SPECIAL COMMISSION OF INQUIRY INTO HEALTHCARE FUNDING

Outline of Submissions by Counsel Assisting

20 December 2024

1 INTRODUCTION[1]

1.1 The Special Commission

1. On 23 August 2023, the Honourable Margaret Beazley AC, KC, Governor of New South Wales, issued Letters Patent appointing Richard Beasley SC as Commissioner pursuant to the *Special Commissions of Inquiry Act 1983* (NSW). Those Letters Patent set out the Terms of Reference for the Special Commission.

2. Further Letters Patent were issued on 21 February 2024 (which amended the Terms of Reference and extended the reporting date) and on 13 January 2024, (which further extended the reporting date to accommodate the request made by New South Wales Health).[2]

1.2 The work of the Special Commission: some statistics

3. The work of the Special Commission has been extensive. In addition to the public hearings, it has involved engagement with a wide range of stakeholders; from health consumers and front-line clinicians, to NSW Ministry of Health ("the Ministry") staff and experts in health systems and funding.

4. As part of its work, the Special Commission:

    a. received over 200 written submissions, comprising more than 4,000 pages;

    b. convened and have sought guidance from a large panel of experts with knowledge and experience within a range of fields with immediate relevance to the Terms of Reference;

    c. took evidence from more than 225 witnesses across almost 70 hearing days;

    d. held public hearings in Sydney, Wagga Wagga, Batemans Bay, Dubbo, Broken Hill, and Tamworth, generating over 7,000 pages of transcript;

    e. received hundreds of documentary exhibits into evidence;

[1] Counsel Assisting wish to acknowledge the valuable contributions made by the solicitors assisting the Special Commission to the preparation of this outline and in the conduct of the Special Commission generally.
[2] See Affidavit of Dr Nigel Joesph Lyons (3 October 2024) [SCI.0011.0700.0001]; Transcript of the Commission, 14 October 2024, T 5563.30-5564.33.

f. visited each of the Local Health Districts, the Specialty Health Networks and Albury-Wodonga Health, during which discussions were held with management, clinicians, health consumers, and other healthcare providers (such as General Practitioners, Non-Government Organisations, and Aboriginal Community Controlled Health Organisations); and

g. held an Aboriginal Community Controlled Health Organisation roundtable over two days in Sydney, with 24 participants attending either remotely or in person.

1.3 The performance of the New South Wales public health system

5. The work of the Special Commission has necessarily directed attention to aspects of the New South Wales public health system that are experiencing challenges.

6. In focussing on those matters, however, it is appropriate to recognise (as was stated in the opening address)[3] that the New South Wales public health system is staffed, at all levels, by individuals who are committed to providing high-quality care to the people of New South Wales. Although views might differ about how that is to be achieved, the commitment and intent of those charged with that responsibility is clear.

7. It is also necessary to bear in mind that, notwithstanding some reviews describing the wider health system as being in or close to "crisis",[4] and headlines that describe the system as "failing",[5] in many ways it performs strongly by objective measures, and is recognised as a high-quality healthcare system by world standards.[6] In August 2021, the Commonwealth Fund ranked 11 high-income countries on the performance of their healthcare systems. Australia ranked third overall, behind Switzerland and the Netherlands, and was ranked first in equity and outcome measures.[7] As the largest public health

[3] Transcript of the Commission, 27 November 2023, T11.37-13.8.
[4] See, for example, Exhibit B.18, Alira Health, Value-Based Procurement in Australia, p 7 [SCI.0003.0001.0048 at 0054]; Exhibit H1.35, Impact Economics, Reform Critical – A Fragmented Health System at Breaking Point (2023) p 4 [SCI.0011.0162.0001 at 0004].
[5] Which often refer to statistics that do not directly measure the quality of care delivered, or the outcomes that flowed from it.
[6] Exhibit A.7, NSW Health Annual Report 2021-2022 (November 2022), p 2 [SCI.0001.0003.0001 at 0014]; Transcript of the Commission, 29 November 2023 T199.32-35 (Chant); Transcript of the Commission, 26 February 2024, T1073.10-26 (Levesque); Transcript of the Commission, 19 November 2024, T6410.19-26, 6413.1-6 (Mains).
[7] Exhibit A.23, The Commonwealth *Fund's Mirror, Mirror 2021 – Reflecting Poorly: Health Care in the US Compared to other High-Income Countries*, pp 3-4 [SCI.0001.0019.0001 at 0003-0004].

system in Australia, New South Wales is a significant contributor to those results.

8. In making these observations, it is recognised that those who engage with the public health system across New South Wales have their own individual experiences of the nature, timeliness and quality of the care they receive. The evidence has revealed instances where the system has fallen well short of what might reasonably be expected. There is also evidence that, in some ways, the system is under significant pressure from a range of factors, many of which are external to it.

9. It is because of those pressures that there is now a pressing need to reconsider how public health services are planned, designed and ultimately funded to best respond to the current and future health needs of the population. A "business as usual" approach is unlikely to sustain a strong public health system into the future.

10. In focussing attention on how the system might respond to the many present and future challenges it faces; sight should not be lost of the fact that the foundation from which that change can be made is a strong one. However, if improvements are not made now, the future sustainability of the system and its ability to continue to provide high quality care are at risk.

1.4 The approach taken to the preparation of this outline

11. Given the breadth of work of the Special Commission and the vast amount of evidence before it, the following matters should be kept in mind when considering the matters set out in this outline:

    a. First, it is not the purpose of this outline to refer to every aspect of the evidence, or every issue raised, before the Special Commission. As is usual in matters such as this, this outline assumes a degree of familiarity with the body of evidence, and the key themes that have emerged from it. That a particular piece of evidence or contrary view has not been referred to does not mean it has been ignored or overlooked.

    b. Secondly, the matters considered in this outline are largely addressed at the system level. While specific examples were used to explore issues

during hearings, the Terms of Reference are best addressed at the system level, rather than at an operational level.

c. Thirdly, this outline identifies several key recommendations as being open to the Commissioner. In identifying those recommendations, it is accepted that that there may be aspects of work that are consistent with the substance of them that are currently underway within the wider system (some of which were referred to in the evidence). However, the purpose of identifying them is to highlight their importance at a system level, and the need for that work to be prioritised and resourced appropriately.

d. Fourthly, whilst the recommendations identified in this outline are focussed at the system level, it is open to the Commissioner to make a range of additional recommendations, including those that are ancillary or complementary to those set out below. Many of those will likely flow from the matters identified and discussed in this outline, which themselves could be made the subject of separate recommendations if the Commissioner were so minded.

1.5 The cooperation of NSW Health with the Special Commission

12. The Commissioner would have no hesitation in concluding that NSW Health, its agencies, and legal representatives have fully cooperated with the work of the Special Commission.

2 EXECUTIVE SUMMARY

13. Counsel Assisting submit that it is open to the Commissioner, on the evidence before the Special Commission, to make recommendations directed to the following matters.

Preventative health

14. Preventative health should be identified as a standing, whole of government, priority against which New Policy Proposals brought forward by all branches of government are to be assessed in the sense discussed elsewhere in this outline.

15. All decisions regarding the implementation and advancement of that priority should be informed and coordinated by a multiagency, multidisciplinary body led by NSW Health – ideally by the Chief Health Officer/Population and Public Health Division – with a view to maximising the long-term health benefits achieved through such decisions and insulating them, to the best extent possible, from the vagaries of the political cycle.

Approach to system planning and funding

16. At a practical level, NSW Health must implement a transparent, committed, and collaborative approach to system-wide planning of the type outlined below. Whilst the local identification of health needs and general perspective of Local Health Districts should remain an important part of this process, there is a need for greater system-wide planning, coordinated through the Ministry, and a far greater level of engagement of community and other providers of health services at every stage in the planning process. That planning process must – in a tangible way – involve at least the following:

    a. Identification of the health needs of the relevant community. This must be done in genuine collaboration with the community, including other providers of health care within the relevant place;

    b. Identification of other entities, including other Local Health Districts, which are already (or are capable of) delivering services to meet the identified needs;

    c. Identification of gaps or areas of need which are not being met;

d. Identification of which of those gaps the public health system 'should' fill and how, both generally and within the relevant community. Once again, this is something that must be done in an open collaboration with the community, clinicians and all other providers of health care within the relevant place;

e. A system-wide approach, coordinated within the Ministry, to determine what services are to be provided through the public health system to ensure that the identified health needs of the relevant population are met in an accessible but sustainable way, recognising that not all services can or should be provided everywhere; and

f. Ongoing and genuine collaboration with the community and other providers of health services to:

   i. Determine how emerging gaps are to be filled and what funding is available to enable that to occur;

   ii. Generate an evolving strategy which is forward looking and covers short, medium and long-term planning horizons; and

   iii. Incorporate genuinely collaborative and transparent processes of monitoring, to ensure the plan is delivering on its intended objectives and enables adjustment to be made where required.

17. Having identified, through a system-wide planning process of that kind, the health system that NSW Health aspires to deliver to the people of New South Wales, the Ministry should – with expert guidance – reformulate its approach to funding so as to devise a funding structure which will ensure that the Local Health Districts and Specialty Health Networks are sufficiently resourced to deliver *that* system. That might include blended, bundled or other funding mechanisms.

Statewide services

18. As part of the system-wide approach to planning discussed above, the governance and accountability structures, planning function, and funding responsibility for all supra-LHD services and their functional equivalents should sit within the Ministry, rather than Local Health Districts.

19. The system wide planning process described above should also include the development of a statewide plan for paediatric services that articulates the roles of the Sydney Children's Hospitals Network, John Hunter Children's Hospital and paediatric services within Local Health Districts. That plan should clearly identify the role of those highly specialised centres, both in providing care and supporting paediatric care that can and should be delivered in Local Health Districts or within the primary care setting.

Primary and aged care

20. NSW Health should significantly increase its involvement in the delivery of primary care and aged care.

21. Where there is market failure of primary care, NSW Health should, via the relevant Local Health District (and as an integral part of the service planning exercise), conduct an assessment of the unmet primary care needs and collaborate with other stakeholders to ensure that adequate primary care is delivered. In many cases, this will inevitably involve NSW Health stepping in to deliver that care; where necessary it should do so in a manner which capitalises on synergies with its wider operations. Access to Commonwealth funding streams for the delivery of this care should clearly be pursued by the Ministry but the delivery of primary care in communities where it is lacking should not await the outcome of those intergovernmental discussions.

22. As part of its system-wide planning process, NSW Health should facilitate more regional training opportunities for primary care workers, and provide the training and support required for those contributing to the delivery of primary care to exercise their full scope of practice.

23. Similarly, where market failure in the aged care sector is having a direct and adverse impact on the delivery of acute care through public hospitals, NSW Health should, via the relevant Local Health District, and in consultation with the community and other stakeholders, conduct an assessment of the unmet aged care needs in the relevant community and coordinate with other stakeholders to support or deliver the required aged care services. Once again, there will inevitably be locations in which NSW Health will need to step in and deliver that care; as it is already doing through numerous Multi-Purpose Services located

in rural and remote areas of the State and capitalising on available synergies with its wider operations. Commonwealth funding streams for the delivery of this care should obviously be pursued by the Ministry but the provision of aged care to the extent required to relieve the existing, and unsustainable, burden on public hospitals should not await the outcome of those intergovernmental discussions.

The health workforce

24. As of the system-wide approach to planning, NSW Health should:

    a. establish a central workforce planning function, located in the Ministry, which collaborates regularly and systematically with local organisations to direct the clinical workforce establishment across the NSW health system with the objective of guiding the deployment of the human resources available within the system in a way that best meets the needs of the New South Wales population as a whole; and

    b. once that function is established, prioritise a thorough, evidence-based, review of specific initiatives that should be implemented to help address current workforce shortages and maldistributions.

25. The Health Education and Training Institute's role should be expanded, with appropriate funding, to include:

    a. coordinating the allocation of students to clinical placements within NSW Health facilities and services in collaboration with universities and relevant NSW Health agencies;

    b. overseeing a graduate recruitment program that capitalises on the clinical placements offered within the public health system and facilitates the early recruitment of those who have held such placements immediately upon graduation and into areas of need; and

    c. the establishment and delivery of specialist medical training networks for all medical specialties, prioritising those with projected shortfalls in trainee numbers compared with service and workforce demands, in collaboration with the relevant medical colleges and local organisations,

with the objective of matching the number and locations of placements and training positions with areas of future service and workforce need and focusing upon maximising opportunities for training and recruitment in rural and regional locations.

26. There should be a legislated award reform process under the auspices of the Industrial Relations Commission of NSW (with external assistance and advice as appropriate), incorporating at least the following features:

    a. a legislated set of objectives to be achieved by the process, which includes:

        i. simplifying and, where appropriate, consolidating the current range of awards, determinations and other instruments setting terms and conditions of employment or engagement for NSW Health workers, to provide a consistent and coherent framework of terms and conditions that is easy to understand and apply; and

        ii. updating instruments so that they reflect the current and expected future service delivery and workforce needs of the NSW health system and current and expected future working conditions; and

        iii. providing fair and reasonable terms and conditions of employment or engagement for workers across the NSW health system, including having regard to the value of their work to the system, the impact of those terms and conditions on attraction and retention, and their fiscal and economic impacts;

    b. a reasonable but expeditious timeframe in which the process is to be completed; and

    c. an extension of the process to Visiting Medical Officers and the VMO Determinations.

27. The model by-laws for local health districts and specialty health networks made under ss 39 and 60 of the *Health Services Act 1997* (NSW) ("*Health Services Act*") should be reviewed and amended with a view to clearly identifying the role and functions each council and committee established by them and ensuring that they:

a. provide an effective and robust forum for consultation and feedback between clinicians and management;

b. are complementary of each other; and

c. extend the standing invitation to attend board meetings to the chairs of all councils created by the Model By-Laws.

28. The Ministry should review its processes for dealing with workplace complaints and grievances, including with a view to:

a. simplifying and, where appropriate, consolidating its policy directives and guidelines relating to complaints, grievances, incidents and workplace behaviour;

b. establishing a central contact within the Ministry for local organisations to seek advice about conducting those processes;

c. establishing a process for monitoring the time taken by local organisations to conduct those processes; and

d. establishing a mechanism for staff to seek review of workplace actions or decisions, external to the local organisation.

29. Consideration should be given to the routine collection and collation of a granular data set directed to the wellbeing of the workforce (similar to that which the evidence reveals has been collected by the Chief Wellness Officer in the Sydney Local Health District) with a view to supporting and improving the wellbeing of the workforce within local organisations and across the system more generally.

Affiliated Health Organisations

30. Each Affiliated Health Organisation should enter into a single service agreement with the Secretary – in much the same way as is currently contemplated for networked Affiliated Health Organisations – and negotiations with those organisations regarding funding and the nature and location of services to be delivered under those agreements should principally occur at Ministry level.

31. Planning around what services are to be provided by each Affiliated Health Organisation and where those services are to be provided should form an integral part of the wider service planning process identified above and discussed elsewhere in this outline.

32. On an annual basis, and in conjunction with the planning and identification of the services to be provided by each Affiliated Health Organisation under their respective Service Agreements, Schedule 3 to the *Health Services Act* should be reviewed to ensure that it accurately records the recognised services and establishments of each of them and amended to the extent necessary to reflect those services.

33. A structured process should be implemented to promptly resolve any dispute between the Ministry and an Affiliated Health Organisation regarding the extent to which funding offered is sufficient to meet the cost of delivering the level of service required under a proposed service agreement. Whatever process might be adopted, it must be independent, able to be unilaterally triggered by either the Affiliated Health Organisation or the Ministry in the event of a dispute, and capable of meaningfully regulating the "purchaser/provider" nature of the relationship to be reflected in any subsequent service agreement.

Procurement

34. NSW Health should develop and implement a systematic approach to embedding value-based healthcare in its procurement processes, including developing and implementing clear and specific processes for:

    a. determining the components of "value" that are to be pursued in a particular procurement process;

    b. evaluating different options for procurement, including tenders, against each of those components of value; and

    c. consulting as appropriate with clinicians, consumers, community members, suppliers and subject matter experts (including the Agency for Clinical Innovation and the Clinical Excellence Commission), in procurement processes.

35. NSW Health should develop and implement a systematic approach to monitoring the performance of suppliers of goods and services at a system-wide level, including developing and implementing clear and specific processes for:

    a. formulating clear and measurable key performance indicators, including with reference to value-based criteria applied in the procurement process;

    b. monitoring those key performance indicators, including designating clear lines of responsibility for performing that monitoring; and

    c. obtaining feedback from and providing feedback to local organisations, including users of the relevant goods or services, in a regular and systematic way.

Innovation

36. As part of a system-wide approach to service planning and design, the Agency for Clinical Innovation must play a clearer role in coordinating the identification and development of innovations, facilitating their implementation statewide and continuing to support them until they are embedded. To do this effectively, the Agency for Clinical Innovation should clearly identify research priorities, including necessary translational research. That must be accompanied by strong leadership that empowers clinical and non-clinical staff at all levels of the health system to reduce unwarranted clinical practice variation, withhold low value care, and prevent over-investigation, over-diagnosis and over-treatment.

37. In setting these research priorities, the Agency for Clinical Innovation should ensure that:

    a. Funding of research should be driven by community needs and priorities.

    b. Investment in innovation and research aligns with capacity to improve health outcomes and include innovations that support prevention and/or are likely to have system management benefits.

    c. Investment in innovation should be evidence-based with controlled introduction and ongoing monitoring to prevent indication creep or indiscriminate use, and to ensure costs are properly reflected and anticipated savings are realised.

First Nations Healthcare

38. A co-ordinated, whole of government approach is required to improve the health outcomes of First Nations people.

39. Meaningful collaboration and consultation must be embedded at an organisational level and should include joint clinical service planning, undertaken with the involvement of all relevant stakeholders and with a focus on reducing duplication, addressing service gaps and improving patient journeys.

40. Wherever possible:

    a. yearly and other short-term funding cycles for programs to be delivered by Aboriginal Community Controlled Health Organisations (particularly in relation to core, ongoing services) should be avoided;

    b. funds devoted to First Nations healthcare should be pooled and allocated to Aboriginal Community Controlled Health Organisations;

    c. Aboriginal Community Controlled Health Organisations should be given flexibility, within the collaborative clinical service planning process referred to above, to use funding allocated to them to design and deliver the services that are required to meet the needs of the communities they service.

41. Reporting requirements that attach to funding allocated to Aboriginal Community Controlled Health Organisations must be rationalised and simplified so as to ensure that they do not impose an unnecessary burden on the already strained resources of those organisations or unnecessarily divert those resources away from the delivery of front line care to First Nations people.

42. There should be greater collaboration and co-ordination with First Nations organisations across the State with a view to building a strong First Nations health workforce, and to optimise training pathways and workplace opportunities including in roles that are shared between, for examples, Aboriginal Community Controlled Health Organisations and NSW Health agencies or facilities.

