR MUSTON: I might come back to that. Dr Fielding, I'll come back to you as well.

The second part of my question was the shepherding function that HETI might potentially be able to play in this process. Perhaps we could expand that shepherding process to a centralised recruitment such that applicants wanting to find their way onto a pathway only need to apply once rather than applying to every different facility that might be offering a position. Is that a role that HETI could play?

DR BURNAND: It's a role that HETI and others currently do play. Whilst it's not HETI's prime responsibility to be involved in recruitment - that is other partners within the health system's responsibility - HETI does have, for some of the vocational training networks, a central coordinating function so that we have centralised panels and one interview for multiple positions, preference matching and so forth. That structure, if you like, already exists for some vocational training programs, and psychiatry, medical administration are two examples.

MR MUSTON: We have heard evidence, though, from a number of people now, who speak of their experience of finding both unaccredited and accredited positions, and that experience involving them having to make sometimes 30 or more applications in subtly different forms to an array of different facilities. That is still a lived experience of many people within the system, is it not?

DR BURNAND: That's right. Dr Harris might like to make further comment on that, given that there is now a centralised recruitment service, but I will leave that to her to expand on.

MR MUSTON: The last part of my question was: to the extent that HETI might play a shepherding role and a role in helping to construct these networks in collaboration with the colleges, is there scope - and again, it might be a question for you, Dr Harris - to use those two things as two separate levers to actually drive at least a registrar workforce and potentially a more permanent workforce into areas of need and future need within the system?

DR BURNAND: To the extent that the success of the vocational training networks - and use basic physicians as an example - I would say yes, they have already moved trainees beyond the metro tertiary. If we go back 20 years, if you wanted to do basic physician training, you predominantly went to the PAs and the St Vincents and the North Shores, you didn't tend to complete your physician training in the Campbelltowns and outer western places.

The vocational training networks have actually distributed the trainees across, but they will rotate around so that each trainee on the program gets opportunities across a range of settings, both outer metro and rural. So I would say yes, there is a role. I think there is a proven structure, a governance structure, but the important thing here is, from a trainee's perspective, this is not only about workforce. Trainees look at this through the lens of, "Where am I going to get quality education and training; where am I going to get supported; where am I going to get opportunities to meet my college requirements?" So there are two - well, there are probably more than two components, but I think it is really important to continue to think about that as a whole.

MR MUSTON: Accepting that those things are critically important, in an environment where we gather that, at least within some areas of specialisation, supply of training scheme positions or guaranteed training pathways is outstripped by demand, there is scope, isn't there, to enable trainees to get those two things - that is, the good experience, the quality training, whilst also, to the extent it might be useful from a workforce point of view, diverting some of those trainees into areas which might not

be their first choice?

To use your example, there might be more positions sought than there are positions available, and if you have a choice between putting one of those positions in your RPA or your Campbelltown, if the system perceived that Campbelltown was a situation of greater need and it was possible for a candidate to do their training through that facility, perhaps rotating out to somewhere else to get the tertiary or quaternary experience in a different hospital for a short period, it's possible to actually create that trainee's journey in a way which forces them into, perhaps encourages them into at least a short term, if not a longer term, position in that hospital.

DR BURNAND: To the extent that the levers that you have just described would be required to do that, I would say that they don't exist within the kind of authority, if you like, of HETI. That probably is a question to ask Dr Harris, because I think it not only goes to some central coordination strategically, it also goes to where the funding is and, you know, across LHDs.

MR MUSTON: Associate Professor Fielding and Professor Haq, I have not forgotten you, but given the baton was passed to Dr Harris on that particular point, I might invite her to take it up momentarily.

DR HARRIS: Yes, I think we could develop those opportunities and I think part of the issue is the opportunities are largely not there or they're not terribly visible, and having defined vocational training networks makes it very visible. If you compare that with a centralised recruitment process of some kind, it makes it much easier for trainees to navigate what opportunities they have available to them. So even in undersubscribed specialties, having the opportunities there will change behaviour of the doctors.

MR MUSTON: What about the funding question? Dr Burnand points out that at least from HETI's point of view, decisions around whether or not to fund a registrar's position in a particular location or to, say, fund a public clinic in the way we heard some evidence about this morning, in a particular location, which would be required to facilitate training in a rural setting, those decisions currently are made by the LHDs?

DR HARRIS: That's correct, yes.

MR MUSTON: Is there any coordinated or centralised process whereby those decisions are being informed by these sorts of broader systemic workforce issues - that is to say, a decision being made that by standing up a particular public clinic in a hospital in Orange provides an opportunity to have ENT surgeons trained through Orange, because Orange is the place that we as a system think they most need those ENT surgeons at the moment, as distinct from, say, Lismore or some other hospital? Is there a coordinated systemic approach being taken to any of that?

DR HARRIS: There are some approaches to it, but I think they are more ad hoc. Sometimes around redevelopment of hospitals or where an LHD reaches out for some assistance to the ministry, or where we have --

MR CHIU: Sorry, Commissioner, I can't hear.

DR HARRIS: -- for example, the example that Dr Page gave before, where the ministry is being made aware of bottlenecks in training and the need to fund particular positions to maximise training opportunities. So it has happened, but it's not coordinated, I think, in the manner that you are describing.

THE COMMISSIONER: Mr Chiu, I did hear you. We'll see how we go from now on. I just didn't want to interrupt the witness while she was talking then. I'm suffering the same thing, but --

MR CHIU: I'm wondering if the transcript --

THE COMMISSIONER: Well, the transcript is doing a brilliant job, as always, so that's why I've got my computer where it is, because of this problem. Sing out if it happens again, but we'll just see how we go from now on.

MR MUSTON: We're just struggling a little bit to hear you, Dr Harris, and also Professor Haq. Both of you, it's being suggested if you are able to lean a little bit closer to the microphone, it would be of assistance.

DR HARRIS: Will do.

MR MUSTON: We can test that theory, Professor Haq, because I'm now going to invite you to tell me what you have been busting to say for a while.