3 THE TERMS OF REFERENCE

43. The Terms of Reference (as amended) require the Commissioner to inquire into, and report on:

A. *The funding models used to provide health services in NSW and whether they most effectively support the safe delivery of high quality, timely, equitable and accessible patient-centred care and health services to the people of NSW, now and into the future.*

B. *The existing governance and accountability structure of NSW Health, including whether:*

i. *It provides the best balance between central oversight and locally devolved decision making (including the current operating model of Local Health Districts);*

ii. *local communities are appropriately engaged in health service development and delivery;*

iii. *the governance structures best support efficient implementation of state-wide reform programs;*

iv. *privatisation and outsourcing has adversely impacted on the delivery of health services and health outcomes to the people of NSW or otherwise;*

v. *governance structures support a sustainable workforce and delivery of high quality, timely, equitable and accessible patient-centred care to improve the health of the NSW population;*

C. *Whether the funding models for health services or the way NSW Health funds health services delivered in public hospitals and community settings;*

i. *incentivises the delivery of health services that provide the overall best health outcomes for the people of NSW;*

ii. *provides the best value for the costs incurred in providing such health services;*

iii. *best supports (and does not obstruct) access to preventive and community health initiatives that provide the best overall health outcomes;*

iv. *maintains a financially sustainable healthcare system;*

D. *Whether the strategies of NSW Health that are in place or in the process of implementation best manage escalating costs, the*

limitation of wastage, minimise overservicing and appropriately identify gaps and improvements in financial accountability and efficiency;

E. *Whether the current procurement strategies and processes of NSW Health are appropriate and enhance support for operational decision making, service planning and delivery of quality and timely health care, including consideration of supply chain disruptions;*

F. *The current capacity and capability of the NSW Health workforce to meet the current needs of patients and staff, and its sustainability to meet future demands and deliver efficient, equitable and effective health services, including inquiry into:*

   i. *the existing skills and distribution of health workers in NSW, including whether there are shortages of workers and particular skill sets in any locations;*

   ii. *the financial and non-financial factors impacting on the retention and attraction of staff;*

   iii. *existing employment standards;*

   iv. *the role and scope of workforce accreditation and registration;*

   v. *the use of locums, Visiting Medical Officers, agency staff and other temporary staff arrangements;*

   vi. *the relationship between NSW Health agencies and medical practitioners;*

   vii. *whether there are opportunities for an expanded (or working to full) scope of practice for the health workforce including paramedics, pharmacists, community and allied health workers, nurses and midwives;*

   viii. *the role of multi-disciplinary community health services in meeting current and future demand and reducing pressure on the hospital system;*

   ix. *opportunities and quality of care outcomes in maintaining direct employment arrangements with health workers;*

G. *Current education and training programs for specialist clinicians and their sustainability to meet future needs, including:*

   i. *placements;*

ii. *the way training is offered and overseen (including for internationally trained specialists);*

iii. *how colleges support and respond to escalating community demand for services;*

iv. *the engagement between medical colleges and local health districts and speciality health networks;*

v. *how barriers to workforce expansion can be addressed to increase the supply, accessibility and affordability of specialist clinical services in healthcare workers in NSW;*

H. *New models of care and technical and clinical innovations to improve health outcomes for the people of NSW, including but not limited to technical and clinical innovation, changes to scope of practice, workforce innovation, and funding innovation; and*

I. *Any other matter reasonably incidental to a matter referred to in paragraphs A to H, or which the Commissioner believes is reasonably relevant to the inquiry.*

44. The Terms of Reference are as broad as the healthcare system is large. On one view, they permitted a wide-ranging examination of almost any issue associated with the healthcare system in New South Wales. In the context of a fragmented, large and complex system, both within New South Wales and across the Commonwealth more broadly,[8] a detailed examination of every issue that might fall within the Terms of Reference – many of which overlapped with others – was not reasonably possible. Whilst the Terms of Reference are not limited in their scope – available time and the responsible use of public resources were.

45. Further, the Terms of Reference do not readily lend themselves to individual consideration or analysis. Accordingly, to ensure that the Special Commission's work was as focused as possible, key themes were identified as vehicles for exploring the broader systemic issues to which the substance of the Terms of Reference was directed.

46. In that context, the Commissioner need not seek to identify direct answers to each sub-clause of the Terms of Reference. Rather, the Terms of Reference

[8] See, for example, the discussion in Exhibit A.45, *Australian Health Services: too complex to navigate,* Australian Health Policy Collaboration (February 2019) [SCI.0001.0041.0001].

can be effectively and fully answered by considering several core themes that have emerged in the evidence.

47. The label "NSW Health" is used throughout the Terms of Reference. That label has been used by some as a reference to the Ministry, and by others as a shorthand description for the wider public health system in New South Wales;[9] it is evident that the drafter of the Terms of Reference adopted the latter definition. Where used in this outline, the term should be understood as a broad reference to that part of the public health system in New South Wales which falls within the "system management" of the Ministry and is delivered through its various agencies and affiliated bodies.

[9] See, for example, Exhibit H2.51, NSW Health Corporate Governance and Accountability Compendium, p 1.01 [MOH.0010.0256.0001 at 0010]; *Health Administration Act 1982* (NSW), s 4(1A).

4 THE NEW SOUTH WALES PUBLIC HEALTH SYSTEM

48. The New South Wales public health system is the largest in the country.[10] It is the State's largest government department, the largest public sector employer, and receives the largest portion of the State budget.[11]

49. The following paragraphs highlight some essential elements of the system, including their structures and governance arrangements. Due to the enormity of the system, not all aspects of it are referred to below.

4.1 Key legislation

50. The two key statutes that create and regulate the operation of the New South Wales public health system are the *Health Services Act 1997* (NSW) and the *Health Administration Act 1982* (NSW) ("*Health Administration Act*").

4.1.1 Health Services Act

51. The *Health Services Act* is the principal statute that regulates the governance and management of the New South Wales public health system. It creates each of the component parts of the system and prescribes the framework for determining their functions and governance structures.[12]

52. Section 6 of the *Health Services Act* creates the public health system in New South Wales, comprising all "*public health organisations*"—being the Local Health Districts, the Statutory Health Corporations, and the Affiliated Health Organisations (in respect of their recognised establishments and services)—together with the Secretary in relation to certain defined services.[13]

53. It is conveniently depicted in the following organisational chart:[14]

[10] Exhibit N.3.27, NSW Health Annual Report 2023-2024 (October 2024), p iii [SCI.0011.0717.0001 at 0005]; Exhibit A.1 Joint Report of Dr Nigel Lyons, Dr Kerry Chant AO PSM and Deb Willcox AM (17 November 2023) [50] [MOH.9999.0001.0001 at 0009].
[11] Exhibit N.2.32, NSW Budget Paper No. 1 2024-2025, p 97 [SCI.0011.0545.0001 at 0098].
[12] Exhibit H.2.51, NSW Health Corporate Governance and Accountability Compendium, p 1.01 [MOH.0010.0256.0001 at 0010].
[13] *Health Services Act 1997* (NSW), ss 6 and 7.
[14] See, for example, *Health Services Act 1997* (NSW) ss 8-14, and chs 3, 4, 5, 5A, 8 and 10; Exhibit H2.51, NSW Health Corporate Governance and Accountability Compendium, p 1.05 [MOH.0010.0256.0001 at 0014].

54. The *Health Services Act* also prescribes the primary purpose and functions of Local Health Districts,[15] the functions of Statutory Health Corporations[16] and the Affiliated Health Organisations,[17] and creates the New South Wales Ambulance Service.[18] It also prescribes the arrangements for employment of staff within the "NSW Health Service"[19] and arrangements with visiting practitioners.[20] Some of those concepts will be discussed in more detail below.

4.1.2 Health Administration Act

55. The *Health Administration Act* prescribes the roles of the Minister, Secretary, and the Health Administration Corporation; constitutes the New South Wales Health Foundation; establishes the Medical Services Committee; provides for the establishment of approved quality assurance committees; and defines the processes required for review of health service incidents.[21]

4.1.3 Other legislation

56. There are many other statutes that form part of the legislative framework in which the New South Wales public health system operates. Many confer additional powers or functions on the Minister for Health and the Secretary. For example, the *Public Health Act 2010* (NSW) confers power on the Minister for

[15] *Health Services Act 1997* (NSW) ss 9 and 10.
[16] *Health Services Act 1997* (NSW) s 12.
[17] *Health Services Act 1997* (NSW) s 14.
[18] *Health Services Act 1997* (NSW) Ch 5A.
[19] *Health Services Act 1997* (NSW) Ch 9.
[20] *Health Services Act 1997* (NSW) Ch 8.
[21] *Health Administration Act 1982* (NSW) pts 2 and 2A.

Health to take actions and make orders in relation to public health risks generally, during a state of emergency, and when risks arise from the conduct of public authorities.[22] As seen during the COVID-19 pandemic, it also includes powers for the purposes of controlling for specified environmental health risks, infectious diseases, and other medical conditions.[23]

57. It is beyond the scope of this outline to seek to identify all such legislation. It is sufficient to observe that across many statutes, a wide range of matters are provided for; from enforcing restrictions on the advertising and sale of tobacco and other smoking products[24] and directing the addition of fluoride to a public water supply,[25] to the provision of care to people with mental illnesses and disorders in hospitals and community facilities,[26] licencing of private health facilities,[27] and the effective operation of the medical indemnity sector.[28]

58. In addition, there is also a range of Commonwealth legislation relevant to the operation of the public health system in New South Wales. Most relevant to the issues arising for consideration by the Special Commission is Commonwealth legislation dealing with the funding of public health services,[29] the operation of the aged-care sector[30] and the National Disability Insurance Scheme,[31] and the collection of health-related information.[32] Some of that legislation will be referred to in more detail below.

4.2 Ministers

59. There are currently four Ministerial appointments with portfolio responsibility for health within the current government – being, the Minister for Health, the Minister for Regional Health, the Minister for Mental Health and the Minister for Medical Research. Currently, the Hon Ryan Park MP holds the Health and

[22] *Public Health Act 2010* (NSW) ss 7-9.
[23] *Public Health Act 2010* (NSW), pts 3-5 and sch 1-3.
[24] *Public Health (Tobacco) Act 2008* (NSW) pts 2-6.
[25] *Fluoridation of Public Water Supplies Act* 1957 (NSW), s 6A.
[26] *Mental Health Act 2007* (NSW) s 3, and chs 2-6.
[27] *Private Health Facilities Act 2007* (NSW) s 4 and pt 2.
[28] *Health Care Liability Act 2001* (NSW) ss 3 and 4.
[29] *National Health Reform Act 2011* (Cth) s 4, chs 2, 4 and 5; *Health Insurance Act 1973* (Cth) pts II, IIA and IIB; National Health Act 1953 (Cth) pt VII.
[30] *Aged Care Act 1997* (Cth); *Aged Care Quality and Safety Commission Act 2018* (Cth).
[31] *National Disability Insurance Scheme Act 2013* (Cth).
[32] *Australian Institute of Health and Welfare Act 1987* (Cth).

Regional Health portfolios, the Hon Rose Jackson MP holds the Mental Health Portfolio, and the Hon David Harris MP holds the Medical Research portfolio.[33]

60. The Ministers for Health, Regional Health, and Mental Health all have joint responsibility for the administration of health related legislation.[34]

61. Both the *Health Administration Act* and the *Health Services Act* refer to the "Minister". Properly understood, such references are to the Minister with responsibility for administering those Acts or (in the case of shared administration) the Minister administering the relevant portion of them or in respect of the power or function being exercised.[35] Although, as noted above, there is presently joint administration of all acts allocated to the Minister for Health – for the purposes of this outline, it is convenient to refer to those functions and powers as falling to the Minister for Health. Accordingly, references to the "Minister" in this outline should be understood as a reference to the Minister for Health.

62. The core functions of the Minister are set out in the *Health Administration Act* and the *Health Services Act*. Relevantly, s 5 of the *Health Administration Act* describes the core function[36] of the Minister for Health as follows:

> *(1) The Minister may formulate general policies, in accordance with which the functions of the Minister, Ministry, Health Secretary, Corporation and Foundation are to be exercised, for the purpose of promoting, protecting, developing, maintaining and improving the health and well-being of the people of New South Wales to the maximum extent possible having regard to the needs of and financial and other resources available to the State.*
>
> *(2) The Minister may—*
>
> *(a) provide, conduct, operate and maintain and, where necessary, improve and extend any health service or any ancillary or incidental service and arrange for the construction of any buildings or works necessary for or in connection with any such service,*

[33] <https://www.parliament.nsw.gov.au/members/Pages/ministers.aspx> (accessed 22 November 2024).
[34] See *Administrative Arrangements (Minns Ministry—Administration of Acts) Order 2023*, sch 1; Exhibit H2.51, NSW Health Corporate Governance and Accountability Compendium, p 1.01 [MOH.0010.0256.0001 at 0010]. The Minister for Medical Research does not presently have responsibility for the administration of any health related legislation.
[35] See *Interpretation Act 1987* (NSW) s 15.
[36] The Minister is also responsible for managing the functions of the New South Wales Health Foundation and appointing advisory bodies and members of the Medical Services Committee under that Act: *Health Administration Act 1982* (NSW) ss 16, 20 and 20B.

> *(b) enter into any agreement or arrangement for any other person to provide, conduct, operate and maintain any health service, and*
>
> *(c) do such supplemental, incidental or consequential acts as may be necessary or expedient for the exercise of the functions under the foregoing provisions of this subsection.*

63. The *Health Services Act* identifies a range of other core functions of the Minister, including the appointment and removal of Local Health District board members,[37] the appointment of committees of review to determine appeals by visiting practitioners against decisions of public health organisations,[38] and the determination of subsidies to be paid to Local Health Districts out of money appropriated from the consolidated fund.[39]

64. The Minister may also make orders requiring public health organisations to obtain services from the Secretary or another specified person.[40]

65. The Minister for Mental Health has responsibility for statewide policy in relation to mental health and a range of functions relating to the New South Wales Mental Health Commission, the Mental Health Review Tribunal, and the Mental Health Visitors Program.[41]

66. The Minister for Medical Research, supported by the Clinical Innovation and Research Division of the Ministry, has responsibilities for medical research and innovation within New South Wales, including strategy setting.[42]

4.3 The Secretary

67. The Health Secretary – currently Susan Pearce AM – has a range of powers and functions prescribed by legislation. Relevantly for present purposes, s 8(1) of the *Health Administration Act* provides that the Secretary has, and may exercise, those functions that are "conferred or imposed" on that office by that, or any other, Act. Section 8(2) goes on to provide that the Secretary "shall have and may exercise any of the following functions":

---

[37] *Health Services Act 1997* (NSW) ss 26, 29, 49 and 52.
[38] *Health Services Act 1997 (NSW)* s 108.
[39] *Health Services Act 1997* (NSW) s 127. The power cannot be delegated: *Health Services Act 1997* (NSW) s 127(3); *Health Administration Act 1982* (NSW) s 21(23).
[40] *Health Services Act 1997(NSW)* ss 126G and 126H. Such orders may only be given to an Affiliated Health Organisation if it consents.
[41] Exhibit H2.51, NSW Health Corporate Governance and Accountability Compendium, p 1.02 [MOH.0010.0256.0001 at 0011].
[42] Exhibit H2.51, NSW Health Corporate Governance and Accountability Compendium, p 1.02 [MOH.0010.0256.0001 at 0011].

> *(a) to initiate, promote, commission and undertake surveys and investigations into—*
>
> *(i) the health needs of the people of New South Wales,*
>
> *(ii) the resources of the State available to meet those needs, and*
>
> *(iii) the methods by which those needs should be met,*
>
> *(b) to inquire into the nature, extent and standards of the health services, facilities and personnel required to meet the health needs of the people of New South Wales and to determine the cost of meeting those needs,*
>
> *(c) to plan the provision of comprehensive, balanced and co-ordinated health services throughout New South Wales,*
>
> *(d) to formulate the programs and methods by which the health needs of the people of New South Wales may be met,*
>
> *(e) to undertake, promote and encourage research in relation to any health service,*
>
> *(f) to facilitate the provision of health services by any council (within the meaning of the* Local Government Act 1993*) or by any other body or person,*
>
> *(g) to facilitate the provision by any Public Service agency, statutory authority, other body or person of social welfare services necessary or desirable to complement any health service,*
>
> *(h) to promote and facilitate the provision of the professional, technical or other education or training of any persons employed or to be employed in the provision of any health service,*
>
> *(i) to promote and facilitate a system of health care for the people of New South Wales provided by private bodies, institutions, associations and persons, as well as by the State and public bodies,*
>
> *(j) to do such supplemental, incidental or consequential acts as may be necessary or expedient for the exercise of the Health Secretary's functions under the foregoing provisions of this subsection.*

68. Relevantly, section 122(1) of the *Health Services Act* confers the following further functions on the Secretary:[43]

[43] *Health Services Act 1997* (NSW) s122.

> *(a) to facilitate the achievement and maintenance of adequate standards of patient care within public hospitals and in relation to other services provided by the public health system,*
>
> *(b) to facilitate the efficient and economic operation of the public health system consistent with the standards referred to in paragraph (a),*
>
> *(c) to inquire into the administration, management and services of any public health organisation,*
>
> *(c1) to provide governance, oversight and control of the public health system and the statutory health organisations within it,*
>
> *(d) to cause public health organisations (including public hospitals controlled by them) to be inspected from time to time,*
>
> *(e) to recommend to the Minister what sums of money (if any) should be paid from money appropriated from the Consolidated Fund in any financial year to any public health organisation,*
>
> *(f) to enter into performance agreements with public health organisations, to review the results of organisations under such agreements and to report those results (and make recommendations about the results) to the Minister,*
>
> *(f1) to give directions to statutory health organisations, including (subject to section 121E(3)) directions relating to the employment of NSW Health Service senior executives,*
>
> *(g) such other functions as may be conferred or imposed by or under this Act.*

69. Other than when making recommendations or reports to the Minister, in exercising her statutory powers and functions, the Secretary is subject to the control and direction of the Minister.[44]

70. The Secretary is also incorporated as a corporation sole called the "Health Administration Corporation".[45] Through the Health Administration Corporation, the Secretary provides a range of services—including NSW Ambulance, NSW Health Pathology, and Health Protection NSW[46] together with a range of shared services to Local Health Districts and specialty networks, through HealthShare

[44] *Health Administration Act 1982* (NSW) s 8(3).
[45] *Health Administration Act 1982* (NSW) s 9.
[46] Exhibit A.1, Joint Report of Dr Nigel Lyons, Dr Kerry Chant AO PSM and Deb Willcox AM (17 November 2023) [56] [MOH.9999.0001.0001 at 0007]; Exhibit H.2.51, NSW Health Corporate Governance and Accountability Compendium, pp 1.03-10.4 [MOH.0010.0256.0001 at 0012-0013].

NSW, eHealth NSW and Health Infrastructure NSW.[47] In exercising those functions, the Secretary is considered to be part of the public health system.[48]

71. Subject to some limited exceptions (such as Chief Executives of Local Health Districts[49]), the Secretary may exercise employer functions on behalf of the Government in relation to NSW Health Service staff.[50] In doing so, the Secretary may fix the salary, wages and employment conditions of NSW Health Service staff (other than the extent to which they have been fixed by other laws and in relation to senior executives).[51] The Secretary may also direct the transfer of senior executives and redundant staff members, and arrange for secondments or for the use of facilities outside NSW Health to assist with the exercise of public health system functions.[52]

4.4 Ministry of Health

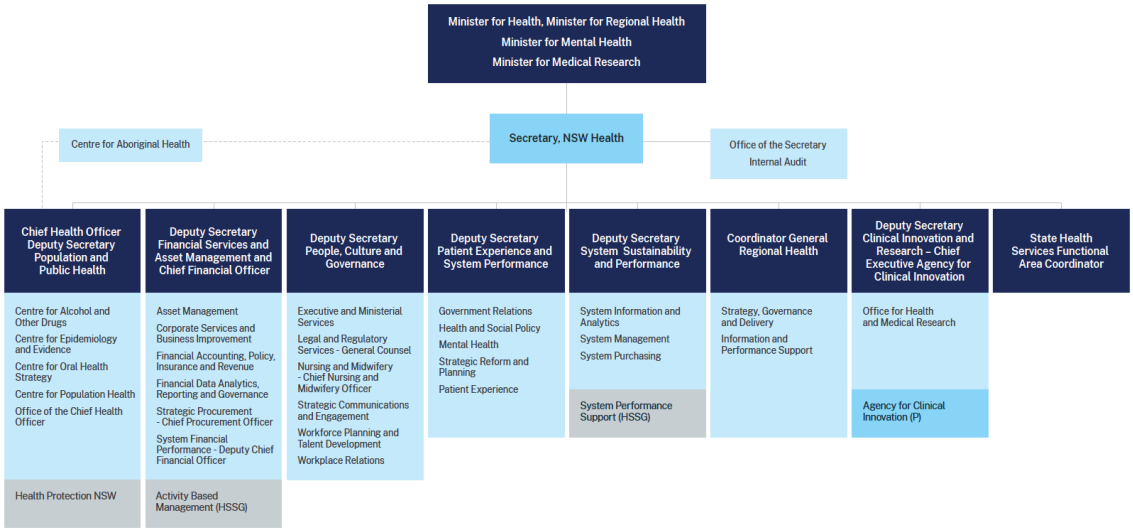
72. The Ministry is the "system manager" of the public health system in New South Wales.[53] In general terms, the role of "system manager" includes overall responsibility for the delivery of services through the public hospital system, system-wide policy, strategy and planning, and ensuring compliance with the requirements of the National Health Reform Agreement.[54] In doing so, the Ministry sets directions for the wider system, provides information to assist with local planning, and coordinates planning of system-wide services, workforce strategy and population health.

73. The Ministry's role in planning is to set directions for the system, provide information and tools to assist with local planning functions, and coordinate planning of system-wide services, workforce strategy and population health

[47] Exhibit A.1, Joint Report of Dr Nigel Lyons, Dr Kerry Chant AO PSM and Deb Willcox AM (17 November 2023) [57] [MOH.9999.0001.0001 at 0007]; Exhibit H2.51, NSW Health Corporate Governance and Accountability Compendium, pp 1.03-10.4 [MOH.0010.0256.0001 at 0012-0013].
[48] *Health Services Act 1997* (NSW) ss 6, 67B and 126B.
[49] *Health Services Act 1997* (NSW) ss 23 and 28(3). That function rests with the Board of the Local Health District.
[50] *Health Services Act 1997* (NSW) ss 20, 43, 64, 116. That includes the provision for staff to be transferred between public health organisations.
[51] *Health Services Act 1997* (NSW) s 116A.
[52] *Health Services Act 1997* ss 116C, 116D and 121D.
[53] Exhibit A.1 Joint Report of Dr Nigel Lyons, Dr Kerry Chant AO PSM and Deb Willcox AM (17 November 2023) [36] [MOH.9999.0001.0001 at 0005]; Ex H.2.51, Health Corporate Governance and Accountability Compendium, p 1.03 [MOH.0010.0256.0001 at 0012].
[54] *Health Administration Act 1982* (NSW) s 8(2)(c); Exhibit A.1 Joint Report of Dr Nigel Lyons, Dr Kerry Chant AO PSM and Deb Willcox AM (17 November 2023) [37] [MOH.9999.0001.0001 at 0005]; Exhibit A.28, Addendum to the National Health Reform Agreement (Consolidated) 2020-2025 (undated), cl 10 [SCI.0001.0024.0001 at 0009]; Exhibit H.2.51 Health Corporate Governance and Accountability Compendium pp 1.03 and 6.02 [MOH.0010.0256.0001 at 0012 and 0067]; Transcript of the Commission, 28 November 2023, T69.9-29, T74.12-75.1 (Lyons).

initiatives.[55] In part, it performs that function through the development of over-arching strategy documents, such as the "Future Health" report, which details the priorities and strategic framework intended to steer the health system through to 2032, and is complemented by other strategic plans.[56]

74. The current organisational structure within the Ministry is depicted in the following organisational chart:[57]



75. That governance structure is based not only on legislation but also on policy, custom and practice.[58]

76. Each Deputy Secretary leads a division within the Ministry comprising a number of branches relevant to the portfolio. Those with dual titles have an additional role that complements or aligns with their position as Deputy Secretary.

4.4.1 Chief Health Officer/Population and Public Health Division

77. The Chief Health Officer has several statutory responsibilities under the *Public Health Act 2010* (NSW), including, issuing public warnings about identified health risks, advising the public regarding the safety of drinking water, making

[55] Exhibit H.2.51, Health Corporate Governance and Accountability Compendium [6.1.2] [MOH.0010.0256.0001 at 0067].
[56] For example, the Regional Health Strategic Plan, Workforce Plan and Aboriginal Health Plan: Exhibit H.2.51 Health Corporate Governance and Accountability Compendium [6.2] [MOH.0010.0256.0001 at 0067-0069].
[57] Exhibit H.2.51, Health Corporate Governance and Accountability Compendium, p 1.05 [MOH.0010.0256.0001 at 0014].
[58] Exhibit D.10, Statement of Deb Willcox (9 April 2024) [7] [MOH.9999.0981.0001 at 0002]; Exhibit D.8, Statement of Matthew Daly (9 April 2024) [9] [MOH.9999.0976.0001 at 0003].

public health orders in respect of individuals with certain diagnoses, and approving the NSW Immunisation Schedule.[59]

78. The function of the Population and Public Health Division within the Ministry is to improve health through the prevention of disease. This includes coordinating and monitoring the State's population health services, public health responses to major incidents, identifying trends and evaluating the impact of health services.[60]

4.4.2 Financial Services and Asset Management Division

79. The Financial Services and Asset Management Division's function is to govern, lead and strengthen sustainable resource allocation and to manage, monitor and report on financial performance, and both recurrent and capital expenditure.[61]

4.4.3 People, Culture and Governance Division

80. The role of the People, Culture and Governance Division is to provide leadership and strategic direction through various professional advisory services, including regulatory and corporate governance functions, legal services and management of the Secretary's function as employer of the NSW Health Service.[62] In practice, the division takes lead responsibility for industrial relations policy, workforce policy, organisational talent development, learning, workforce culture and development and a range of related issues.[63]

4.4.4 Health System Strategy and Patient Experience Division

81. The role of the Health System Strategy and Patient Experience Division extends over a range of portfolio areas, including government relations, strategic reform and oversight of programs aimed at enhancing patient experience, particularly for priority populations.[64] The division has responsibility for engagement with

[59] *Public Health Act 2010* (NSW) ss 12A, 22, 62 and 85.
[60] Exhibit B.36, NSW Health Annual Report 2022-2023, p 8 [SCI.0001.0059.0001 at 0017]; Transcript of the Commission, 28 November 2023, T66.26-38 (Chant).
[61] Exhibit B.36, NSW Health Annual Report 2022-2023, p 8 [SCI.0001.0059.0001 at 0017]; Transcript of the Commission, 28 November 2023, T71.43-72.4 (Willcox).
[62] Exhibit B.36, NSW Health Annual Report 2022-2023, p 9 [SCI.0001.0059.0001 at 0018]; Transcript of the Commission, 28 November 2023, T72.6-10 (Willcox).
[63] Transcript of the Commission, 28 November 2023, T72.6-10 (Willcox).
[64] Exhibit B.36, NSW Health Annual Report 2022-2023, pp 9-10 [SCI.0001.0059.0001 at 0018-0019].

other agencies and jurisdictions, including negotiations concerning the National Health Reform Agreement.[65]

4.4.5 System Sustainability and Performance Division

82. The System Sustainability and Performance Division is responsible for front-end system management, including the annual purchasing process, monitoring system performance and the oversight of programs relating to hospital avoidance, virtual care and environmental sustainability.[66] The division also oversees some of the key access areas such as emergency departments and elective surgery, and performs a key analytics and data function.[67]

4.4.6 Regional Health Division

83. The Regional Health Division was established in 2022 to oversee and support health service delivery in regional, rural and remote New South Wales.[68]

4.4.7 Clinical Innovation and Research Division / Agency for Clinical Innovation

84. The Clinical Innovation and Research Division integrates the Office of Health and Medical Research with the Agency for Clinical Innovation. The division has responsibility for coordination and strategy setting in relation to statewide research and innovation priorities.[69]

4.5 Health Administration Corporation

85. The following entities form part of the Health Administration Corporation.[70]

4.5.1 Ambulance Service of New South Wales

86. The statutory functions of the Secretary in relation to ambulance services include to:[71]

    a. provide, conduct, operate and maintain ambulance services;

    b. consult and co-operate with individuals and organisations providing ambulance services;

[65] Exhibit B.36, NSW Health Annual Report 2022-2023 p 10 [SCI.0001.0059.0001 at 0019].
[66] Exhibit B.36, NSW Health Annual Report 2022-2023 p 10 [SCI.0001.0059.0001 at 0019].
[67] Transcript of the Commission, 28 November 2023, T72.12-18 (Willcox).
[68] Exhibit B.36, NSW Health Annual Report 2022-2023 p 11 [SCI.0001.0059.0001 at 0020]; Transcript of the Commission, 28 November 2023, T72.20-73.3 (Willcox).
[69] Exhibit B.36, NSW Health Annual Report 2022-2023 p 21 [SCI.0001.0059.0001 at 0020].
[70] Exhibit B.36, NSW Health Annual Report 2022-2023, p 4 [SCI.0001.0059.0001 at 0013].
[71] *Health Services Act 1997* (NSW) s 67B.

c. adopt measures including planning, management and quality control to ensure the efficient and economic use of resources in the provision of ambulance services;

d. plan future development of ambulance services, with community involvement;

e. set objectives, determine priorities and monitor outcomes;

f. achieve and maintain adequate standards of ambulance services;

g. make public reports, and provide information and advice about the operation of ambulance services;

h. assist or co-operate with the depiction of ambulance services in news or entertainment media.

87. Ambulance services include out-of-hospital care, medical retrieval and health related transport across the State.[72] The Ambulance Service also provides support for whole of government planning in relation to major events and mass gatherings and is involved in State emergency and rescue management.[73]

88. The Ambulance Service is led by a Chief Executive and an Advisory Board with between eight and 12 members, each appointed by the Secretary.[74]

4.5.2 Health Protection NSW

89. Health Protection NSW develops strategies and policies for the surveillance, prevention, control and response to infectious and environmental health threats, together with Local Health District public health units, other agencies and health care providers.[75] It monitors notifiable disease incidence and provides public health responses to control the spread and reduce the burden of disease.[76]

[72] Exhibit H.2.51, NSW Health Corporate Governance and Accountability Compendium, p 1.03 [MOH.0010.0256.0001 at 0012].
[73] Exhibit B.36, NSW Health Annual Report 2022-2023, p 40 [SCI.0001.0059.0001 at 0049]; *State Emergency and Rescue Management Act 1989* (NSW) s 3.
[74] *Health Services Act 1997* (NSW) ss 67A, 67C and sch 6.
[75] Exhibit B.36, NSW Health Annual Report 2022-2023, p 4 [SCI.0001.0059.0001 at 0013].
[76] Exhibit A.1, Joint Report of Dr Nigel Lyons, Dr Kerry Chant AO PSM and Deb Willcox AM (17 November 2023) [56] [MOH.9999.0001.0001 at 0007].

90. Health Protection NSW is headed by an Executive Director who reports to the Chief Health Officer.[77]

4.5.3 NSW Health Pathology

91. NSW Health Pathology was established in 2019 to provide services for the diagnosis and monitoring of disease, and a forensic and analytical science service. Its primary function is to operate as the preferred provider and commissioner of these services within the New South Wales public health system.[78]

92. Subject to some limited exceptions, public health organisations must acquire their pathology, forensic and analytical science services from NSW Health Pathology to the extent it provides those services.[79] In certain circumstances, NSW Health Pathology may also provide services for persons and entities outside the public health system.[80]

93. The board of NSW Health Pathology is appointed by the Secretary, and its function is to provide effective and ethical governance and endorse the strategic direction of the organisation.[81]

94. NSW Health Pathology has the following clinical streams: pre- and post-analytical; haematology; transfusion; microbiology; immunology; chemical pathology; anatomical pathology; and forensic pathology. It also provides statewide services in genomics, point of care testing, public health pathology, biobanking and perinatal post-mortems.[82]

95. NSW Health Pathology is primarily funded through service recovery charges levied to Local Health Districts and Specialty Health Networks, revenue generated from private patients and corporate customers, and block grants.[83]

[77] Exhibit B.36 NSW Health Annual Report 2022-2023 p 4 [SCI.0001.0059.0001 at 0013]; Exhibit H.1 NSW Health Public Health Delegations Manual [MOH.9999.0817.0001].
[78] Exhibit B.23.173, Instrument of Establishment - NSW Health Pathology (6 June 2019) [MOH.0001.0382.0001].
[79] Exhibit B.10, Statement of Vanessa Janissen (8 February 2024) [19] [MOH.9999.0008.0001 at 0005]. By consent in the case of Affiliated Health Organisations: Ex B.23.86, Order pursuant to s 126G of the *Health Services Act 1997* (13 June 2019) [MOH.0001.0383.0001].
[80] Exhibit B.23.173, Instrument of Establishment - NSW Health Pathology Division (6 June 2019) [MOH.0001.0382.0001]; Exhibit B.10, Statement of Vanessa Janissen (8 February 2024) [21] [MOH.9999.0008.0001 at 0006].
[81] Exhibit B.23.82, Instrument of Constitution – NSW Health Pathology Board, cl 1 [MOH.0001.0377.0001].
[82] Exhibit B.23.94, NSW Health Pathology Clinical Services Plan 2019-2025, pp 6-7 [MOH.0001.0384.0001 at 0008-0009].
[83] Exhibit B.10, Statement of Vanessa Janissen (8 February 2024) [32]-[50] [MOH.9999.0008.0001 at 0010-0014].

4.5.4 HealthShare NSW

96. HealthShare NSW provides a range of services in support of patient care delivery across the state, including procurement, food and linen, patient transport, and payroll services.[84] HealthShare NSW also administers statewide (whole-of-government and whole-of-health) contracts and the warehousing and distribution of goods supplied under those contracts.[85]

97. Generally, public health organisations[86] must acquire those health support services from HealthShare NSW.[87]

98. Previously, HealthShare NSW entered into service agreements with Local Health Districts and Specialty Health Networks. However, it no longer does so.[88] HealthShare NSW now enters into an annual agreement with the Secretary, described as a "Statement of Service", which sets out the budget allocated to HealthShare NSW and a range of key performance indicators.[89]

99. HealthShare NSW is board governed, and its members are appointed by the Secretary.[90] The board has strategic oversight and corporate governance functions, together with an advisory role including in relation to strategies and business improvements that may support improved efficiency and customer service by HealthShare NSW.[91]

100. HealthShare NSW is funded through a combination of block funding and "intra-health charges" levied by HealthShare NSW on other NSW Health entities for the provision of services.[92]

4.5.5 eHealth NSW

101. eHealth NSW is responsible for the development and implementation of the whole-of-NSW Health digital strategy, policy, standards and investment plans,

[84] Exhibit B.36, NSW Health Annual Report 2022-2023, pp 4 and 19 [SCI.0001.0059.0001 at 0013 and 0028].
[85] Exhibit B.11, Statement of Carmen Rechbauer (12 February 2024) [31] [MOH.9999.0009.0001 at 0011].
[86] By consent in the case of Affiliated Health Organisations.
[87] Exhibit B.23.39, Order pursuant to s 126G of the *Health Services Act 1997* (10 November 2008) [MOH.0001.0404.0001]; Exhibit B.23.35, NSW Ministry of Health Accounts & Audit Determination for Public Health Entities in New South Wales (9 March 2020), pp 26-27 [MOH.0001.0278.0001 at 0027-0028].
[88] Exhibit B.11, Statement of Carmen Rechbauer (12 February 2024) [13]-[14] [MOH.9999.0009.0001 at 0004].
[89] Exhibit B.11, Statement of Carmen Rechbauer (12 February 2024) [14] [MOH.9999.0009.0001 at 0004]; Exhibit B.23.179, HealthShare NSW Statement of Service 2023-2024 (8 February 2024) pp 8-16 [MOH.9999.0010.0001 at 0009-0017].
[90] Exhibit B.11, Statement of Carmen Rechbauer (12 February 2024) [7] [MOH.9999.0009.0001 at 0002].
[91] Exhibit B.23.37, Delegation of Functions - HealthShare NSW Board (29 November 2022) [MOH.0001.0308.0001].
[92] Exhibit B.11, Statement of Carmen Rechbauer (12 February 2024) [25]-[28], [MOH.9999.0009.0001 at 0009].

the delivery and management of information communication, and establishing, implementing and ensuring compliance with policy and standards.[93]

102. Its functions broadly include the design, procurement, build, operation and maintenance of ICT, digital infrastructure and cyber security services, statewide support, and procurement (including on behalf of other NSW Health entities).[94]

103. Like other shared services, eHealth NSW is funded primarily on a cost recovery model, with funding for "business as usual" provided through user charges levied to other NSW Health entities. In addition, eHealth also receives capital funding for statewide programs, and a level of recurrent funding from the Ministry to support its core functions.[95]

104. eHealth NSW is led by a Chief Executive, who reports to the Secretary. In January 2024, the Secretary established a board of eHealth (as an advisory board) to oversee its operations, replacing the previous Executive Council.[96]

4.5.6 Health Infrastructure NSW

105. Health Infrastructure NSW delivers the New South Wales major works hospital building program, and can also be engaged by local health districts to assist with smaller projects.[97]