PROFESSOR HAQ: I have been, and I'm sure Professor Kanhutu and Kerin will echo what I'm going to say here. This is the crux of the matter. At the moment, if hospital X says, "I need another cardiology registrar", then they will ask us, the college, or the relevant college, to accredit that position and it will be based on the capacity to train within that organisation, but there isn't that broader view of what actually the whole system needs, and I think that's the crux. If we're going to make a significant step change here, I fully support that HETI's role needs to be enhanced with appropriate funding so that there is that overarching workforce data and strategy understanding so that when we say, "How many cardiologists do we need in New South Wales", we know how many and where, and we do that for all our specialties.

Professor Kanhutu, I'm sure, will be able to talk on the issues of workforce data and how we're working with that. Colleges are getting more involved with that, partly because it's really important, but also the AMC are nudging us in that direction too. Again there's shared purpose here.

But at the moment it is a demand-led process, so hospital X can say, "I want X", a trainee can say, "I want to be a cardiologist and I'm going to do it here because there's a position here" - is there that overarching shepherding, as you put it, which I think is exactly the right word, and nudging and changing of behaviour, to say, "Okay, if you want to do cardiology, actually, you can only do it here because that's where the need is."

People will respond to that. The issue is, of course, some of the larger metro hospitals may not like it because they will see it as a potential taking away of resource from them out to elsewhere.

So that needs to be managed probably at other levels, but if we're going to make a step change, there has to be that change - that increasing use of strategic workforce data to help guide where and how recruitment happens in all of our specialties, otherwise we'll be back where we are again, which is very demand led and sort of the biggest

tends to get more.

Kudzai, what do you think?

ASSOC PROFESSOR KANHUTU: I think the point has been well made, and I'm looking at Kerin here. We've had conversations for years and years and years around what does it take to build a well-coordinated pathway into professional practice. It's very clear at every stage what is required and it's also very clear, from the colleges' perspective, what we have greatest control over and where our greatest input or value can be, and it's around that really clear line of sight to what are the scopes and competencies that a person needs to have in order to be able to deliver good quality care.

And you're quite right. The missing link here is that we just haven't had that level of longitudinal and system coordination that would actually allow us to then ask of each of the individual stakeholders, "Right now what we need from you, RACP, is, from a data perspective, a list of all BPTs who have indicated an interest in cardiology so that we can start to see what's happening next year and to start to forecast and actually plan."

What we're always doing is looking with the retrospectoscope and saying, "Oh, boy, hospital X suddenly had extra advanced trainee roles for cardiology and now they are spilling out largely into private practice", when, if we'd actually been prospective around that move, we could have been able to say to them, "Hey, if you do this, in a few years' time we can see that there will actually be a public position available for you in Wagga or in Dubbo, and this is what the pathway looks like."

I see that really as an act of respect to people who are investing their time and energy, is that we should have the level of coordination that allows people to plan, because we know when they spill out, we don't have constitutional leads, you know, for conscripting people, so they spill out and then they just do the best that they can and it's just wasteful.

I think we all know what we're good at and we all know what we can contribute, but it's that central coordination piece that is missing and it also scales up and out to the federal level, because we are all binational colleges, from

the ones that I see here on the line, we also have a responsibility across jurisdictions, and I think it would be a shame if we missed that element, even though I know you've been tasked to look at NSW Health alone, because fixing it here, while all the other jurisdictions are still struggling with the same challenges, means that we're actually driving perverse incentives and advantaging one jurisdiction over another, and we're not in that business, as colleges.

Also, it would be great to see how the report and the work that you do will also inform that approach to interdisciplinary workforce planning, because, you know, Inam is a rheumatologist, Kerin, you're an orthopod, you know that if you've done excellent work, there's no point if there's not a physiotherapist or good nursing in community to then help that person to succeed.

So there is also this other layer that I hope will start to come out around it's not only medical specialty pathway mapping and planning; it's also the overlay of the interdisciplinary support that actually makes that quality care as opposed to, "Hooray, I've got a cardiologist who trained in hospital X and is really skilled to do stroke management and acute heart attacks, but there is actually nobody there to support them to do the work they need to do because we didn't think about nursing, allied health, community engagement, general practice."

That's where I see the bigger picture around where does the data sit, who's responsible, who's accountable, and that we're not missing interdisciplinary and also cross-jurisdictional responsibilities to make sure people are safe, not only in New South Wales but everywhere, because we train everywhere.

MR MUSTON: Dr Fielding, you've been waiting a long time.

ASSOC PROFESSOR FIELDING: That's all right. Saying that, if we can get some really good things over the line in New South Wales, we can be leaders in the space, Kudzai.

I think, first of all, everyone needs to understand that there's actually excellent evidence across the world for rural training. Rural training is often better, there's more supervision. People live in their communities, they're very visible in their community and so

this tend not to leave trainees unsupervised, for example, and our trainees rate our training extremely high. In fact, many metropolitan trainees come to rural to get good training. So that's another question. But the answer is that we can train in rural.

The HETI funding - and I did work at HETI for 20 years - is very metropolitan based. It was very difficult for rural sites to get any of that funding. There is funding, and there is funding often sitting in places that have workforce oversupply, and we do know there are parts of New South Wales where we do have an oversupply of some types of specialists, and again, it's that we don't conscript and we can't send them to rural.

So that funding does need to be a little bit more evenly shared. It's been very difficult for HETI. Jo can't say this, but I can now that I've left: it's been very difficult for HETI because HETI didn't control those funds. Those funds sat out in the area health services and often went into a black hole and it was very difficult to get them. So they need to be used for what they were given to the system for. They are to support education and training for the medical workforce.

As Kudzai said, we need to be training for workforce need. It's extremely ad hoc. You train where someone's organically grown a program, where, you know, this sir and that sir decide they wanted a trainee 30, 40 years ago. That's kind of what we've got and it's really not scientific. It's not looking at the data. We need to work together so we really need to consider those regional training hubs, rural training hubs, working together with HETI and with the colleges and the hospitals to plan for the future.