106. It has the following core functions:

a. To manage capital works projects with an estimated construction cost of $10 million or more in partnership with public health organisations;

b. To manage or provide support and advice as requested by public health organisations for capital works projects with an estimated cost of less than $10 million;

c. To have a system risk management role for approved capital works projects by developing standardised contracts and other documents that support best practice and government policy compliance;

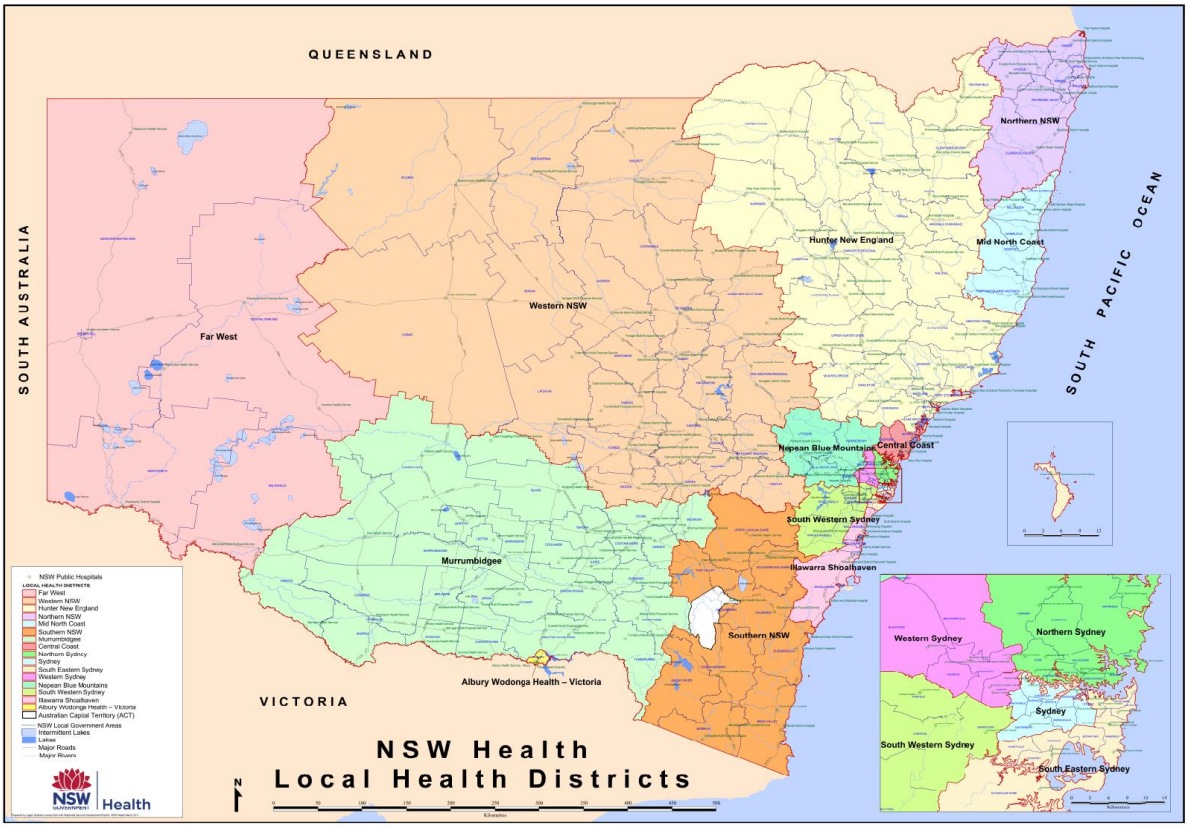
[93] Exhibit B.6, Statement by Dr Zoran Bolevich (31 January 2024) [7]-[9] [MOH.0001.0433.0001 at 0002].
[94] Exhibit B.6, Statement by Dr Zoran Bolevich (31 January 2024) [10]-[12] [MOH.0001.0433.0001 at 0002-0003]; Exhibit B.23.124, Instrument of Establishment – eHealth NSW [MOH.0001.0312.0001].
[95] Exhibit B.6, Statement by Dr Zoran Bolevich (31 January 2024) [15]-[17] [MOH.0001.0433.0001 at 0003].
[96] Exhibit D.5, Statement of Phillip Minns (9 April 2024) [141] [MOH.9999.0764.0001 at 0039].
[97] Exhibit A.1, Joint Report of Dr Nigel Lyons, Dr Kerry Chant AO PSM and Deb Willcox AM (17 November 2023) [57] [MOH.9999.0001.0001 at 0008].

d. To support and oversee asset management by public health organisations;

e. To provide such other infrastructure delivery services in connection with public health organisations as may be determined from time to time.[98]

4.6 Local Health Districts

107. There are 15 Local Health Districts across New South Wales.[99]



108. Each Local Health District is constituted as a body corporate.[100]

4.6.1 The purpose and functions of Local Health Districts

109. Local Health Districts are established by chapter 3 of the *Health Services Act* for the "principal reason" to facilitate the conduct of public health facilities and provision of health services in areas of the State in respect of which the relevant district is constituted.[101]

[98] Exhibit B.35, Health Infrastructure Statement of Service 2023-2024 (31 October 2023) cl 1.2 [SCI.0003.0001.0386 at 0389].
[99] *Health Services Act 1997* (NSW) s 17 and sch 1; Exhibit A.5, Local Health Districts Map [SCI.0001.0001.0001].
[100] *Health Services Act 1997* (NSW) s 17.
[101] *Health Services Act 1997* (NSW) s 8; Exhibit H.2.51, NSW Health Corporate Governance and Accountability Compendium, [1.2.1] [MOH.0010.0256.0001 at 0015].

110. The “primary purposes” of a Local Health District, in its area, are to provide relief to sick and injured persons through the provision of care and treatment, and to promote, protect and maintain the health of the community.[102]

111. Section 10 of the *Health Services Act* identifies the various functions of a Local Health District to be:

> *(a) generally to promote, protect and maintain the health of the residents of its area,*
>
> *(b) to conduct and manage public hospitals, health institutions, health services and health support services under its control,*
>
> *(c) to give residents outside its area access to such of the health services it provides as may be necessary or desirable,*
>
> *(d) to achieve and maintain adequate standards of patient care and services,*
>
> *(e) to ensure the efficient and economic operation of its health services and health support services and use of its resources,*
>
> *(f) generally to consult and co-operate (as it considers appropriate) with any one or more of the following—*
>
> *(i) the Health Care Complaints Commission constituted under the* Health Care Complaints Act 1993*,*
>
> *(ii) health professionals practising in its area,*
>
> *(iii) other individuals and organisations (including voluntary agencies, private agencies and public or local authorities) concerned with the promotion, protection and maintenance of health,*
>
> *(f1) to co-operate with other local health districts and the Health Secretary in relation to the provision of services involving more than one public health organisation or on a State-wide basis,*
>
> *(g) to investigate and assess health needs in its area,*
>
> *(h) to plan future development of health services in its area, and, towards that end—*
>
> *(i) to consult and plan jointly with the Ministry of Health and such other organisations as it considers appropriate, and*

[102] *Health Services Act 1997* (NSW) s 9.

(ii) to support, encourage and facilitate the organisation of community involvement in the planning of those services, and

(iii) to develop strategies to facilitate community involvement in the planning of those services and to report on the implementation of those strategies in annual reports and to the Minister,

(i) to establish and maintain an appropriate balance in the provision and use of resources for health protection, health promotion, health education and treatment services,

(j) to provide services to persons with whom it has contracted or entered into an agreement under section 37(2),

(k) to administer funding for recognised establishments and recognised services of affiliated health organisations where that function has been delegated to it by the Minister under section 129,

(l) to provide training and education relevant to the provision of health services,

(m) to undertake research and development relevant to the provision of health services,

(n) to make available to the public information and advice concerning public health and the health services available within its area,

(o) to carry out such other functions as are conferred or imposed on it by or under this or any other Act or as may be prescribed by the regulations.

4.6.2 Local Health District services and facilities

112. A Local Health District may establish such health facilities, services and support services as it thinks necessary for the exercise of its functions. It may close a public health facility, or cease or restrict a service or support service. Decisions to establish, or to close or restrict, a service may only be implemented if the Local Health District has first notified the Secretary of the decision and ensured that the decision is appropriate having regard to its functions.[103]

113. However, each Local Health District remains subject to the oversight and control of the Secretary and the Minister.[104] In this respect, the Secretary may

[103] *Health Services Act 1997* (NSW) s 31. The practical ability of Local Health District to exercise those functions, however, is significantly affected by external factors, some of which will be explored below.
[104] Exhibit H.2.51, NSW Health Corporate Governance and Accountability Compendium, [1.2.3] [MOH.0010.0256.0001 at 0015].

determine, and give directions as to, the role, functions and activities of a public health facility, service or support service that is under the control of a Local Health District.[105] The Minister may also direct a Local Health District to establish, or close or restrict, a public health facility, service or support service, if satisfied it is in the public interest.[106]

114. Local Health Districts are expected to engage in planning over both the short and long term to support service delivery that meets the health needs of the population for which they are responsible.[107] In doing so, Local Health Districts have a responsibility to ensure that government health policy goals are achieved through the planning and funding of a range of health services, whether those services are provided by that Local Health District, by other Local Health Districts or Specialty Health Networks, or other service providers.[108] Through that approach, Local Health Districts are expected to plan their services in a holistic way, including by reference to the availability of services in other districts, specialty networks, and by providers outside of the New South Wales public health system.

115. As part of that planning function, Local Health District boards must ensure the views of providers, consumers and other community members are sought about the district's policies and plans for provision of health services.[109]

116. Of the strategic and operational planning done by Local Health Districts, the most comprehensive is the Health Care Services Plan, which details priorities and service direction over a five to 10 year horizon. Health Care Services Plans reflect inter-dependent foundational planning for clinical and support services, workforce, health improvement and assets, including for individual facilities and particular categories of services. Health Care Services Plans ought to reflect what can be done safely and efficiently within the available budget, opportunities to network/partner with other providers, and continuing improvement processes to ensure intended outcomes are met.[110]

[105] *Health Services Act 1997* (NSW) s 32(1).
[106] *Health Services Act 1997* (NSW) s 32(2).
[107] Exhibit H.2.51, NSW Health Corporate Governance and Accountability Compendium [6.1.1] [MOH.0010.0256.0001 at 0066].
[108] Exhibit H.2.51, NSW Health Corporate Governance and Accountability Compendium [6.1.1] [MOH.0010.0256.0001 at 0066].
[109] *Health Services Act 1997* (NSW) s 28(1)(h).
[110] Exhibit H.2.51, NSW Health Corporate Governance and Accountability Compendium [6.3.1] [MOH.0010.0256.0001 at 0069-0070].

117. As noted below, the evidence received by the Special Commission casts real doubt over the extent to which the planning structures and obligations referred to in the above paragraphs are reflected in practice.

118. In performing its functions, a Local Health District may enter into contracts or agreements for goods, machinery, materials, and services.[111] However, a Local Health District cannot employ staff; instead, its functions are performed through NSW Health Service staff employed by the Government of New South Wales in the service of the Crown, but not as part of the Public Service.[112]

4.6.3 The governance and management structure of Local Health Districts

119. Each Local Health District is headed by a Chief Executive and has a board.[113]

a. The Chief Executive

120. Chief Executives of Local Health Districts are appointed by the board with the concurrence of the Secretary and employed by the New South Wales Government. They are responsible for the management and control of the affairs of the Local Health District and are accountable to the board.[114]

b. The board

121. Local Health District boards are comprised of between six and 13 members, who are appointed by the Minister. In making appointments to the board of a Local Health District, the Minister is required to select its members so that it has an appropriate mix of skills and expertise required to oversee and provide guidance to the district.[115]

122. Section 28 of the *Health Services Act* provides that Local Health District boards have the following functions:

> *(a) to ensure effective clinical and corporate governance frameworks are established to support the maintenance and improvement of standards of patient care and services by the local health district and to approve those frameworks,*

[111] *Health Services Act 1997* (NSW) s 37.
[112] *Health Services Act 1997* (NSW) ss 22 and 115.
[113] Exhibit A.1, Joint Report of Dr Nigel Lyons, Dr Kerry Chant AO PSM and Deb Willcox AM (17 November 2023) [39] [MOH.9999.0001.0001 at 0005].
[114] *Health Services Act 1997* (NSW) ss 23-25; Exhibit H.2.51, NSW Health Corporate Governance and Accountability Compendium, [1.2.4] [MOH.0010.0256.0001 at 0016].
[115] *Health Services Act 1997* (NSW) s 26. In doing so, ss 26(3) and (4) identify specific fields of experience and expertise that must be represented in the board membership.

(b) to approve systems—

(i) to support the efficient and economic operation of the local health district, and

(ii) to ensure the district manages its budget to ensure performance targets are met, and

(iii) to ensure that district resources are applied equitably to meet the needs of the community served by the district,

(c) to ensure strategic plans to guide the delivery of services are developed for the local health district and to approve those plans,

(d) to provide strategic oversight of and monitor the local health district's financial and operational performance in accordance with the State-wide performance framework against the performance measures in the performance agreement for the district,

(e) to appoint, and exercise employer functions in relation to, the chief executive of the local health district,

(e1) to ensure that the number of NSW Health Service senior executives employed to enable the local health district to exercise its functions, and the remuneration paid to those executives, is consistent with any direction by the Health Secretary or condition referred to in section 122(2),

(f) to confer with the chief executive of the local health district in connection with the operational performance targets and performance measures to be negotiated in the service agreement for the district under the National Health Reform Agreement,

(g) to approve the service agreement for the local health district under the National Health Reform Agreement,

(h) to seek the views of providers and consumers of health services, and of other members of the community served by the local health district, as to the district's policies, plans and initiatives for the provision of health services, and to confer with the chief executive of the district on how to support, encourage and facilitate community and clinician involvement in the planning of district services,

(i) to advise providers and consumers of health services, and other members of the community served by the local health district, as to the district's policies, plans and initiatives for the provision of health services,

> *(j) to endorse the local health district's annual reporting information for the purposes of the Government Sector Finance Act 2018,*
>
> *(k) to liaise with the boards of other local health districts and specialty network governed health corporations in relation to both local and State-wide initiatives for the provision of health services,*
>
> *(l) such other functions as are conferred or imposed on it by the regulations.*

123. Local Health District boards must establish the following committees:

    a. Audit and Risk;

    b. Finance and Performance,

    c. Quality and Safety;

    d. Medical and Dental Appointments Advisory (with at least one Credentials (Clinical Privileges) Subcommittee);[116]

    and, in addition, may establish other committees as it considers appropriate to provide advice or assistance to enable the Local Health District to perform its functions.[117]

124. Pausing there, it was submitted by NSW Health in the context of potential ways in which governance arrangements could be improved that "[r]eviewing [sic] employment arrangements for Chief Executives to ensure a single line of accountability to the Secretary NSW Health could also be undertaken".[118] That submission did not find support in the evidence. Indeed, many benefits of the present arrangements were identified. For example, Mr McLachlan (then Chief Executive of the Central Coast Local Health District) described the benefit of the current structures as follows:[119]

> *Well, it is a balance. I think the board helps us focus, particularly for the Central Coast, on the health needs, the services we provide and a range of things that are within our control to directly influence and manage for the Central Coast health services.*

[116] The purpose of which is to provide advice, and make recommendations to, the Chief Executive in relation to the appointment of visiting practitioners or staff specialists, and the clinical privileges that should be allowed to visiting practitioners and staff specialists: Exhibit H.2.51, NSW Health Corporate Governance and Accountability Compendium [5.2.2] [MOH.0010.0256.0001 at 0061].
[117] Exhibit A.6, NSW Health Model By-laws for Local Health Districts and Specialty Health Networks, Pts 5, 10 and 11 [SCI.0001.0002.0001 at 0004-0006, 0016-0019].
[118] Submission of NSW Health to the Special Commission of Inquiry into Healthcare Funding (7 November 2023) [193].
[119] Transcript of the Commission, 22 April 2024, T2310.37-47 (McLachlan).

> *The secretary and the ministry's role I actually see as a supportive one in helping to guide and direct both those health services for the coast, the network of health services across the whole of the state and for our population to access. So it is a dual responsibility.*

125. Other Chief Executives and board members gave evidence to similar effect.[120] None embraced a substantive change to the present arrangement.

126. Accordingly, the weight of the evidence does not support a conclusion that the current arrangements concerning the employment of Chief Executives should be altered.

c. Committees and Councils

127. Pursuant to s 39 of the *Health Services Act*, the Secretary has made Model By-Laws dealing with governance and management responsibilities.[121] Local Health Districts may make by-laws that adopt the provisions of the Model By-Laws. In doing so, they may only omit or modify aspects of the model by-laws with prior approval of the Secretary. However, Local Health Districts are free to make additional by-laws in respect of matters that are not covered by the Model By-Laws provided they are not inconsistent with them.[122]

128. There is no doubt that clinician input is an important aspect of the planning and operation of public health services across the State.

129. The Model By-Laws require Local Health Districts (and Specialty Health Networks) to establish certain "structures and forums to provide input for medical, nursing and allied health staff" including "Medical Staff Councils", "Medical Staff Executive Councils" and several "Clinical Councils".[123] Such structures have the following objectives:[124]

    a. facilitate effective patient care and services through a co-operative approach to the management and efficient operation of public hospitals between hospital executive management, clinical staff (including medical

[120] See, for example, Transcript of the Commission, 20 September 2024, T5521.28-5522.31 (Cohen/Carter/Treseder); Transcript of the Commission, 16 August 2024, T5035.14-46 (Clout/Hoskins); Transcript of the Commission, 24 April 2024, T2472.37-2473.33 (Danos); Transcript of Commission, 23 April 2024, T2329.39-2340.38 (MacLellan); Transcript of Commission, 22 April 2024, T2253.45-2254.44, T2268.19-33 (Schembri).
[121] Exhibit A.6, NSW Health Model By-laws for Local Health Districts and Specialty Health Networks [SCI.0001.0002.0001].
[122] *Health Services Act 1997* (NSW) s 39.
[123] Exhibit H.2.57, NSW Health, Model By-Laws for LHDs and specialty health networks, cl 21 [SCI.0001.0002.0001 at 0006].
[124] Exhibit H.2.57, NSW Health, Model By-Laws for LHDs and specialty health networks, cl 22 [SCI.0001.0002.0001 at 0006-0007].

practitioners, nurses, midwives and allied health practitioners) and clinical support staff; and

b. provide a forum for information sharing and to support feedback to staff on issues affecting the administration of the hospital(s) through the members of the councils.