We have no succession planning in my hospital in rural. There is no support for the staff there to succession plan for the future. We have enormous trouble recruiting specialists in Wagga, and it's a fabulous site, and when people move there - and we've got people locally that would like to stay, but there actually is no promise of a job in the future, there's no connection between medical school and getting a job at the other end.

The whole pipeline needs to be connected with some data and with some science behind it to say, "Okay, we know

that we're going to need five orthopaedic surgeons in five years. Let's train them." We can do that. We can do that, but we need to be together and we need to have support for a sort of an education hub in those sites to do it.

Clinics, absolute disaster. We have no clinics in Wagga. We have to train the registrars in our rooms. The registrars have to leave the hospital to come to our offices to see cold orthopaedics, cold spinal surgery, et cetera. We do not have any clinics. We've asked and we've asked and we've asked. The hospital is completely hamstrung financially and cannot support it, and it really does significantly affect looking after patients fairly and equitably in rural, particularly Indigenous patients and people from a long way away.

THE COMMISSIONER: When you say "we need to be training for workforce needs", I take that to mean that we need to be training a workforce for the needs of the health demographics of a particular region, so that we get good population health outcomes for the needs --

ASSOC PROFESSOR FIELDING: Absolutely.

THE COMMISSIONER: -- of that particular community.

ASSOC PROFESSOR FIELDING: So we know that we need at any one time, 10 orthopaedic surgeons in Wagga. We'll have two or three dropping off in the next three years, so, you know, we should be training at least three at the moment that are local, that are going to stay.

We have three medical schools now working in Wagga and we have plenty of local talent of people who want to do training in Wagga, but the system is not connected well enough to do that. But we can do it. We just need some support to get that moving along.

All the colleges in this room today, we've all been working together and we're all really keen to do this, and we know what we need to do, but the system is not well designed and coordinated to do that.

THE COMMISSIONER: It's not a lack of data or evidence; it's a lack of connectivity?

ASSOC PROFESSOR FIELDING: Well, we do need some data. The colleges need some data to know how many we need in spots. We do need that, and that hasn't been very very clear, Commissioner.

THE COMMISSIONER: It's there somewhere, though?

ASSOC PROFESSOR FIELDING: It's there somewhere, and we have been talking together between DOHA and the jurisdictions to try and get that data together, and we're really keen to see it. We're ready to go, but we need to have those conversations not at the city level, we need it locally. We need support locally to get on with it and do this. We've got agreement with the universities, with the regional training hub, people who support that. You can see in the room, we're all talking this talk all the time. We know each other and we know what we need to do. But we need the government agencies to actually start working with us at a grassroots level.

MR MUSTON: Dr McRae, I think you were next to put your hand up.

DR McRAE: I guess this is a comment following up from the previous discussions from physicians and surgeons. Can I direct the question to Dr Harris: I agree that the rural pathway is there, and we've said that and described it. We know that we have capability of teaching, although it is stretched. I think that over many years, the goodness of rural doctors providing teaching out of their own will and the need to help support areas to teach more to come far exceeds any monetary gain ever for any of our rural people. We don't get paid for the majority compared to any metropolitan staff specialist or VMO, because I have been providing on-call for 10 years with no VMO. I've never been able to - I'm a HMO and I provide advice every day, and that's not my bugbear.

I would like to know if NSW Health has ever considered more of a statewide funding governance, based on the previous discussion, of basing funding of specialist training positions - because that's what it comes down to - and funding of lists once those specialists actually complete their training, because half of the pipeline is not actually your training, it's when you finish, is there a job in the hospital where you want to go?

For example, currently our haematologist is FTE 1. Two more haematologists come in but they take part of his FTE. There is no new position created, so they are sharing the same FTE.

This is what happens in our major regional hospitals. There are not increased jobs, there are increased shared arrangements, and we provide a significant amount of care off our own bat and in our own time.

So, one, we really need equity of funding of training positions compared to metropolitan, and the need is there; and, two, we need equity of funding for positions within the hospitals once you actually obtain fellowship. Has the ministry ever looked at a way of having a statewide governance looking at those areas of need or, as we've discussed, putting money where the actual need is, rather than the demand of a hospital, such as RPA, which has a bigger bag of funding, obtaining more training positions?

DR HARRIS: A good question, and I don't know that I can actually answer it. I'm new to the ministry. In the past there was a centralised planning function, I think reflected in the statement that Mr Minns gave for this round of the hearings, which was lost with the break-up of the area health services back in, I think, 2011. It hasn't really been replaced.

The governance of NSW Health funding is a devolved model. The LHDs fund positions in a way that they need for their services and their communities. So I think the answer is there may have been in the past, but I might have to clarify that, and I think that the ministry is keen to redevelop some centralised governance, but still with local and community input so that the services that are needed by communities are still being delivered as well.

THE COMMISSIONER: This could be part of the missing middle.

DR HARRIS: Yes.

MR MUSTON: A follow-up question for you, Dr Harris. Presumably, in order to work, a centralised approach to the building of networks and shepherding of registrars through networks in a way that is informed by system-wide workforce data would require either some strong buy-in from the LHDs

or, alternatively, some quarantined funding delivered to the LHDs so as to enable that to occur, rather than the funding which is delivered being used for no doubt the ever-present business as usual demands that place LHDs in what we've heard described variously or frequently as "a constrained budgetary environment", or "a challenging budgetary environment" I think is another one.

DR HARRIS: Yes. I think it would probably need some centralised quarantining of funding to coordinate this. It would need to be for not only the training positions but sometimes the supervisors - having sufficient supervisors in regional and rural bases, as a lot of the witnesses have said, and the infrastructure around them to do that, so administrative support, particularly, for delivering training and education requirements. But those kinds of centralised funding to meet all those things would be wonderful.

THE COMMISSIONER: I think we can note for the transcript that there was a lot of head nodding going on during the course of that answer.

MR MUSTON: Professor Lim, I think you were next with your hand up.

PROFESSOR LIM: Yes, thank you. I fully echo what has been said in terms of the training, the quality of training in the rural areas. We know that our specialist registrars really love to go to rural areas, because the statistics show that they're able to get all their procedural gynaecological, or the majority of the gynae procedures/operating, done in the rural areas, but sadly they return to metropolitan areas and stay on and become specialists in a metropolitan area.

In terms of the funding and identification in training, to provide a safe maternity service, particularly in the rural and regional setting, we rely heavily on the GP obstetricians. We've talked a lot about specialist training but also in terms of RANZCOG's focus, it's also on the GP proceduralists, in the old term, the GP diplomates. Nearly half of our membership consists of GP obstetricians, and we have to recognise that we need to train them adequately but also provide support for them, because I think they are a breed of doctors that are being threatened by isolation and lack of support as well.

RANZCOG has been able to secure federal funding to provide training for them, ongoing training in terms of the obstetrics and gynaecology education and training, "OGET". Unfortunately, the funding is only for a certain period of time. It runs out in February next year and we have no indication as to whether we're going to get more funding, like all these initiatives.

The objective of the training is to provide them support and ongoing training in terms of managing obstetric emergencies and also gynaecological emergencies, which has been very, very successful. We would like to see it carry on in different centres.

There are eight hubs across Australia. The only hub in New South Wales is based in Orange and it supports units in Mudgee, Parkes, Forbes and also Nowra as well. We see that as very important in terms of trying to retain GP obstetricians, because if they don't get the support they need and they come across an adverse outcome, they will probably just walk away from providing GP obstetric support. So that's very important. I think in terms of when we talk about funding, I think that needs to be recognised in terms of supporting GP obs in the rural and regional centres.

MR MUSTON: Associate Professor Kanhutu, I think you had your hand up next.

ASSOC PROFESSOR KANHUTU: Thanks. I just wanted to revert back to the point that was made around data and the existence of data. It is very true, we are actually awash in data. It is everywhere. But what is missing is the movement of that data into something which can actually be classed as a proper supply/demand model. That is tentatively on the horizon at the Department of Health level, and that's great, because it actually gives us, for the first time, a baseline that we can all contend with and contest with and have a look at and make statements as to the veracity of it, because whatever model is built, it will have holes, because models are just that: it's a representation of the truth; it's not the truth.

I think at this point it would be great to start to get a sense of what that conversation or that dialogue will look like once those supply and demand models are developed

and also how we as colleges can help, I guess, the wider healthcare sector to make sense of them. Because from what I have seen of the data models, the supply side is actually pretty easy. We can see who's coming in from medical schools. That's very tightly regulated. Yes, there's an overlay of people coming in from overseas that might augment or change the cadence of rises or falls in numbers, and then people move through programs and we have good control there.

But it's actually the demand side that I think sometimes gets forgotten, because what that asks of the health system is to see people who have latent or undiagnosed disease, and we have routinely underinvested in preventive care. So we don't ask questions like - you know, GPs who are seeing people - is there a trend that they're seeing in their community of people who are starting to have signs of early diabetes? We wait until someone comes in with sky-high sugars or their first heart attack and then we make the diagnosis.

So I think I would also urge, if we're serious about really mapping for demand, that there will also need to be some level of investment in preventive disease. I say that because one of our college streams or training streams is in population and prevention health with public health and that is a repeated ask: where is the investment in actually mapping true demand across community as opposed to acute service need, which is where, I think, everybody ends up focused because you just need to move people through acute hospital systems, but we're not actually doing the wider view across the community to understand what is really happening and what is really coming, and that's, I think, something that worries us. If we don't get that right or if we're not paying close attention to that, we'll continue to get the supply and demand modelling wrong because we're not actually seeing the torrent of people who have preventable disease that we're not attending to.

So that's a point on supply/demand. I think the other thing --

THE COMMISSIONER: Just on that point, it's probably obvious, and almost goes without saying, but any investment in that demand data is highly likely, ultimately, to end up in savings down the track, in avoiding hospitalisations that can be avoided, and thereby a cost saving, but even if

there's not a cost saving, just better population health outcomes anyway; correct?

ASSOC PROFESSOR KANHUTU: Correct, absolutely. And it's the old adage, you know, it's so much easier to prevent and manage before the disease happens than it is to try and do disaster recovery down the line. That applies for all cohorts.

I know there's been a big conversation in New South Wales around paediatric care and behavioural management in schools, and anyone will tell you, if you manage it early in childhood, it's a lot easier than waiting until someone is in high school and then you realise they can't read write or interact in the classroom, and then that flows on to other health consequences as well. So absolutely.

I think the burden then becomes if you've seen it, it's very hard to unsee that, and I think that's the moment of tension that we now all have, that once it's been built and everyone can see what's really happening, is there the will to then actually commit to the change that is required to address what we then observe?

In the same breath - and I know, Kerin, we discussed this over the weekend at the FATES forum - there's also a gap in structural supports. If we say we need 10 cardiologists, or whatever, in Wagga, the thing that we consistently hear from trainees is that there aren't any structural supports. That's not to say that we have to do it as colleges or as government, but if people are repeatedly telling you that they couldn't get housing, they couldn't get accommodation, they really struggled to move between sites across their training journey and then once they're finished, is that something that we all just say, "Look, no-one owns that and it is what it is?" Because that is the thing that keeps being unowned by anybody but it is a key driver as to why people won't commit to certain rural areas and then see it through. The process that they go through and the trauma that they go through in moving, without some of those structural supports, is the reason why people don't bother. They just go back home.

THE COMMISSIONER: I was going to ask what you meant by "structural supports" but I think in the course of that answer you explained it, it's things like housing, child care, that sort of thing?

ASSOC PROFESSOR KANHUTU: Yes.

THE COMMISSIONER: Sorry, did my prior question interrupt you from finishing a point you wanted to make?

ASSOC PROFESSOR KANHUTU: No.

THE COMMISSIONER: Okay. Professor Fielding, did you want to say something?

ASSOC PROFESSOR FIELDING: Just to support what Kudzai said. Yes, the structural supports are really important. In particular, if we're having rural training, we're going to need to think about that in the metropolitan centres, because most of our trainees have a house in Wagga and in the rural sites, you know, in Tamworth, et cetera, and have family supports which they won't have in the city, and that will need to be provided. They won't need to spend a lot of time in the city but they will need to spend a little bit so that they're building that network, so that they're getting to know who they're going to refer to when they're in the country and they have a patient with something that we can't handle and for those unusual sub-specialty things that we don't do in rural. That is across the network, we have to support them.