130. The Model By-laws go on to provide for the establishment and operations of these structures. In relation to Medical Staff Councils, these provisions include that:[125]

a. the Chief Executive is to establish at least two Medical Staff Councils in the case of Local Health Districts and at least one Medical Staff Council in the case of Specialty Health Networks;

b. the Medical Staff Councils are to be comprised of all visiting practitioners, staff specialists, career medical officers and dentists appointed to the organisation or the hospital or hospitals the Council represents;

c. sufficient Medical Staff Councils should be established to ensure that all visiting practitioners, staff specialists, career medical officers and dentists of the Local Health District are members;

d. unless there is only one Medical Staff Council in a Local Health District or Specialty Health Network, there is then to be a Medical Staff Executive Council composed of representatives of the Medical Staff Councils for the hospitals under the control of an Local Health District (and representatives of the Mental Health Medical Staff Council), with the number of representatives from each Medical Staff Council depending on its size (generally one representative per 50 members). The function of the Medical Staff Executive Council is to provide advice to the Chief Executive and the Board of the Local Health District on "medical matters" and nominate medical practitioners for consideration as members of the Board. The chair of the Medical Staff Executive Council is a standing invitee to board meetings.[126]

[125] Exhibit H.2.57, NSW Health, Model By-Laws for LHDs and specialty health networks, cll 24-26 [SCI.0001.0002.0001 at 0007-0008].
[126] *Health Services Act 1997* (NSW) Sch 4A, cl 18(1)(b).

131. The Model By-laws also provide for the establishment of:[127]

a. Hospital Clinical Councils, for the purposes of providing "a structure for consultation with, and involvement of, clinical staff in management decisions impacting public hospitals and related community services". Hospital Clinical Councils include representatives of nursing and midwifery and allied health staff as well as medical staff and the general manager of the relevant hospital; and

b. Local Health District Clinical Councils and Specialty Health Network Clinical Councils, which include members from the relevant Hospital Clinical Councils as well as the Chair of the Medical Staff Executive Council, with the function of providing advice to the Board and Chief Executive on "clinical matters affecting the organisation".

132. In addition, the Chief Executive may establish such other committees and councils as may be required to assist the Local Health District to exercise its functions.[128]

133. As can be seen from that general overview of the arrangements created by the Model By-Laws, those structures endeavour to provide a range of opportunities and forums for clinician consultation and input. However, there is scope to review them in order to enhance and strengthen them, and to ensure that they are complimentary of each other, so as to better harness the benefits of meaningful clinician engagement. Those matters are addressed further below.

4.6.4 Service Agreements and Key Performance Indicators

134. Every year, the Secretary enters into a Service Agreement with each Local Health District.

135. Those Service Agreements set out a range of matters, including:[129] the initial budget allocation,[130] a range of key performance indicators (which are classified according to categories identified in the "Future Health" report and similar

[127] Exhibit H.2.57, NSW Health, Model By-Laws for LHDs and specialty health networks, cll 33-37, 43-44 [SCI.0001.0002.0001 at 0010-0013, 0015-0016].
[128] *Health Services Act 1997* (NSW) s 29B.
[129] See, for example, Exhibit B.23.27, Sample NSW Health Service Agreement 2023-2024 [MOH.0001.0288.0001]
[130] Which generally includes a breakdown of funding to be allocated on an activity or block basis, capital funding and own source revenue targets, and other program services that are to be purchased (for example, Transitional Aged Care Program services).

between districts),[131] particular performance deliverables with milestones and timeframes for reporting on progress, and a series of other provisions that are largely common to all Service Agreements.[132]

136. A Local Health District must, as far as practicable, exercise its functions in accordance with the terms of its Service Agreement with the Secretary.[133]

137. The NSW Health Performance Framework sets out the process by which performance will be monitored and managed. That process includes:[134]

    a. Monthly reports produced by the Ministry for each Local Health District/Specialty Health Network showing variations in their performance against key performance indicator targets and against their performance from the previous year;

    b. Monthly reports submitted by the Local Health District/Specialty Health Network showing cost, budgeting and forecast data and a narrative regarding the results, as well as progress with Efficiency Improvement Plans;

    c. Quarterly performance meetings between the Ministry and Local Health District/Specialty Health Network executives to review performance against service agreement key performance indicators, progress against Future Health strategic outcomes, priority areas impacting service delivery, and opportunities to collaborate to improve performance;

    d. An annual safety and quality account produced by the Local Health District/Specialty Health Network that documents outcomes for planned safety and quality initiatives, performance against key performance indicators, and commitment to consumer participation and staff culture; and

    e. An annual Aboriginal Health Progress Report.

138. Each Local Health District/Specialty Health Network is assigned a performance level from zero (nil performance concerns) to four (the recovery strategy for

[131] Transcript of the Commission, 28 November 2023, T90.10-42 (Lyons).
[132] Such as an overview of the legislative and governance framework that underpins the agreement, strategic priorities from the "Future Health: Strategic Framework", "Regional Health Strategic Plan", Government priorities and the NSW Health Outcome and Business Plan, A list of cross district referral networks, supra-LHD Services and nationally funded centres.
[133] *Health Services Act 1997* (NSW) s 126.
[134] Exhibit B.23.26, NSW Health Performance Framework (June 2023) p 8-9 [MOH.0001.0363.0001 at 0010-0011].

serious under-performance and changes that may be required to governance of the organisation).[135]

139. Performance is reviewed monthly through the Ministry's Performance Advisory Meeting, which makes recommendations to the Health System Performance Monitor Committee (consisting of the Secretary and Deputy Secretaries). When a decision is made to escalate or de-escalate the level for a Local Health District/Specialty Health Network, the Chief Executive and board chair is formally notified and given reasons for the change.[136] Ministry support is provided to assist performance recovery, with more frequent performance meetings and strategies, such as independent reviews, if an organisation reaches level three or four.[137]

4.7 Health Service Types

140. A range of services are delivered through the public health system, including public hospitals, community and preventative health services, supra-LHD and other statewide services. Some features of key service types are explored in the paragraphs below.

4.7.1 Public hospitals

141. There are more than 220 public hospitals in New South Wales,[138] ranging from Multi-Purpose Services (which are typically small facilities that integrate hospital and aged care services) to tertiary and quaternary facilities providing highly specialised care. They provide a mix of emergency, inpatient, medical, surgical, maternity, paediatric and sub-acute care in accordance with their role delineation.[139] The role delineation guide defines the support services, workforce and other minimum requirements to ensure safe delivery of clinical services, and is used for service planning and development by Local Health Districts and Specialty Health Networks.[140]

[135] Exhibit B.23.26, NSW Health Performance Framework (June 2023) p 10 [MOH.0001.0363.0001 at 0012].
[136] Exhibit B.23.26, NSW Health Performance Framework (June 2023) p 10 [MOH.0001.0363.0001 at 0012].
[137] Exhibit B.23.26, NSW Health Performance Framework (June 2023) p 11 [MOH.0001.0363.0001 at 0013].
[138] For the purposes of the *Health Services Act 1997* (NSW), a "public hospital" is a hospital controlled by a Local Health Districts or Statutory Health Corporations, recognised establishments of Affiliated Health Organisations, and hospitals controlled by the Crown (including the Minister or Health Administration Corporation)
[139] Exhibit A.1, Joint Report of Dr Nigel Lyons, Dr Kerry Chant AO PSM and Deb Willcox AM (17 November 2023) [68]-[70] [MOH.9999.0001.0001 at 0009].
[140] Exhibit N3.15, NSW Health Guide to the Role Delineation of Clinical Services (1 August 2024), pp 5 and 9 [SCI.0011.0598.0001 at 0005-0009]; Exhibit A.1, Joint Report of Dr Nigel Lyons, Dr Kerry Chant AO PSM and Deb Willcox AM (17 November 2023) [70] [MOH.9999.0001.0001 at 0009].

142. Public hospitals operate in networks with protocols to facilitate transfer of patients to higher-level services as required.[141]

143. In addition to acute care, public hospitals also provide secondary care, such as outpatient clinics, ambulatory care, and rehabilitation services.[142]

4.7.2 Community and preventive health services

144. Community health services are designed to complement care given in public hospitals through a range of services for early intervention, assessment, treatment, health maintenance and continuing care. The aim of such services is to ensure adequate clinical care, whilst attempting to address the social and environmental determinants of health.[143] The range of community health services delivered in the public health system include, mental health and drug and alcohol services, dental care, palliative care, Hospital in the Home and community nursing, child, youth and family health, Aboriginal health, women's health, refugee health and urgent care services.[144]

145. Preventive health services delivered by NSW Health include measures to support the prevention and worsening of disease, support healthy living in those with chronic disease, support healthy ageing, and of range of preventative actions to keep people healthy and well such as those designed to improve immunisation rates, health promotion in vulnerable cohorts, and early detection and treatment of health conditions.[145]

146. For what would appear to be largely historical reasons – stemming, perhaps, from the fact that they tend not to be delivered through hospitals – community and preventative health services have not received the same level of prioritisation within the public health system as the more traditional acute services; such as elective surgery and care delivered through emergency departments. Whilst this approach may be shaped by history, it cannot be assumed that it remains a logical or appropriate way to conceptualise the public

[141] Exhibit A.1, Joint Report of Dr Nigel Lyons, Dr Kerry Chant AO PSM and Deb Willcox AM (17 November 2023) [71] [MOH.9999.0001.0001 at 0009].
[142] Exhibit A.1, Joint Report of Dr Nigel Lyons, Dr Kerry Chant AO PSM and Ms Deb Willcox AM (17 November 2023) [73] [MOH.9999.0001.0001 at 0010].
[143] Exhibit A.1, Joint Report of Dr Nigel Lyons, Dr Kerry Chant AO PSM and Deb Willcox AM (17 November 2023) [74]-[76] [MOH.9999.0001.0001 at 0010].
[144] Exhibit A.1, Joint Report of Dr Nigel Lyons, Dr Kerry Chant AO PSM and Deb Willcox AM (17 November 2023) [79] [MOH.9999.0001.0001 at 0010].
[145] Exhibit A.1, Joint Report of Dr Nigel Lyons, Dr Kerry Chant AO PSM and Deb Willcox AM (17 November 2023) [80]-[88] [MOH.9999.0001.0001 at 0011]; Transcript of the Commission, 28 November 2023, T190.29-193.5, 224.38-226.3 (Willcox/Chant),

health system in New South Wales. As is touched on below, the Special Commission has received an overwhelming amount of evidence which points to the critical importance of prevention and health services delivered to outpatients (in the form of both primary and specialist care) to the wellbeing of the population of New South Wales, and the sustainability of its public health service.

4.7.3 Supra-LHD Services

147. Supra-LHD services are established to provide high cost, low volume, highly specialised services across district/network boundaries at a limited number of sites. Those highly specialised services are concentrated for a range of reasons, including the need to concentrate the skills and infrastructure required to deliver those services to ensure that it is available at all times and to provide best clinical outcomes for the patients accessing them.[146] The Ministry is responsible for planning and oversight of highly specialised services, which includes analysing and prioritising new health technologies proposed for statewide adoption.[147] As developed elsewhere in this outline, the evidence received by the Special Commission casts real doubt on the extent to which this planning and oversight occurs in practice; at least in relation to one of the supra-LHD services.

148. Recognised supra-LHD services are listed in annual service agreements and include:

    a. Intensive care services – adult, paediatric, neonatal, and mental health;

    b. Transplantation services – heart and lung, adult liver, blood, and marrow;

    c. Retrieval services – organ and extracorporeal membrane oxygenation;

    d. Stroke services – neurointerventional (endovascular clot retrieval) and Telestroke;

    e. High-risk Transcatheter Aortic Valve Implantation;

    f. Severe burn services;

[146] Transcript of the Commission, 28 November 2023, T81.15-82.37 (Lyons/Chant).
[147] Exhibit B.23.68, NSW Health New Technologies and Specialised Services Guideline, pp 3-5 [MOH.0001.0343.0001 at 0006-0008].

g. Genetic therapies;

h. CAR T-cell therapy;

i. State Spinal Cord Injury Service (adult and paediatric); and

j. Hyperbaric medicine.[148]

149. In addition, New South Wales hosts three nationally funded centres providing pancreatic, islet cell, and paediatric liver transplant services.[149]

4.8 Statutory Health Corporations

150. Statutory Health Corporations form part of the public health system and are constituted to enable health services and health support services to be provided across the State, rather than on an area basis.[150]

151. There are currently six statutory health corporations, those being:[151]

a. Agency for Clinical Innovation,

b. Bureau of Health Information,

c. Clinical Excellence Commission,

d. Health Education and Training Institute,

e. Justice Health and Forensic Mental Health Network,

f. The Sydney Children's Hospitals Network (Randwick and Westmead) (incorporating the Royal Alexandra Hospital for Children).

152. “Pillars” is the collective term used for five of the statutory health corporations, those being: the Agency for Clinical Innovation, Bureau of Health Information, Clinical Excellence Commission, Health Education and Training Institute and the Cancer Institute (NSW).[152]

153. Section 12 of the *Health Services Act* provides that the functions of the statutory health corporations are:

[148] Exhibit B.23.27, Sample Annual Local Health District/Specialty Health Network Service Agreement 2023-24, pp 8-12 [MOH.0001.0288.0001 at 0009-00012].
[149] Exhibit B.23.27, Sample Annual Local Health District/Specialty Health Network Service Agreement 2023-24, p 12 [MOH.0001.0288.0001 at 00012].
[150] *Health Services Act 1997* (NSW) ss 6(b) and 11(2).
[151] *Health Services Act 1997* (NSW) s 11(1) and sch 2.
[152] Exhibit A.56, Financial Requirements and Conditions of Subsidy (Government Grants) for year ending 30 June 2024, p 4 [SCI.0001.0048.0001 at 0005].

> *(a) to conduct public hospitals or health institutions or to provide health services or health support services (or any combination of these),*
>
> *(b) to conduct such public hospitals and health institutions and provide such health services or health support services as the Minister determines from time to time under section 53,*
>
> *(c) to achieve and maintain an adequate standard in the conduct of any public hospital or health institution, or the provision of a health service or health support service, under its control,*
>
> *(d) to ensure the efficient and economic operation of any such public hospital, health institution, health service or health support service,*
>
> *(e) to carry out such other functions as are conferred or imposed on it by or under this or any other Act or as may be prescribed by the regulations.*

154. Statutory Health Corporations are bodies corporate and may be either chief executive governed, board governed or a specialty network governed health corporation.[153] Irrespective of the particular governance arrangements of the Statutory Health Corporation, each has a Chief Executive. [154]

155. Each Statutory Health Corporation also has a "relevant authority".[155] The Minister is the relevant authority for board governed statutory health corporations, and the Secretary is the "relevant authority" for chief executive and specialty network governed statutory health corporations. The "relevant authority" may determine the role, functions and activities of facilities and services under the Statutory Health Corporation's control, and the Minister may give directions about starting, ceasing or restricting facilities or services if satisfied that it is in the public interest.[156]

156. The "relevant authority" may also make model by-laws for Statutory Health Corporations regarding governance and management functions.[157] As observed above, the Specialty Health Networks are subject to the same model by-laws as Local Health Districts.[158]

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[153] *Health Services Act 1997* (NSW) s 41.
[154] Appointed by the Secretary in relation to board governed and chief executive governed statutory health corporations, and by the specialty network board with the concurrence of the Secretary in relation to specialty network governed statutory health corporations: *Health Services Act 1997* (NSW) ss 51, 52A and 52G.
[155] *Health Services Act 1997* (NSW) ss 53, 58, 60 and 61.
[156] *Health Services Act 1997* (NSW) s 53.
[157] *Health Services Act 1997* (NSW) s 60.
[158] Exhibit A.6, NSW Health Model By-laws for Local Health Districts and Specialty Health Networks [SCI.0001.0002.0001].

157. Statutory Health Corporation boards have between five and 11 members who are appointed by the Minister.[159]

158. Statutory Health Corporations can enter into contracts or agreements for goods, equipment, machinery, materials, and services necessary for carrying out their functions. With the approval of the Secretary, they may also contract or agree with any person to provide a service for that person.[160] Two or more Statutory Health Corporations may agree to control and manage a public health facility, service or support service jointly, or one may agree to manage (or assist with managing) such a facility or service on behalf of the other.[161]

159. Like the Local Health Districts, Statutory Health Corporations cannot employ staff; their functions are again exercised through the NSW Health Service staff employed by the Government of New South Wales in the service of the Crown, not as part of the Public Service.[162]

160. The Specialty Health Networks (which also have a responsibility to ensure the needs of their catchment populations are met) have a relevantly similar planning function to that of Local Health Districts.[163]

4.8.1 The Agency for Clinical Innovation

161. The Agency for Clinical Innovation is a chief executive governed statutory health corporation.[164] Its primary role is to bring clinicians, consumers and system leaders together to design and implement innovations. Its functions include to:

    a. Work with public health organisations (and their consumers, clinicians, managers and leaders) to adopt evidence based clinical guidance, adapt best practice models to fit the local context, and collaborate on or lead new models of care and clinical guidance;

    b. Connect leaders across NSW Health to progress innovative ideas that will address local needs and the system agenda;

[159] *Health Services Act 1997* (NSW) s 49. The Chief Executive is an *ex-officio* member.
[160] *Health Services Act 1997* (NSW) s 58.
[161] *Health Services Act 1997* (NSW) s 53A.
[162] *Health Services Act 1997* (NSW) ss 45 and 115.
[163] Exhibit H.2.51, NSW Health Corporate Governance and Accountability Compendium [6.1] [MOH.0010.0256.0001 at 0066].
[164] *Health Services Act 1997* (NSW) s 41 and sch 2.

c. Identify and develop promising clinical innovations to pilot and scale across NSW Health;

d. Ensure that clinical guidance and models of care focus on priority challenges and: are evidence driven; are multidisciplinary; improve accessibility, effectiveness and efficiency of care including non-hospital settings; reduce unwarranted clinical variation; are well coordinated and promoted; and involve research and evaluation as to their implementation and impact;

e. Use and foster consumer and clinician engagement structures; and

f. Advise the Secretary and Ministry Executive Group, Health System Advisory Council and public health organisations.[165]

162. The Agency for Clinical Innovation has two clinical directorates and four expertise-focused directorates.[166]

163. The clinical directorates are:

a. Preserving and Restoring Interventions in Surgery and Medicine (PRISM), which focusses on acute health crises and their aftermath, and has streams for surgery and anaesthesia; intensive and urgent care; interventional medicine; and trauma, pain and rehabilitation; and

b. Care Across the Lifecycle and Society (known as CATALYST), which seeks to address the needs of groups with complex chronic or multiple conditions, with streams for child and family care; acute, aged and end of life care; chronic and long-term care; and integrated care and Aboriginal health.[167]

164. The "expertise-focussed" directorates are:[168]

a. The EVIDENCE directorate, which seeks to ensure the availability of sound evidence relating to clinical care, change and effectiveness through research, evidence synthesis, data analytics, evaluation and audit;

[165] Exhibit B.23.48, Determination of Functions - Agency for Clinical Innovation (21 August 2023) [MOH.0001.345.0001]; Exhibit B.3, Statement of Adjunct Professor Jean-Frédéric Levesque (30 January 2024), [22]-[23] [MOH.0001.0435.0001 at 0005]; Transcript of the Commission, 26 February 2024, T1020.24-43 and 1040.42-1041.7 (Levesque); Exhibit A.1, Joint Report of Dr Nigel Lyons, Dr Kerry Chant AO PSM and Deb Willcox AM (17 November 2023) [50] [MOH.9999.0001.0001 at 0007].
[166] Exhibit B.3, Statement of Adjunct Professor Jean-Frédéric Levesque (30 January 2024) [25]-[26] [MOH.0001.0435.0001 at 0006].
[167] Exhibit B.3, Statement of Adjunct Professor Jean-Frédéric Levesque (30 January 2024) [25] [MOH.0001.0435.0001 at 0006].
[168] Exhibit B.3, Statement of Adjunct Professor Jean-Frédéric Levesque (30 January 2024) [26] [MOH.0001.0435.0001 at 0006].

b. The System Transformation, Enablement and Patient Partnerships (STEP), which purports to provide clinical networks with expertise and coaches Local Health District staff in project co-design and implementation;

c. The Integrated Digital Enablement Accelerator (IDEA), which includes the patient reported measures program, clinician reported measures and virtual care teams; and

d. The Strategy, Communication and People Engagement (SCOPE), which attempts to help ensure consistent planning, prioritisation, communication and dissemination of projects and resources.