Also some of our trainees actually have to leave the state. New South Wales already does try to support them when they leave the state. Occasionally, for some of our sub-specialties like paediatric surgery, neurosurgery and cardiac surgery, they do need to do a term in another state, because not every state covers every single part of the specialty. But NSW Health, I'm comfortable, does that quite well. It doesn't do the structural stuff that well.

As far as the preventative health goes, I really want to support her in that. NSW Health had some wonderful programs running, like the osteoporosis chronic care programs, but many of those programs are hospital based, so you get your osteoporosis treated when you break something and go into hospital. Those programs need to be much more in the community.

Dare I say again another problem in rural, people in rural are not getting access to the scanning they require and the medication they require to prevent them, for

example, having a fractured femur. We know that that treatment works, but again, it's about that first step, that preventative health that is really hard to get.

MR MUSTON: If we could come back to this idea that, informed by workforce data and projections, and to pick up on your point, Associate Professor Kanhutu, projections about future health needs, do any of you see a difficulty with the idea that, let's say HETI or an educational pillar within the ministry, takes on a role in collaboration with the colleges of building these networks in a way that's consistent with the delivery of good training but equally assists in addressing workforce and community need on the one hand, and being a central body that assists to shepherd candidates through their vocational training in the way that each of your respective colleges are currently doing independently and in your own unique ways at the moment? Dr McRae?

DR McRAE: Can I clarify with Dr Burnand the role of HETI being a supporter of education to, say, the positions pathway, or are you assisting in allocation within the training networks as well? I'm just wondering is it more of a management of positions or both?

DR BURNAND: It's probably the first thing you said, which is assisting in the oversight and support. I think when we're talking about shepherding, the governance structure allows individual network directors of training, if you like, to do the actual mentoring and shepherding, which I think is appropriate, but that's done within the envelope of the governance structure. Does that answer your question?

MR MUSTON: That raises another question for me. What fundamentally is the difference between the two?

DR BURNAND: Between?

MR MUSTON: Between, on the one hand, HETI doing the shepherding, and on the other hand, HETI facilitating a system through which people are able to be shepherded?

DR BURNAND: To my mind, it is HETI having the oversight and the governance structure and a kind of committee structure which is based within the training networks at ground, as I've described before, the network governance

committees, that then report up to the state training council, or equivalent. So there's capacity for oversight of the whole, but actually, at an individual trainee level, what they're experiencing is a network director of training who is part of that governance structure actually having the connectivity with them, you know, an individual at an individual level. Does that help?

MR MUSTON: Is that meaning that decisions about where that trainee might go are being informed by system-wide considerations, or are they still being informed by, to the greatest extent possible, the preference of that candidate, which might tend to drive people into metropolitan areas?

DR BURNAND: They are being decided generally within the networks themselves, so the network governance committee. Look, there are different structures, and not all of our vocational training networks engage in the sort of workforce, but if I use physicians, they would have a number of trainees that are part of that network, and then the individual rotations that they complete for basic physician training - you know, a three-month rotation in this particular clinical specialty, then they might be sent three months to a rural location, three months - that would be decided at the network level.

Again, the positions would be coordinated, and just to kind of clarify, at the network governance level there is local LHD representation on that usually through director of medical services and so forth. So there is some management, to answer your question, oversight, but as well as through the lens of training.

MR MUSTON: Professor Haq, I think you've put your hand up.

PROFESSOR HAQ: I think it is a really interesting point that has been raised about where does the delegation lie within this whole ecosystem to say trainees go here or there. Because I think we just need to reflect that some networks and some directors of education are quite powerful within their local organisation, and can use that in different ways, if I can say, but is that to the good of the whole of the state? Question mark, question mark, I won't judge either way.

I think if HETI's role and remit is enhanced - which

I entirely support in collaboration, I don't think they should take over everything in toto; this is a collaborative exercise - that there is one aspect of it that looks at the big data time and says, "We can take this many of subject X and we think they should be here", and then sort of the management within that at the network level is managed within the network leaders, if I can put it that way and the directors of medical services. But the overarching nudging and strategic aims have to be, I think, directed at a higher level, perhaps, otherwise individual interests perhaps take hold, and that's human nature, where, in fact, there could be more strategic engagement and direction. Thanks.

MR MUSTON: Associate Professor Fielding?

ASSOC PROFESSOR FIELDING: I think that the network governance committee structure will work fine as long as it actually lives at the hub, and the hub should be rural, so I think you will probably need to develop some more network governance committees, dare I say, but the rural sites do actually need to be empowered to be involved with this. They need to be provided with the data, as Kudzai said, and I think that the colleges could absolutely be - you know, those network directors need to be empowered by us as colleges to sit on our state training committees. So I think that could absolutely be done, and then the whole state can be overseen, if you like, from a college perspective, in relation to the curriculum and the other things that are looking at quality and standards.

MR MUSTON: Dr Harris, you have your hand up, I think?

DR HARRIS: I was just going to add to what Dr Burnand said: if you put in a stronger workforce governance as described, you can create agreements in the networks of how they need to behave, and then you still rely on the local network directors and network governance committees to then do the delivery of the individual doctor allocations, but if you have high-level principles and governance over them, some shared governance between the colleges, HETI and the ministry, I think that would meet the need.

MR MUSTON: To pick up on Dr Fielding's suggestion that that decision-making body or that central body needs to be rural, there might be differing views about that, but at the very least, it needs to be at least at the centre, as

opposed to sitting in a metropolitan --

ASSOC PROFESSOR FIELDING: I mean for that network. For the rural network, it needs to sit rurally. That's what the evidence shows, that it won't work if you have a network governance committee in the city telling the rural what to do. We've tried that for 20 years and it doesn't work.

MR MUSTON: I'll come back to you in a minute, Dr McRae. Professor Lim and Dr Page and Dr Ingram, I'm not sure that I necessarily have got an answer from you in relation to my earlier proposition or question around whether there's any challenge that you see with HETI, or a HETI-like organisation within the ministry, properly resourced, taking a greater role in collaboration with the colleges in this network building and shepherding process through vocational training pathways within each of your respective areas or your disciplines.

PROFESSOR LIM: Well, I think the coordination is important, but again, what has been said earlier on, the colleges are binational colleges so they've got processes in place already. In obstetric/gynae, in RANZCOG's position, we've got our training and accreditation committee, which is local, and then that feeds up to the federal TAC. They're the ones who have got what you call the ITP coordinators from all the centres on the committee, and they decide collectively the rotation and movement of the trainees, obviously in collaboration with HETI locally, that might help them sort of identify where the centres are. The statistics and the data would show you where - you know, the capacity to train, and the experience that the trainees can get will certainly help as well. So I think that's maybe where HETI's role is very important, in identifying where the good opportunities for training will be.

MR MUSTON: What I think I'm suggesting, though, is that some of those roles - that a greater role in a lot of that be played by HETI, perhaps in collaboration with the colleges. So decisions around how a particular trainee might be shepherded through each of the requirements of the curriculum might, in a collaborative way with the college, be made more by HETI than they currently are. As I understand your evidence, currently those decisions are made by the college.

PROFESSOR LIM: Yes.

MR MUSTON: And the college, obviously, is not able to make those in a way which is informed by the workforce data available to the ministry.

PROFESSOR LIM: I think it's informed also by the accreditation standards that all the training units comply with and whether they meet standards or not. Invariably, various units will have different levels of having met the standards, some are one-year provisional, some are two-year provisional, and I think - I mean, HETI's role currently is in the prevocational space. I'm not sure how that will transcend into the vocational training space if HETI gets involved. But currently the process is, you know, the colleges have already identified where trainees can get the adequate - well, the requisite training requirements, and if the units don't comply, the trainees can be moved to another unit as required.

MR MUSTON: Dr Page, do you see a challenge with the transcendence of HETI?

DR PAGE: I think ANZCA would probably welcome it, to be quite honest. You asked me earlier if the majority of schemes were metro based and I said yes, and they are. Prior to the curriculum change in 2011, we had 10 schemes in New South Wales - nine in Sydney, one in Newcastle. The Central Coast was the first non-metro. We were considered a regional site at that stage. We're now outer metro, just, with the boundary changes, but we were the first non-Sydney, non-Newcastle scheme to come on line.

We've then had Wollongong. We've now got a new scheme that has just come on line down south. Port Mac is developing its own scheme, and Orange and Dubbo I think will come on line fairly soon. All of these additional non-Sydney/Newcastle schemes have come about because the individual hospitals want to be involved in training, want to be able to recruit those good quality, keen, enthusiastic, motivated registrars that are going to be the next generation of anaesthetists.

But some additional help in coordinating that, understanding where the need is greatest - we know that we need more anaesthetists in rural New South Wales. There

are lots of barriers to the training of regional anaesthetists. Some of those have been talked about in terms of the movement for particularly short periods of time. It's really difficult, if you need to go to Sydney for a three-month stint to do some cardiac or do some paeds or whatever it is, when your home and your family is all based in Orange or Dubbo, to even find accommodation, let alone afford it.

There are all sorts of programs that are available to support people moving out to the regions, but there are far fewer of those to support regional people moving for a short term to the metro. Some of those are coming on line, but they do need to be a lot more robust to actually facilitate the training of people from regional areas.

Then I think we need some support for people to retain their skills in regional centres. So, like anything, if you don't use it, you lose it. So you might be trained in a particular sub-specialty area of interest that is of use and needed in a rural site, but you don't do lots and lots of it every single day, and if you don't do lots and lots of it, you will eventually become a little bit rusty at it. So we need to work on ways to, again, particularly with things like paediatrics - how do we support somebody who has an interest in paediatric anaesthesia, who works in a regional hospital, to maintain those skills? It's about giving them opportunities, meaningful opportunities, to get back to some of the metro centres to work periodically with some of their metro colleagues, just for a short period of time, just for a bit of upskilling to maintain those professional links. That kind of stuff is really not well worked out but would make a huge difference.

MR MUSTON: That's probably a conversation for another day, but if we build up networks around training which enable, in the ideal world, trainees to be popped out at the other end of their training pathway having spent a period in a regional area which needs their services, and then to step into a job within that regional area because the services are required, the next step is perhaps a different network, which is ensuring --

DR PAGE: Postgraduate, yes.

MR MUSTON: -- that once you're out there in the workforce you are potentially part of a wider team, so an

anaesthetist in Griffith might actually be networked in some way to Royal Prince Alfred Hospital, for example, and if you've got a difficult case coming up at the Monday morning of the anaesthetics department at RPA, you dial it in in exactly the same way as other people might and sit around, and you can talk about your case, they can talk about their cases - opportunities to go in and do procedures in there.

DR PAGE: Absolutely.

MR MUSTON: Dr Ingram, I haven't ignored you.

DR INGRAM: Thank you. I very much agree with what my colleagues have said, and I think the concept of HETI assisting in coordinating this process has a lot of merits, but I do think that it has challenges as well.

In emergency medicine - and it may not be true of the other colleges - part of the problem is supply of trainees. So there may be plenty of places in metropolitan and funded places in rural and regional areas for emergency medicine trainees, but there's simply a paucity of trainees. I think bringing the trainees into the state is one of the first problems, and obviously equitable pay with the other states is a simple way of attempting to achieve that.

The other comment on the proposal around HETI is if you take that in the context that New South Wales is potentially an unattractive place for an Australasian emergency medicine trainee to work based on pay, the concept of, then, maybe not forcing them but encouraging them or placing them in their second, third, thirteenth preference to work may further endanger the emergency medicine workforce in New South Wales and needs careful consideration, on how that could subsequently be dealt with or --

THE COMMISSIONER: Imagine a scenario where there was award reform, that would at least remove that --

DR INGRAM: Heaven forbid.