165. The Agency for Clinical Innovation must develop annual workplans and three-year strategic plans, and work consistently with these and its performance agreement with the Secretary.[169] The 2023-2026 strategy sets a path for the Agency for Clinical Innovation to build on core competencies while rebalancing to focus on transformational change in light of the Future Health Strategy, new Regional Health Division, pandemic response, and virtual care.[170] The strategic areas adopted by the 2023-2026 plan include:[171]

a. Taking a portfolio approach by refining the guidance processes for existing models of care and shifting to focus on evolving models through incremental change as well as supporting the system to transform;

b. Expanding current structures for agile clinician engagement, strengthening consumer voices, partnering with leaders to support system change, and connecting innovators with stakeholders to progress ideas;

c. Triangulating experiential, empirical and research evidence and enhancing the use, translation and dissemination of research; and

d. Building capability for redesign and implementation of change through various methods that can be tailored to local context and needs to facilitate innovation.

[169] Exhibit B.23.48, Determination of Functions of Agency for Clinical Innovation (31 August 2023) p 2 [MOH.0001.0345.0001 at 0002].
[170] Exhibit B.23.50, Agency for Clinical Innovation Strategy 2023-2026 p 2 [MOH.0001.0350.0001 at 0002]
[171] Exhibit B.23.50, Agency for Clinical Innovation Strategy 2023-2026 pp 7-13 [MOH.0001.0350.0001 at 0007-0013]

166. Whilst these are seemingly noble objectives, they are cast in terms – and at a level – which renders it almost impossible for an objective assessment ever to be made of the extent to which they might have been achieved; a common, and regrettable, feature of many plans and strategies received into evidence.

4.8.2 Bureau of Health Information

167. The Bureau of Health Information is a board governed statutory health organisation.[172] It has the following functions:

a. To prepare and publish reports about the performance of the public health system in New South Wales, describing its safety and quality, effectiveness, efficiency, and responsiveness to health needs;

b. To publish reports that benchmark performance of the New South Wales public health system with comparable health systems;

c. To maintain a website that has information, analysis, and tools for data analysis in relation to the performance of the New South Wales public health system;

d. To develop reports and tools that enable data analysis of the performance of health services, clinical units and clinical teams across the New South Wales public health system;

e. To analyse data, when requested by the Secretary, to facilitate the planning and oversight of effective, efficient and safe health services, and to meet national commitments (such as those under the National Health Reform Agreement);

f. To advise the Ministry as to the quality of existing datasets and development of enhanced information analysis and reporting for clinicians, the community and Parliament;

g. To undertake and/or commission research that supports the Bureau to perform its functions;

[172] *Health Services Act 1997* (NSW) s 41 and sch 2.

h. To liaise with other entities that report on health system performance in Australia and internationally.[173]

168. The Bureau of Health Information must also provide an annual report to the Minister and Parliament about the performance of the New South Wales public health system, and provide advice to the Minister and Secretary about issues arising from its functions.[174]

169. A key purpose of the Bureau of Health Information is to provide independent information about health system performance for the community, health professionals and policymakers.[175] In seeking to achieve that purpose, the Bureau has a stated focus on:[176]

a. Driving awareness and effective use of information with enhanced digital access and by leveraging its measurement expertise to advance value-based health care;

b. Delivering high value information through timely and meaningful analysis, data linkage and sharing, actionable insights based on advanced analytics, and new sources of information;

c. Sustaining trust in the Bureau of Health Information and its data with rigorous data management and governance and stakeholder engagement; and

d. Investing in its people and capabilities and encouraging innovation and improvement.

170. Without wishing to downplay the importance of the Bureau's existing reporting – or the critical role it plays in introducing transparency to the New South Wales public health system – the range of matters on which it regularly reports is limited. The Bureau's regular reporting is heavily focussed on care delivered in Emergency Departments and the timeliness of that care, waiting times for elective surgery and ambulance response times. This reporting fuels media interest in these particular aspects of the public health system and, as a

[173] Exhibit D.26, Determination of Functions - Bureau of Health Information (27 June 2018) [SCI.0008.0033.0001]; Exhibit A.1, Joint Report of Dr Nigel Lyons, Dr Kerry Chant AO PSM and Deb Willcox AM (17 November 2023) [51] [MOH.9999.0001.0001 at 0007].
[174] Exhibit D.26, Determination of Functions - Bureau of Health Information (27 June 2018) [SCI.0008.0033.0001].
[175] Exhibit D.27, Bureau of Health Information Strategic Plan 2023-2026, p 2 [SCI.0008.0036.0001 at 0003].
[176] Exhibit D.27, Bureau of Health Information Strategic Plan 2023-2026, pp 8-10 [SCI.0008.0036.0001 at 0009-0011].

consequence, these same matters are reflected in key performance indicators included in the Local Health District service agreements and resources are focussed upon them. Whilst each of these matters is important, they represent a narrow portion of the New South Wales public health system.

171. It is apparent that there is scope for the Bureau to report on a wide range of other measures that also provide indications of system performance (such as outpatient clinic waiting times), some of which may be as valuable as (if not more valuable than) those currently reported on, for the purposes of making an assessment of whether Local Health Districts are fulfilling their primary purpose.

4.8.3 Clinical Excellence Commission

172. The Clinical Excellence Commission is a board governed statutory health corporation.[177] Established in 2004 to reduce adverse events in public hospitals, support improvements in transparency and review of those events, and to promote improved clinical care, safety and quality, it is responsible for leading statewide safety and quality improvement.[178]

173. Its functions include to:[179]

    a. Provide system wide clinical governance leadership, and support the implementation and ongoing development of local quality systems;

    b. Develop policy and strategy for clinical quality and safety improvement in the public health system, and promote and support improvement in both public and private health services;

    c. Identify, develop and disseminate clinical quality and safety information, including by:

        i. working on programs with the Health Education and Training Institute; and

        ii. identifying priorities for, and promoting conduct of, relevant research;

[177] *Health Services Act 1997* (NSW) s 41 and sch 2.
[178] Exhibit B.2, Statement of Adjunct Professor Michael Nicholl (29 January 2024) [8] and [19] [SCI.0001.0262.0001 at 0001 and 0005]; Exhibit D.2, Statement of Adjunct Professor Michael Nicholl (8 April 2024) [26] [MOH.9999.0761.0001 at 0007]; Exhibit A.1, Joint Report of Dr Nigel Lyons, Dr Kerry Chant AO PSM and Deb Willcox AM (17 November 2023) [53] [MOH.9999.0001.0001 at 007].
[179] Exhibit B.24, Determination of functions - Clinical Excellence Commission (13 July 2022) [SCI.0003.0001.0385]; Exhibit D.2 Statement of Adjunct Professor Michael Nicholl (8 April 2024) [27] [MOH.9999.0761.0001 at 0007].

d. Review adverse clinical incidents in the New South Wales public health system and develop responses including:

   i. coordinating responses to incidents with system or statewide implications; and

   ii. advising the Secretary on urgent or emergent patient and staff safety issues in a clinical setting;

e. Monitor and report to the Secretary and Minister on clinical quality and safety processes and performance of public health organisations;

f. Provide the Bureau of Health Information with clinical quality and safety performance data for the public health system to support the Bureau's public reporting function;

g. Consult broadly with public health organisations, health professionals and members of the community in performing its functions; and

h. Provide advice to the Secretary and Minister on issues arising out of its functions.

174. The Clinical Excellence Commission also conducts improvement programs that address national and state priorities, and monitors data on clinical outcomes, incidents and healthcare acquired complications.[180] Rather than managing performance issues, it escalates any concerns to the Patient Safety First Unit within the Ministry, which then oversees the system response.[181]

175. The Clinical Excellence Commission is required to develop annual work plans and three-year strategic plans that link to NSW Health directions and priorities and must work in accordance with these plans and its performance agreement with the Secretary.[182] In its 2021-2024 strategic plan, the Clinical Excellence Commission defined three overarching system-level goals it sought to achieve – mature safety systems, increased safety capability and reduced preventable harm.[183] Four strategic priorities were identified to achieve those outcomes:[184]

[180] Exhibit D.2 Statement of Adjunct Professor Michael Nicholl (8 April 2024) [32] [MOH.9999.0761.0001 at 0010].
[181] Exhibit D.2 Statement of Adjunct Professor Michael Nicholl (8 April 2024) [30] [MOH.9999.0761.0001 at 0009].
[182] Exhibit B.24, Determination of functions - Clinical Excellence Commission (13 July 2022) [SCI.0003.0001.0385].
[183] Exhibit D.1.189, Clinical Excellence Commission Strategic Plan 2021-2024, p 5 [MOH.9999.0935.0001 at 0003].
[184] Exhibit D.1.189, Clinical Excellence Commission Strategic Plan 2021-2024 pp 6-7 [MOH.9999.0935.0001 at 0004].

a. Embedded safety systems in a whole care system model underpinned by governance, partnerships, roles and responsibilities, capability and capacity;

b. Safety intelligence using triangulated data, connected technologies and real-time insights to enable a predictive and proactive approach to safety;

c. Safety culture with accountability, meaning the whole care system (patients, staff, management and boards) is equipped to lead a positive culture and improve performance; and

d. Safety priorities and programs targeting priority groups and focus areas using programs, tools, resources and safety expertise, with flexibility and agility to respond to urgent needs.

176. Once again, these objectives are cast in language which makes it very difficult – if not impossible - to make any objective assessment of the extent to which they might have been achieved.

4.8.4 Health Education and Training Institute

177. The Health Education and Training Institute is a chief executive governed health corporation.[185]

178. The primary role of the Health Education and Training Institute is to assist public health organisations and training providers with the development and delivery of education and training across the New South Wales public health system. In undertaking that role, it seeks to ensure that education and training across the public health system supports safe, high quality, multidisciplinary team-based patient centred care; meets service delivery needs and operational requirements; and enhances workforce skills and productivity.[186]

179. The stated functions of the Health Education and Training Institute include:[187]

a. Designing, commissioning, conducting, coordinating, supporting and evaluating:

[185] *Health Services Act 1997* (NSW) s 41 and sch 2.
[186] Exhibit H.1.17.1, Determination of Functions - Health Education and Training Institute (13 September 2017) [SCI.0001.0060.0001]; Exhibit A.1, Joint Report of Dr Nigel Lyons, Dr Kerry Chant AO PSM and Deb Willcox AM (17 November 2023) [54] [MOH.9999.0001.0001 at 0007].
[187] Exhibit H.1.17.1, Determination of Functions - Health Education and Training Institute (13 September 2017) [SCI.0001.0060.0001].

i. education and training programs for clinical, corporate and support staff;

ii. management, leadership and professional development programs; and

iii. other education and training programs as directed by the Secretary;

b. Establishing governance for whole of health education and training programs for NSW Health;

c. Supporting reform and improve workforce capacity and quality of training by:

i. identifying and developing statewide programs for clinicians to become skilled teachers, trainers and supervisors;

ii. managing a registered training organisation;

iii. maintaining an online learning management system (including provision of quality assurance standards and resource development);

iv. statewide oversight, coordination and implementation of best practice learning including simulation and other technologies;

d. Maintaining registration as a higher education provider and develop and deliver higher education courses as appropriate for identified workforce needs;

e. Instituting, coordinating, overseeing and evaluating education and training networks that support service delivery needs, meet operational requirements, optimise education and training resource use and are consistent with clinical service networks to the extent possible;

f. Setting standards for education and training including medical training, and accredit institutions for prevocational education and supervision;

g. Establishing effective systems to meet statewide and national reporting requirements for education and training in the health sector;

h. Ensuring that education and training programs and other projects it undertakes:

i. are responsive to local needs;

ii. are cost effective, affordable and accessible;

iii. meet local and whole of system needs;

iv. support staff to provide safe, high quality, multidisciplinary team-based, patient centred care;

v. support inter-professional learning and team-based practice;

i. Working closely with local health districts, specialty networks and education providers; and

j. Providing advice to the Secretary on matters relevant to its functions.

180. The Health Education and Training Institute is also required to develop annual workplans and a three-year strategic plan that align with the statewide directions and priorities of NSW Health, and to work consistently with these plans and the performance agreement with the Secretary.[188]

181. In its strategic plan for 2023-2026, the Health Education and Training Institute identified the following strategic priorities and key initiatives:[189]

a. Targeted learning and pathways – through delivery of world class education and training for the NSW Health workforce to respond to system priorities;

b. Trusted partnerships – with collaborative relationships driving compassionate, sustainable and safe care and improved patient outcomes and experiences; and

c. Inspired people – supported to thrive and deliver exceptional learning outcomes.

182. Achievement of these apparent priorities is, once again, difficult – if not impossible – to measure. The evidence suggests that the Health Education and Training Institute is currently performing only a small number of its stated functions and doing so in a relatively limited way. As conceptualised, this pillar has a central role to play in the development, delivery and distribution of the

[188] Exhibit H.1.17.1, Determination of Functions - Health Education and Training Institute (13 September 2017) [SCI.0001.0060.0001].
[189] Exhibit H.1.46, Health Education and Training Institute Strategic Plan 2023-2026, pp 10-11 [MOH.0010.0045.0001 at 0006].

most important asset available to NSW Health; its workforce. It is not currently delivering on its full conceptual potential.

4.8.5 Cancer Institute NSW

183. The Cancer Institute NSW is also a statutory health corporation, created and constituted by its own statute.[190] It is the New South Wales Government's dedicated "cancer control agency".[191]

184. The board of the Cancer Institute NSW has five to 11 members (plus the Chief Cancer Officer, who is the Cancer Institute Chief Executive).[192] The board must establish an ethics committee, clinical services advisory committee, research advisory committee, and quality and clinical effectiveness advisory committee, and may establish other committees as appropriate.[193]

185. The objectives of the Cancer Institute NSW are to reduce the incidence of cancer, increase survival rates, improve quality of life, and be a source of expertise on cancer control for government, practitioners, researchers and the community.[194]

186. The Cancer Institute NSW may do whatever is necessary or convenient to give effect to those objectives, including but not limited to:[195]

    a. undertaking, commissioning or sponsoring cancer research, facilitating collaboration between cancer research bodies and providing a system for expeditious ethics approval;

    b. fostering evidence-based best practice to cancer control including through development or endorsement of guidelines and protocols;

    c. accrediting cancer prevention and screening programs;

    d. reviewing, evaluating and making recommendations about cancer programs and proposed initiatives, and developing or commissioning innovative programs for cancer control;

[190] *Cancer Institute (NSW) Act 2003* (NSW).
[191] Exhibit M.2, Statement of Professor Tracey O'Brien AM (12 November 2024) [7] [MOH.0011.0087.0001 at 0002].
[192] *Cancer Institute (NSW) Act 2003* (NSW) ss 7-8 and 10 and sch 1.
[193] *Cancer Institute (NSW) Act* 2003 (NSW) s 9.
[194] *Cancer Institute (NSW) Act 2003* (NSW) s 5; Exhibit M.2, Statement of Professor Tracey O'Brien AM (12 November 2024) [7] [MOH.0011.0087.0001 at 0002]; Exhibit A.1, Joint Report of Dr Nigel Lyons, Dr Kerry Chant AO PSM and Deb Willcox AM (17 November 2023) [52] [MOH.9999.0001.0001 at 0007].
[195] *Cancer Institute (NSW) Act 2003* (NSW) s 12.

e. investigating, evaluating and advising on complementary therapies having regard to their clinical effectiveness, safety and effect on quality of life for cancer patients;

f. obtaining and analysing information relating to cancer control;

g. disseminating information and advice about cancer control;

h. provide training and education relevant to cancer control;

i. consulting and collaborating with public health organisations, consumers, health professionals, government agencies, non-government organisations and others involved in cancer control;

j. engaging in fund raising activities for cancer-related purposes and establishing a publicly available register of the bodies that conduct any such fund raising activities;

k. advising and recommending to the Minister how funding designated for the Cancer institute is to be expended;

l. advising the Minister and Secretary as required on cancer control matters including assessing and reporting on cancer control services or programs in the public health system.

187. The Cancer Institute NSW leads and implements the statewide Cancer Plan in conjunction with the Ministry and other public health organisations.[196]

188. The Cancer Institute NSW also:[197]

a. collects feedback about patients' experiences;

b. provides information in multiple languages;

c. maintains an online specialist directory to facilitate referrals;

d. maintains a database for clinicians with evidence-based, peer-reviewed cancer treatment protocols and provides actionable data insights to the health system through its "Reporting for Better Cancer Outcomes" program; and

[196] Exhibit M.2, Statement of Professor Tracey O'Brien AM (12 November 2024) [11]-[12] [MOH.0011.0087.0001 at 0003]; *Cancer Institute (NSW) Act 2003* (NSW) s 12(i).
[197] Exhibit B.36, NSW Health Annual Report 2022-2023, pp 19, 25, 31, 44, 54 and 273 [SCI.0001.0059.0001 at 0028, 0034, 0040, 0053, 0063, and 0282].

e. delivers public education campaigns aimed at prevention, funds research fellowships, and prioritises value-based care with data analysis, benchmarking and providing support and information.

4.8.6 The Specialty Health Networks

189. There are two Specialty Health Networks that are also Statutory Health Corporations - the Sydney Children's Hospitals Network and the Justice Health and Forensic Mental Health Network. The St Vincent's Health Network is also referred to as a Specialty Health Network, although it is not a Statutory Health Corporation.