THE COMMISSIONER: I know that's wishful thinking, maybe not, but that would remove one of those concerns you have.

DR INGRAM: So I think that's a risk to the concept, but

it clearly has benefits.

MR MUSTON: Professor Haq?

PROFESSOR HAQ: Just a final comment, I know we're probably a bit over time, just regarding governance, the devil is always in the detail here. I absolutely encourage looking at what local communities need and having that sort of devolution, if I can, but in any governance arrangements with HETI, as Kudzai has said, we're binational organisations and we've got to make sure that, you know, the college is represented in the right way to understand strategic directions across all the states, territories and countries, to ensure that there is some level of consistency, as the AMC wants all of our colleges to be, knowing that there is still local nuance. I think that has to be worked out as we get through the detail of it all - the right people at the right table to have the right delegated decision-making.

MR MUSTON: Dr McRae?

DR McRAE: Just going back to HETI being involved in a broader organisational or managerial role, I guess once you're on a program it's evident that all the colleges have a different scheme of allocation within the state. So there's networks or - given we're a small college, in dermatology, we don't have networks as such, you get rotated through positions based on where your director of training for the state places you - and that's evident across all of them. Obviously there's different requirements. So I'm guessing under an organisation such as HETI overseeing that, I think the networks is really important. The extra benefit of that in allowing the colleges to still allocate as they currently do, but with having networks with local representation and also having data to show demand or allocate funding from a centralised system, that also allows the local fellows or supervisors, such as myself, to collegially work with our other fellows in that same hospital, because at the moment my feeling is that the LHDs divide and conquer based on funding. So if anaesthetics need more funding but the ED department requests more, there's only so much budget, you end up having areas that feel like they've lost funding because of another department obtaining that funding over them. I see that regularly from an observer point of view.

I think having a network where the local doctors can work together as a network and have maybe a college representation from that point of view, too, or overlooking with the funding, would be of benefit. How that would actually roll out - in terms of physicians, I understand it's different, given that it has been running since 2004, 20 years, I'm assuming what you're able to do is based on what funding you receive, and whether that can be expanded, obviously, would need more funding and support.

But I think in terms of taking some of that decision or potential conflict away from doctors that are in each area, because they think they're missing out on funding, might be important.

MR MUSTON: I have no further questions for these witness.

THE COMMISSIONER: I think Professor Fielding has her hand up.

ASSOC PROFESSOR FIELDING: Can I just say I would like to support Dr McRae. Dermatology is really important, particularly in rural with our farmers and our workforce that work outside, and it's an absolute - you know, it's a crisis in dermatology and the dermatologists are mostly in the private sector and supporting the funding completely on their own without much support, so if we could bring them into the networks and help them, that would be really good, and I think a multidisciplinary approach would be really, really helpful.

She's absolutely right about the difficulties in a public hospital of different people and their concerns, which is why if we have the data clear about what we need, then there's no question: it's not about somebody's turf; it's about the fact that we need a dermatologist in Orange and we need three orthopods in Wagga and we need five physicians in Dubbo, whatever, but we've got some clear data, we're making scientific decisions based on the future.

So I just wanted to support what she said. They're out on their own and they're very small numbers, and this is why we need to make rural decisions to support small specialties like that in particular.

THE COMMISSIONER: Thanks.

ASSOC PROFESSOR FIELDING: I also wanted to make a point for Dr Lim. HETI's been doing vocational training and been involved in vocational training since 2004, so they have extensive experience in the vocational training sector as well as the prevocational sector. He didn't seem to realise that, so I just wanted to - having been at HETI for longer than Dr Burnand, I just wanted to really confirm with everybody that HETI has extensive experience in the vocational space.

THE COMMISSIONER: All right.

MR MUSTON: Having thrust transcendence upon them, I should probably ask Dr Burnand if she wants to say anything about it.

DR BURNAND: I just want to reflect that each specialty - and it's true that the vocational training networks at HETI that we are involved with are different. Dr McRae has just given a wonderful example of dermatology. So any structure and support needs to take into consideration the specialty-specific aspects of this. I think we've had a sort of general conversation here. Not all colleges allocate their trainees. Some trainees apply to positions and then retrospect - so there are actually quite a lot of differences.

As Professor Haq said, the devil is in the detail, but there is clearly an opportunity here to have better coordinated training pathways for trainees, but also, as has been suggested, that trainees are actually being trained in ways that are going to meet future community needs. We know that there is very significant importance to having rural/regionally trained specialists and generalists who want to live and work in regional communities.

THE COMMISSIONER: Thank you.

Just before we finish, this is to all of you. Is there anything any of you would like to say to conclude that has emerged from the discussion today? I don't want any of you to leave if you feel like there is something important you want to add. So does anyone have anything further they want to say?

DR PAGE: Can I just add a comment to what Dr Burnand was saying. You mentioned earlier that it's difficult for HETI to do some of the things that have been suggested within the current funding that they have, and I think that that's super important. If we're going to get HETI having a more overarching role, it's got to have enough funding to do that, but there will be cost savings in that, because at the moment, this work is being done, it's just that it's being done piecemeal, ad hoc, multiple times over, at each individual tree and lamppost across the state.

We're doing so much duplication of work all over the place, and if we can stop running around like headless chickens doing the same thing over and over again everywhere and just do it once properly in a more coordinated way across the state, we will actually do it better and do it cheaper. It's just that you can't do it for free, and different disciplines do have hugely different sort of numbers that they're playing with.

We talk about dermatology and the particular issues and problems facing dermatology, and one of the issues is the size of dermatology being such a small little niche group, and how do you cater for the problems that that brings.

Look at anaesthetics, on the flip side of it, and we're huge. We're the largest single discipline in any single hospital anywhere. We field 400, sometimes even 450, trainees applying for anaesthesia training posts across the state, and at the moment, every single hospital that offers anaesthesia training gets all of those applications because everybody's told, "Apply widely", and you wonder why the system is broken, you wonder why you can't get fair, equitable, unbiased recruiting, because clinicians who are trying to anaesthetise patients, trying to administer departments, are also trying to rush through 400-odd applications in less than a week, and it doesn't work.

MR MUSTON: Could I ask you a very quick question about that. Where you refer to "fair, equitable and unbiased recruiting", are you referring to what we have heard a fair bit about, which is people who find their way into an unaccredited position or an internship within a particular hospital take the view, perhaps realistically, that their chances of actually getting on to a training plan or

getting an accredited position within that hospital are enhanced because they're there?

DR PAGE: If that hospital also offers scheme training, yes, but if it doesn't, then maybe. The way the college of anaesthetists organises training and accreditation, it accredits the site and it accredits the site for a period of time, and if the site has enough experience that it can offer, then it can be accredited as a scheme training site, and if it doesn't, then it's just accredited for a shorter duration of time.

So if your hospital is only accredited for one or two years of training, then you would be an independent trainee for that period of time and you would need to go somewhere else, probably, to complete your training, and depending on what links have been individually set up by that hospital with other sites to support those independent trainees to get on to schemes, then they may or they may not.

There are only two hospitals in the state that actually have both - sorry, three, that have both scheme and independent, and ours is one of them. I'm quite sure - whilst I might like to think that I am an unbiased individual, I know I'm not, because none of us are, I'm a human being, and so I'm quite sure that people who come on to our training program as independent trainees are much more likely to end up in scheme positions with us because we've had the opportunity to see them, work with them and see their capability. Does that make them inherently better than the other independent people that are applying to us? No, but we just don't know them, as people.

MR MUSTON: Because the other 395 applications that you have received and read at 10 o'clock at night have not necessarily had an opportunity to impress upon you their skills in the way that the five that you know are good have.

DR PAGE: Yes, that's right.

THE COMMISSIONER: Dr Harris?

DR HARRIS: This might be slightly off topic, but I think I wanted to say, some of the principles of what we are talking about here around vocational training apply equally to the non-vocational space or the unaccredited registrars,

SRMOs. Strengthening up those pathways also will, one, enhance their education and training and general experience and retention, but also direct them into the vocational training programs that we might need them in. So I think this conversation could be a bit broader into that space.

THE COMMISSIONER: Ms Newton?

MS NEWTON: Thank you. I was going to reflect that our training and education system is in a state of extraordinary strain and upheaval. As recommendations or propositions are being formulated from the Inquiry, I guess having a sense around the change fatigue and the delicate nature of our system will be something that I encourage the Inquiry to keep in mind.

Too much change can fracture a system that's at risk, so having a think around sequencing, relationships, structures that can come into play will be something our college would like to see emerging from the Inquiry, as well as some of those goals about how the system can be moved forward, but the "how", and how we can support that transition from A to B.

THE COMMISSIONER: Thank you. Professor Kanhutu?

ASSOC PROFESSOR KANHUTU: I was applauding Libby.

THE COMMISSIONER: Sorry, I misread the signal. Okay. That's noted. Is there anything --

MR MUSTON: Professor Lim, I think has --

THE COMMISSIONER: Sorry. Yes, go ahead.

PROFESSOR LIM: Thank you, just a final remark. I think when I responded to the question about HETI coordinating, I think from the specialist training pathway, I think I did comment that there might be lack of clarity in terms of how HETI can be involved. But I think in the GP ob space it's very useful, because the GP obstetricians are currently trained by ACRRM and RACGP, and RANZCOG contributes towards the obstetric and gynaecology bit. But it's still a bit unclear in terms of how the funding stream works, because RANZCOG subsidises the training part of it, whereas the RACGP and ACRRM receive federal funding for it. So in terms of coordination of that training pathway, I think

HETI would be very helpful in terms of helping all the colleges to collaborate and identify training pathways for GPs.

MR MUSTON: You put your hand up again, Dr McRae?

DR McRAE: I was just wanting to clarify that in dermatology - and I am assuming in the other colleges - the roles that we hold as part of, say, director of training or being on the selection committee or reading 400 - I only get to read about 70 - CVs is all in our own time and unpaid. So this is a lot of hours that, you know, if we are looking also at change, as mentioned, big change can fracture, but if these are big things, there are a lot of man hours that are unpaid in these roles.

THE COMMISSIONER: Professor Fielding?

ASSOC PROFESSOR FIELDING: Two things. We have an ageing workforce and a lot of our ageing workforce are very keen to use their expertise and help out in supervision and lots of things that they could do. There's no plan in the sector to utilise those people who may be not operating anymore or may be not doing as much technical work and so there is opportunity for many of our fellows to be involved in training at a slightly different level, running clinics, et cetera - something for the system to think about.

Secondly, just to make it clear that rural people need every kind of specialty and we don't want a two-tiered system, so we want to have specialists, and we have in rural that need for obstetricians as well, so we need training pathways for all specialties, dermatology, obstetrics, emergency medicine, all of those things. And yes, if we could get the ministers to talk together nationally, to get the salaries equivalent, that would really change the whole system - and for nurses.

THE COMMISSIONER: All right. Thank you. Mr Cheney, Mr Chiu?

MR CHIU: No questions, Commissioner. There seems to be heated agreement.

THE COMMISSIONER: All right. I won't thank the 10 of you individually. I was initially concerned that with 10 witnesses it might get a bit unwieldy, but I think, thanks

in no small part to the considerable skill of Mr Muston, the evidence today has been of great assistance. So first of all, to all of you, thank you for your time, because we know it's valuable, and thank you for the assistance you've given the Inquiry. We're very grateful. So thank you.

And absent an imaginary witness box appearing at Albury, I think we adjourn until Monday, 11 November.

MR MUSTON: Can I add, any skill that I brought to this task was eclipsed by the skill that those who are taking the transcript of 10 different people have. Their efforts very much exceed mine.

THE COMMISSIONER: Yes, all right. Noted as well, and I agree.

All right. Absent something unexpected happening, we will adjourn until Monday, 11 November. Thank you everyone.

<THE WITNESSES WITHDREW

AT 4.21PM THE SPECIAL COMMISSION OF INQUIRY WAS ADJOURNED TO MONDAY, 11 NOVEMBER

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