190. Specialty Health Networks have boards that are appointed by the Minister.[198] The membership and functions of those boards are comparable to those of the Local Health District boards, modified as required to accommodate the specialty network context.[199]

191. The Chief Executives of the Specialty Health Networks are, as with Local Health Districts, appointed by their respective boards with the concurrence of the Secretary.[200] The role and functions of Specialty Health Network Chief Executives are largely consistent with those of the Local Health District Chief Executives.[201]

192. The Specialty Health Networks have the same type of annual service agreement with the Secretary as the Local Health Districts and are (as noted above) subject to the same Model By-Laws.[202]

a. Sydney Children's Hospitals Network

193. The Sydney Children's Hospital Network is a specialty network governed health corporation.[203]

194. It is the largest provider of paediatric services nationally and includes Sydney Children's Hospital Randwick, the Children's Hospital at Westmead, the Newborn Paediatric Emergency Transport Service, Bear Cottage, the

[198] *Health Services Act 1997* (NSW) s 52F(1).
[199] *Health Services Act 1997* (NSW) s 52F(2).
[200] *Health Services Act 1997* (NSW) ss 23 and 52G(1).
[201] *Health Services Act 1997* (NSW) s 52G(2).
[202] Exhibit B.23.26, NSW Health Performance Framework (June 2023) p 7 [MOH.0001.0363.0001 at 0009]; Exhibit A.6, NSW Health Model By-laws for Local Health Districts and Specialty Health Networks, cl 43 [SCI.0001.0002.0001 at 0015].
[203] *Health Services Act 1997* (NSW) ss 12 and 41 and sch 2.

Children's Court Clinic, the virtualKIDS service, and the New South Wales Poisons Information Centre.[204]

195. The Network's core function is the provision of specialist paediatric services in an acute setting – rather than lower complexity acute care and community health services provided within Local Health Districts.[205] It does not have responsibility for the overall governance of paediatrics in New South Wales.[206]

196. The Sydney Children's Hospitals Network strategic plan for 2023-2027 sets six priorities, namely:[207]

    a. "What we do matters", which includes:

        i. Engaging with patients and families as equal partners, co-designing services and building on partnership models to deliver shared care closer to home;

        ii. Adopting evidence-based, contemporary and responsive models of care, and ensuring teams, systems and processes are integrated;

    b. "Safe care everywhere", which includes:

        i. Providing safe, high quality, evidence-based care including extension of integrated models to regional and rural areas through partnerships;

        ii. Strengthening and extending support during the transition to adult care;

    c. "Children and young people are healthy and well", which includes:

        i. Targeting priority populations and supporting diversity and inclusion;

        ii. Focusing on mental health and wellbeing, health promotion and harm prevention;

    d. "We value our people", which includes:

[204] Exhibit G.97, Statement of Cathryn Cox PSM (6 June 2024) [4]-[5], [10] [MOH.9999.1869.0001]; Exhibit B.36, NSW Health Annual Report 2022-2023, pp 277-278 [SCI.0001.0059.0001 at 0286-0287].
[205] Exhibit G.97, Statement of Cathryn Cox PSM (6 June 2024) [7] [MOH.9999.1869.0001].
[206] Exhibit G.97, Statement of Cathryn Cox PSM (6 June 2024) [12] [MOH.9999.1869.0001 at 0002].
[207] Exhibit G.22, Sydney Children's Hospitals Network Strategic Plan 2023-2027, p 6 [SCI.0010.0015.0001 at 0008].

i. Creating a unified organisation and advancing a values-based, learning culture;

ii. Prioritising collaboration and enabling leaders to engage with their people and build constructive, effective relationships and teams;

e. "Leverage research, innovation and technology – to transform clinical service delivery" which includes:

i. Embedding an integrated approach to education, research and innovation, and optimising systems, processes, governance and digital and data capability;

ii. Expanding the connection between research and practice, supported by data, and ensuring data and information are high quality, integrated and accessible;

iii. Leveraging partnerships with health and innovation partners;

f. "Sustainability for the future", which includes:

i. Prioritising sustainability across systems, procurement and practices;

ii. Focusing on environmental design that supports health and wellbeing;

iii. Aligning the workforce for the future to deliver on emerging opportunities.

4.8.7 Justice Health and Forensic Mental Health Network

197. The Justice Health and the Forensic Mental Health Network is a specialty network governed health corporation.[208]

198. The Network provides health care to adults and young people in contact with the forensic mental health and criminal justice systems in New South Wales. It is a statewide service, operating in more than 100 locations and provides care for approximately 13,000 individuals across custodial, inpatient and community settings. Its services include primary care, drug and alcohol, mental health,

[208] *Health Services Act 1997* (NSW) ss 12 and 41 and sch 2.

population health, women's and midwifery, oral health, Aboriginal health, and a range of allied health services.[209]

199. In a correctional setting, the Network is responsible for the provision health services to those in custody, monitoring the provision of health services in managed correctional centres, implementing measures to prevent the spread of infectious diseases in, or in relation to, correctional centres, maintain medical records of persons in custody, and provides advice to the Commissioner of Corrective Services on the "diet, exercise, clothing, capacity to work and general hygiene of inmates".[210]

200. The critical importance of this organisation must not be underestimated. It delivers care to a highly marginalised group, often dealt the poorest of hands by the social determinants of health and largely invisible to the public health system prior to their entering the correctional or forensic mental health environment. In these circumstances, the benefits to be obtained through compassionate and adequately resourced health interventions can greatly outstrip those seen in the wider population; into which the individuals will return at the conclusion of their detention.

4.9 Affiliated Health Organisations

201. Affiliated Health Organisations are not-for-profit, religious, charitable or other non-government organisations and institutions that provide health services and are recognised as part of the public health system under the *Health Services Act*.[211]

202. Their recognition in this way enables those organisations to be treated as part of the public health system for health facilities and services they control that contribute significantly to the system.[212] That approach was adopted to recognise the historically integral part the religious and charitable sector has played in the New South Wales public health system.[213]

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[209] Exhibit M.3, Statement of Wendy Hoey (13 November 2024) [4]-[5] [MOH.0011.0086.0001 at 0001-0002].
[210] *Crimes (Administration of Sentences) Act 1999* (NSW) s 236A; Transcript of the Commission, 19 November 2024, T6312.12-6314.37 (Hoey).
[211] Exhibit H.2.51, NSW Health Corporate Governance and Accountability Compendium [1.4] [MOH.0010.0256.0001 at 0018]; Exhibit B.36, NSW Health Annual Report 2022-2023, p 5 [SCI.0001.0059.0001 at 0014].
[212] *Health Services Act 1997* (NSW) s 13(3).
[213] New South Wales, *Parliamentary Debates,* Legislative Assembly, 12 November 1997, p 1606 <https://www.parliament.nsw.gov.au/Hansard/Pages/HansardResult.aspx#/docid/HANSARD-1323879322-16303> (accessed 25 November 2024).

203. Many Affiliated Health Organisations are engaged in a range of philanthropic activities, some of which are not related to the health system. As a result, Affiliated Health Organisations constitute part of the public health system only in relation to their recognised establishments or recognised services. It is in respect of those recognised establishments or services that the Affiliated Health Organisation falls within the meaning of a "public health organisation" for the purposes of the *Health Services Act*.

204. There are currently 13 Affiliated Health Organisations. Those organisations, and their recognised establishments and services, are as follows:[214]

Name of organisation	**Recognised establishment or recognised service**
Benevolent Society of New South Wales	Central Sydney Scarba Services. Early Intervention Program. Eastern Sydney Scarba Services. South West Sydney Scarba Services.
Calvary Health Care (Newcastle) Limited	Calvary Mater Newcastle.
Calvary Health Care Sydney Limited	Calvary Health Care Sydney.
Hammondcare Health and Hospitals Limited	Braeside Hospital, Prairiewood. Greenwich Hospital, Greenwich. Neringah Hospital, Wahroonga. Northern Beaches Palliative Care Service.
Karitane	Child and Family health services at Carramar, Fairfield, Liverpool and Randwick.
Mercy Hospitals NSW Ltd	Mercy Care Centre: Young, excluding Mount St Joseph's Nursing Home. Mercy Health Service Albury.
NSW Service for the Treatment and Rehabilitation of Torture and Trauma Survivors (STARTTS)	NSW Service for the Treatment and Rehabilitation of Torture and Trauma Survivors (STARTTS)
Royal Rehab	General rehabilitation services. Brain injury rehabilitation services. Spinal injury rehabilitation services. Extended care services.
Royal Society for the Welfare of Mothers and Babies	Tresillian Family Care Centres at Belmore, Broken Hill, Coffs Harbour,

[214] *Health Services Act 1997* (NSW) s 62(1) and sch 3.

Name of organisation	Recognised establishment or recognised service
	Dubbo, Lismore, Penrith, Queanbeyan, Taree, Willoughby and Wollstonecraft.
St Vincent's Hospital Sydney Limited	Sacred Heart Health Service. St Vincent's Hospital, Darlinghurst.
Stewart House	Child health screening services at Stewart House Preventorium, Curl Curl.
The College of Nursing	Nursing Education Programs conducted under agreement with the NSW Ministry of Health.
Uniting Church in Australia	War Memorial Hospital (Waverley).

205. Where an Affiliated Health Organisation has more than one recognised establishment or service or provides statewide or services of state significance, the Minister may declare them to be treated as a network for the purposes of receiving funding under the National Health Reform Agreement, with the consent of the Affiliated Health Organisation concerned.[215] The St Vincent's Health Network, which comprises St Vincent's Hospital and Sacred Heart Health Service in Darlinghurst, is the first (and only) networked Affiliated Health Organisation.[216]

206. Affiliated Health Organisations are required to achieve and maintain adequate standards, and to ensure efficient and economic operation, of their recognised establishments and services, and must also carry out such other statutory functions as are conferred or imposed upon them.[217]

207. The Minister may determine the role, functions and activities of any recognised establishment or service of an Affiliated Health Organisation, and give the necessary directions for that purpose, following consultation with the organisation having regard to its health care philosophy.[218]

208. Relevantly, s 127(2) of the *Health Services Act* provides that:

> *[i]n determining what amount of money (if any) is to be paid to each statutory health corporation and affiliated health organisation out of money*

[215] *Health Services Act 1997* (NSW) s 62B.
[216] Exhibit G.29, Statement of Anna McFadgen (4 June 2024) [14]-[18] [SVH.9999.0002.0001 at 0003].
[217] *Health Services Act 1997* (NSW) s 14.
[218] *Health Services Act 1997* (NSW) s 65.

appropriated from the Consolidated Fund, the Minister may have regard to such matters as the Minister thinks fit.

209. The Minister may delegate to Local Health Districts the function of determining the subsidy to be received by any Affiliated Health Organisation.[219] Significantly, for the purposes of exercising that function, the determination of subsidy to be paid to a Local Health District by the Minister is essentially assumed to include a sufficient amount to enable a Chief Executive to determine and pay a subsidy to Affiliated Health Organisations within the geographic boundaries of the Local Health District.[220]

210. Local Health Districts may enter into performance agreements with Affiliated Health Organisations in respect of their recognised establishments and recognised services. Any such agreement may include performance targets and provide for evaluation and review of results in relation to those targets.[221] Where performance agreements between an Affiliated Health Organisation and a Local Health District have been entered into:[222]

    a. Affiliated Health Organisations must, as far as practicable, exercise their functions in accordance with the performance agreement;

    b. Affiliated Health Organisations must report the results of their performance under the performance agreement during a financial year to the Local Health District within 3 months of the end of that financial year; and

    c. Local Health Districts must evaluate and review the results of the Affiliated Health Organisation's performance for each financial year under the performance agreement and report the results to the Secretary.

211. As a matter of practice, the purchasing of services from Affiliated Health Organisations has often been managed by the Local Health District in which they sit geographically, pursuant to local service agreements;[223] although these linkages are often historical and many of these Affiliated Health Organisations provide services that extend across Local Health District boundaries.

[219] *Health Services Act 1997* (NSW) s 129.
[220] Exhibit N.3.5, NSW Ministry of Health – Schedule of Delegates [MOH.9999.1089.0001 at 0020].
[221] *Health Services Act 1997* (NSW) s 130.
[222] *Health Services Act* 1997 (NSW) s 130(3)-(5).
[223] Exhibit D.8, Statement of Adjunct Professor Matthew Daly (9 April 2024) [16] [MOH.9999.0976.0001 at 0005].

212. As a networked Affiliated Health Organisation, the St Vincents Health Network has a service agreement with the Secretary.

213. The governance and funding of services provided by Affiliated Health Organisations is considered further below.

4.10 Other entities within the New South Wales public health system

4.10.1 Health Care Complaints Commission

214. The Health Care Complaints Commission is an independent statutory body.[224] Its functions include: dealing with complaints about care and treatment provided by practitioners and health services; investigating complaints; prosecuting cases before disciplinary bodies; providing advice to the Minister on complaint trends.[225] It operates through a co-regulatory model with the Health Professional Councils.

4.10.2 Health Professional Councils

215. In New South Wales a Health Professional Council for each registrable health profession participates in a co-regulatory model with the Health Care Complaints Commission to manage complaints about practitioners, rather than this being done by national boards as in other States.[226]

216. The Health Professional Councils Authority, an administrative unit of the Health Administration Corporation, supports the Councils to perform their regulatory and legislative functions under the National Registration and Accreditation Scheme.[227]

4.10.3 Mental Health Review Tribunal

217. A quasi-judicial body established under the *Mental Health Act 2007* (NSW) to make and review orders, and hear some appeals, relating to clinical management of people with mental illness.[228]

[224] Established by the *Health Care Complaints Act 1993* (NSW).
[225] Exhibit H.2.51, NSW Health Corporate Governance and Accountability Compendium [1.6.1] [MOH.0010.0256.0001 at 0021].
[226] Exhibit H.2.51, NSW Health Corporate Governance and Accountability Compendium [1.6.2] [MOH.0010.0256.0001 at 0021].
[227] Exhibit H.2.51, NSW Health Corporate Governance and Accountability Compendium [1.6.3] [MOH.0010.0256.0001 at 0021-0022].
[228] Exhibit H.2.51, NSW Health Corporate Governance and Accountability Compendium [1.6.2] [MOH.0010.0256.0001 at 0021].

4.10.4 NSW Mental Health Commission

218. The NSW Mental Health Commission has been established under the *Mental Health Commission Act 2012* (NSW).

219. It is responsible for drafting a strategic plan for the mental health system and monitoring its implementation, as well as promoting knowledge, undertaking research and advocating for prevention and early intervention strategies.[229]

[229] Exhibit H.2.51, NSW Health Corporate Governance and Accountability Compendium [1.6.4] [[MOH.0010.0256.0001 at 0022].

5 THE HEALTH NEEDS OF THE POPULATION AND THE SHIFTING BURDEN OF DISEASE

220. Over recent decades, there have been notable changes in population demographics and disease burden. The population is growing and living longer but, as a cohort, is ageing and living with greater levels of chronic disease. Each of those matters is likely to have a significant impact on the demand for health services in the future, not only in respect of volume, but also service type.[230]

5.1 The growing and ageing population

221. In 2000, the population of New South Wales was approximately 6.5 million[231], rising to 8.2 million in 2020.[232] By 2061, the projected population will be 11.5 million people.[233] This represents an increase of approximately 40%, attributable to projected natural increases (i.e., births exceeding deaths) and net migration.[234]

222. The median age in New South Wales in 2000 was almost 36 years.[235] In 2021, it was 38 years and by 2061, the median age is projected to be 44 years.[236] By 2061, 25% of New South Wales's population is expected to be aged 65 or older.[237] The ageing population has been attributed to the combination of "sustained low fertility and increasing life expectancy".[238] The latter is in turn "driven by general improvements in living standards, hygiene and nutrition…[and] advances in medical technology".[239]

223. By 2041, the distribution of ageing populations will be predominantly focused in regional New South Wales.[240] Meanwhile, metropolitan areas will see slower growth due to the intra-state movement of younger people to pursue

[230] See, for example, Exhibit A.1, Joint Report of Dr Nigel Lyons, Dr Kerry Chant AO PSM and Deb Willcox AM (17 November 2023) [102]-[144] [MOH.9999.0001.0001 at 0014-0022]; Exhibit A.14, NSW Health Future Health Report, pp 7-9 [SCI.0001.0010.0001 at 0007-0009].
[231] Australian Bureau of Statistics, *Population by Age and Sex, New South Wales, Jun 2000* (Catalogue No 3234.1, 8 December 2006) <https://www.abs.gov.au/AUSSTATS/abs@.nsf/Lookup/3235.1Main+Features1Jun%202000?OpenDocument> (accessed 30 November 2024)
[232] Exhibit A.20, NSW Intergenerational Report 2021-2022 (June 2021) [SCI.0001.0016.0001 at 0008].
[233] Exhibit A.20, NSW Intergenerational Report 2021-2022 (June 2021) [SCI.0001.0016.0001 at 0008].
[234] Exhibit A.20, NSW Intergenerational Report 2021-2022 (June 2021) [SCI.0001.0016.0001 at 0008].
[235] 'Twenty years of population change', Australian Bureau of Statistics (Web Page, 17 December 2020) <https://www.abs.gov.au/articles/twenty-years-population-change> (accessed 30 November 2024).
[236] Exhibit A.20, NSW Intergenerational Report 2021-2022 (June 2021) [SCI.0001.0016.0001 at 0026].
[237] Exhibit A.20, NSW Intergenerational Report 2021-2022 (June 2021) [SCI.0001.0016.001 at 0026].
[238] 'Twenty years of population change', Australian Bureau of Statistics (Web Page, 17 December 2020) <https://www.abs.gov.au/articles/twenty-years-population-change> (accessed 30 November 2024).
[239] Exhibit A.20, NSW Intergenerational Report 2021-2022 (June 2021) [SCI.0001.0016.0001 at 0030].
[240] Exhibit A.20, NSW Intergenerational Report 2021-2022 (June 2021) [SCI.0001.0016.0027].

educational and employment opportunities, as well as younger people migrating to New South Wales.[241]

224. As the "second driver of population change" in New South Wales, net migration is projected to average 48,000 people per year until 2061, leading to an overall population increase of almost in that period. Approximately 90% of those migrating to New South Wales are expected to settle in the metropolitan areas of Sydney, Newcastle and Wollongong.[242]

5.2 Life expectancy

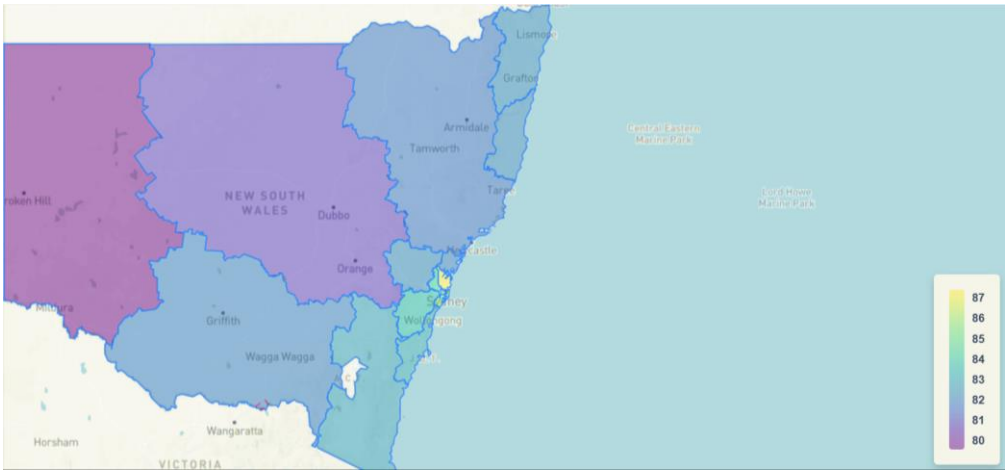
225. Life expectancy in Australia is among the highest in the world and, in recent decades, has risen significantly.[243]

226. For example, the life expectancy for a girl born in 2020 is approximately 86 years, and for a boy is 82 years, up from 79.2 and 72.7 years respectively, for those born in 1984. By 2061, life expectancy is projected to increase to approximately 92 years and 89 years for women and men, respectively.[244]

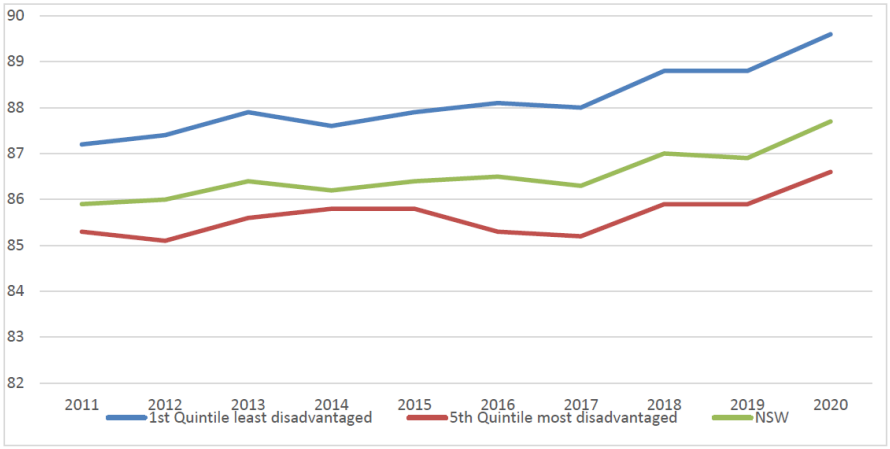
227. However, the growth in life expectancy has not been consistent and varies according to where people live and their socio-economic status. People from low socio-economic areas or who experience disadvantage are recognised as being more likely to suffer poor health outcomes.[245]

228. The following diagram highlights the differences in life expectancy of those living in each of the Local Health Districts. It can be seen that those residing in metropolitan areas generally have a higher life expectancy than those living in regional or remote New South Wales:[246]

[241] Exhibit A.20, NSW Intergenerational Report 2021-2022 (June 2021) [SCI.0001.0016.0001 at 0003, 0027 and 0032].
[242] Exhibit A.20, NSW Intergenerational Report 2021-2022 (June 2021) [SCI.0001.0016.0001 at 0032].
[243] Exhibit A.20, NSW Intergenerational Report 2021-2022 (June 2021) [SCI.0001.0016.0001 at 0025].
[244] Exhibit A.1, Joint Report of Dr Nigel Lyons Dr Kerry Chant AO PSM and Deb Willcox AM (17 November 2023) [120] [MOH.9999.0001.0001 at 0015]; Exhibit A.20., NSW Intergenerational Report 2021-2022 (June 2021) [SCI.0001.0016.0001 at 0008].
[245] Exhibit A.1, Joint Report of Dr Nigel Lyons, Dr Kerry Chant AO PSM and Deb Willcox AM (17 November 2023) [127] [MOH.9999.0001.0001 at 0020].
[246] Centre for Epidemiology and Evidence, 'Life expectancy at birth for Persons by LHD for 2018', *HealthStats NSW* (Web page) <https://www.healthstats.nsw.gov.au/r/118399> (accessed 30 November 2024).



229. Similarly, the following graph demonstrates that those with the lowest levels of socio-economic disadvantage have seen the greatest increase in their life expectancy, whilst the most disadvantaged group had the lowest:[247]



230. The 2022 Parliamentary Inquiry into Health Outcomes and Access to Health and Hospital Services in Rural, Regional and Remote New South Wales found:[248]

a. rural, regional and remote patients have significantly poorer health outcomes, greater incidents of chronic disease and greater premature deaths when compared to their counterparts in metropolitan areas;

b. residents in rural, regional and remote New South Wales have inferior access to health services;

[247] A.1, Joint Report of Dr Nigel Lyons, Dr Kerry Chant AO PSM and Deb Willcox AM (17 November 2023) [106] [MOH.9999.0001.0001 at 0015].
[248] Exhibit E.37, Legislative Council, Health Outcomes and Access to Health and Hospital Services in Rural, Regional and Remote New South Wales, 2022, p xii [SCI.0009.0077.0001 at 0014].

c. rural, regional and remote medical staff are significantly under resourced when compared with their metropolitan counterparts, exacerbating health inequities; and

d. the Commonwealth/State divide in terms of the provision of health funding has led to both duplication and gaps in service delivery.

5.3 The First Nations population: a different story

231. The correlation between lower life expectancy and disadvantage is most keenly demonstrated in the significantly lower life expectancy of First Nations people. In this respect, life expectancy at birth in 2015-17 for Aboriginal and Torres Strait Islander people in New South Wales was 70.9 years for men and 75.9 years for women, compared with 80.3 years and 84.6 years for all men and women.[249]

232. It has been suggested that the greatest contributors to that massive discrepancy are chronic disease (in particular, cardiovascular disease), mental health, diabetes and cancers.[250]

5.4 The shifting burden of chronic disease

233. While life expectancy is increasing, so too is the burden of chronic disease.

234. Since 2011, chronic diseases have become the leading cause of illness, disability and death in Australia, accounting for approximately 90% of all deaths.[251] Almost half of all Australians live with at least one chronic condition[252], and almost a quarter live with two or more.[253] Those with multiple chronic health conditions often require complex care needs, which frequently necessitate regular interaction across the primary and acute care settings, and with multiple clinicians.

235. Due to Australia's aging population, the burden of chronic disease has changed over time. The past two decades have seen an increases in type 2 diabetes,

[249] Exhibit A.20, NSW Intergenerational Report 2021-2022 (June 2021) [SCI.0001.0016.0001 at 0031]; see also Stephen Duckett, *The Australian Health Care System* (Oxford University Press, 6th ed, 2022) p 39.
[250] Exhibit A.1, Joint Report of Dr Nigel Lyons, Dr Kerry Chant AO PSM and Deb Willcox AM (17 November 2023) [129] [MOH.9999.0001.0001 at 0001 at 0020].
[251] Exhibit A.1, Joint Report of Dr Nigel Lyons, Dr Kerry Chant AO PSM and Deb Willcox AM (17 November 2023) [116] [MOH.9999.0001.0001 at 0001 at 0017].
[252] 'Health conditions prevalence', *Australian Bureau of Statistics* (Web page, 15 December 2023) <https://www.abs.gov.au/statistics/health/health-conditions-and-risks/health-conditions-prevalence/latest-release> (accessed 30 November 2024).
[253] Exhibit A.1, Joint Report of Dr Nigel Lyons, Dr Kerry Chant AO PSM and Deb Willcox AM (17 November 2023) [116] (MOH.9999.0001.0001 at 0017].

dementia, mental health and self-inflicted injuries, and osteoarthritis, while rates of coronary heart disease, stroke, lung cancer and bowel cancer have decreased.[254]

236. These shifts in chronic disease can also be attributed to the implementation of lifestyle changes. For example, tobacco use has steadily declined in the past 20 years,[255] contributing to the decline in lung and heart-related diseases such as coronary heart disease and some cancers. Increased screening and early interventions have also contributed to a decrease in the incidence of some cancers.

237. Obesity is a major contributor to chronic diseases, including type 2 diabetes, chronic kidney disease, coronary heart disease, and osteoarthritis.[256] The increase in the prevalence of those conditions corresponds with the increasing proportion of the adult population who are overweight and obese. In this respect, the percentage of people aged 16 and over who are overweight or obese now accounts for 59% of the New South Wales population, compared to 46% in 2002.[257] However, the percentage of New South Wales children aged 5-16 years who are overweight or obese has remained relatively stable since 2007, at 23%.[258]

238. Over 40% of the New South Wales population, or 2.5 million people, have a lifetime mental illness, such as an anxiety disorder or substance use disorder.[259] The number of adults experiencing high or very high psychological distress has also increased – in 2013, those adults accounted for 9.8% of the population, rising to 18.1% in 2023.[260]

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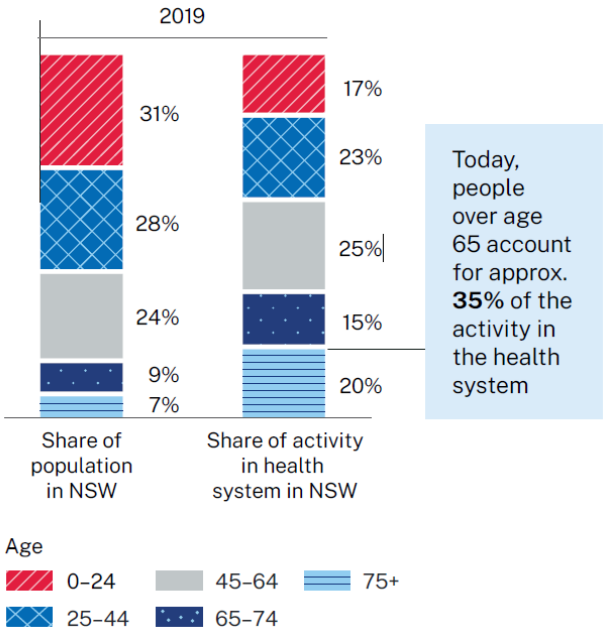
[254] Exhibit A.1, Joint Report of Dr Nigel Lyons, Dr Kerry Chant AO PSM and Deb Willcox AM (17 November 2023) [119] [MOH.9999.0001.0001 at 0018].
[255] Exhibit N.3.18, Centre for Epidemiology and Evidence, 'Daily smoking in adults', *HealthStats NSW* (Web page) <https://www.healthstats.nsw.gov.au/r/111277> (accessed 30 November 2024) [SCI.0011.0709.0001]. However, the relatively recent emergence of e-cigarettes or vapes has contributed to a significant increase in vaping in NSW: Exhibit N.3.19 Centre for Epidemiology and Evidence, 'E-cigarette use (vaping)', *HealthStats NSW* (Web page) [SCI.0011.0710.0001] <https://www.healthstats.nsw.gov.au/r/118400> (accessed 30 November 2024).
[256] Exhibit N.3.20, Australian Institute of Health and Wellbeing, 'Overweight (including obesity), (Report, 24 November 2021) <https://www.aihw.gov.au/reports/burden-of-disease/abds-2018-interactive-data-risk-factors/contents/overweight-including-obesity> (accessed 30 November 2024) [SCI.0011.0711.0001].
[257] Exhibit N.3.21 Centre for Epidemiology and Evidence, 'Overweight and obesity in adults', *HealthStats NSW* (Web page) <https://www.healthstats.nsw.gov.au/r/114335> (accessed 30 November 2024) [SCI.0011.0712.0001]
[258] Exhibit N.3.22, Centre for Epidemiology and Evidence, 'Overweight and obesity in children', *HealthStats NSW* (Web page) <https://www.healthstats.nsw.gov.au/r/111282> (accessed 30 November 2024) [SCI.0011.0713.0001].
[259] Exhibit N.3.23, 'National Study of Mental Health and Wellbeing', *Australian Bureau of Statistics* (Web page, 5 October 2023) <https://www.abs.gov.au/statistics/health/mental-health/national-study-mental-health-and-wellbeing/2020-2022> (accessed 30 November 2024) [SCI.0011.0714.0001].
[260] Exhibit N.3.24, Centre for Epidemiology and Evidence, 'High or very high psychological distress in adults by Period', *HealthStats NSW* (Web page) <https://www.healthstats.nsw.gov.au/r/118402> (accessed 30 November 2024) [SCI.0011.0715.0001].

239. Cancer diagnosis and relative survival rates also support a conclusion that people are living longer but are doing so with chronic disease or health conditions. For example, half of the New South Wales population is expected to be diagnosed with cancer by the age of 85, although only one in six dies from it.[261]

5.5 The impact of population changes on the demand for health services

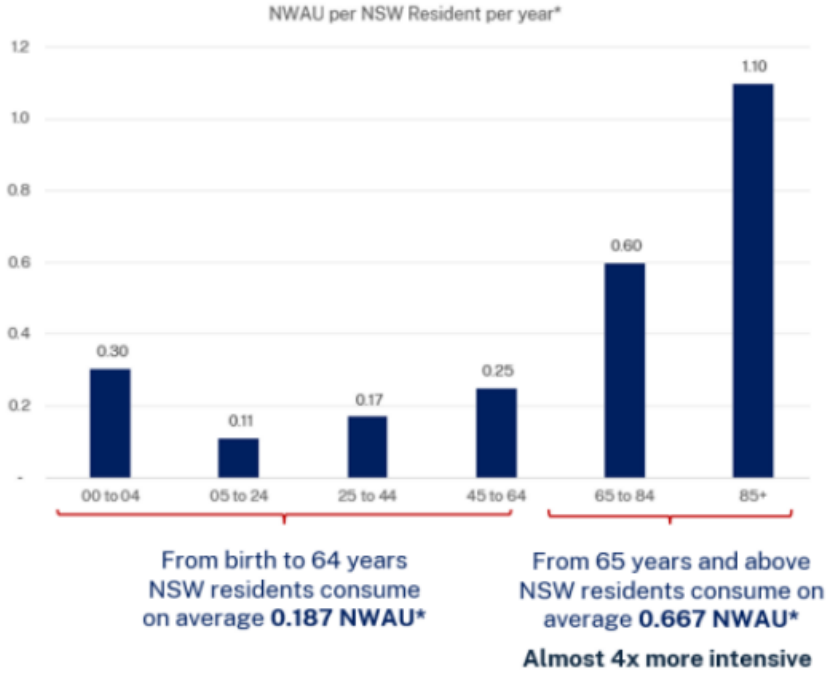
240. Population changes and the shift in the burden of disease are having – and will continue to have – a significant impact on the demand for health services.

241. At a general level, most interaction with the health system occurs later in life. As a result, the highest users of health services in New South Wales are those aged 65 and above, who in 2019 constituted approximately 19% of the population, but accounted for 35% of the activity in the health system: [262]



242. Not only do those who are 65 and older account for a significant portion of activity in the public health system, but the care they require is generally more intensive than the rest of the population:[263]

[261] Exhibit N.3.25 Cancer Institute NSW, 'Cancer incidence, mortality and relative survival', *Cancer Statistics NSW* (Web page) <https://www.cancer.nsw.gov.au/research-and-data/cancer-data-and-statistics/data-available-now/cancer-statistics-nsw/cancer-incidence-mortality-survival> (accessed 30 November 2024) [SCI.0011.0716.0001].
[262] Exhibit A.14, Future Health: Guiding the next decade of care in NSW 2022-2032 (May 2022) [SCI.0001.0010.0001 at 0008].
[263] Exhibit M.6, Statement of Neville Onley, Alfa D'Amato and Steven Carr (14 November 2024) [52(b)] [MOH.0011.0091.0001 at 0013].



243. By 2031, it is predicted that people over 64 will account for 45% of healthcare activity, and 25% of that cohort will have two or more chronic diseases requiring more complex care. [264]

244. The confluence of an aging population, increases in life expectancy, and living more years with chronic disease (and, in some instances, multiple chronic conditions) will challenge the public health system in New South Wales in a significant way. That challenge has been described in the "Future Health" report as follows (emphasis added): [265]

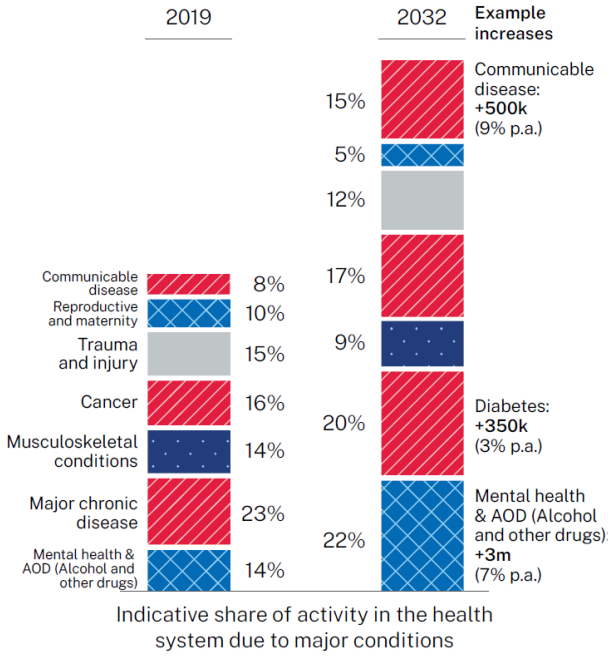
> *Nearly 90% of citizens come into contact with the broader health system of NSW each year, and of those, about 30% are accessing NSW Health services.*
>
> *Population growth, demographic changes and changes in the disease burden mean that the* ***increasing volume of demand is outpacing the population growth rate****, especially in mental health, diabetes and other chronic diseases. Communicable disease, such as that experienced by COVID-19, is also predicted to have high growth over the next decade.* ***By 2032, 1.5 million more people will need to access care from the NSW health system compared with today****.*

[264] Exhibit A.14, Future Health: Guiding the next decade of care in NSW 2022-2032 (May 2022) [SCI.0001.0010.0001 at 0008].
[265] Exhibit A.14, Future Health: Guiding the next decade of care in NSW 2022-2032 (May 2022) [SCI.0001.0010.0001 at 0008].

*In addition, the **complexity of demand is increasing due to an increase in the number of co-morbidities**. By 2032, at least 750,000 more people will have multiple chronic diseases, increasing the complexity of care they need.*

If the health system continues to rely on the current models of care to address this increase and more complex demand, indicative estimates suggest future demand would drive 1.7 times more activity in the health system by 2032.

245. Those demand pressures will be reflected in an increase in activity, but also in the mix of services required to meet that demand. Demand for services related to chronic disease will increase significantly in that same period:[266]



5.6 Responding to those challenges

246. There is a need to adapt existing systems of service delivery and funding across the public health system, and across government more broadly to meet those challenges.[267] Dr Lyons described the path to meeting some of them in the following way:[268]

I think it's work in progress. It's clearly something that we would say where there needs to be an even greater shift over time for the whole system. I think the whole system is geared up around that historical approach of

[266] Exhibit A.14, Future Health: Guiding the next decade of care in NSW 2022-2032 (May 2022) [SCI.0001.0010.0001 at 0008].
[267] Transcript of the Commission, 29 November 2023, T200.16-24 (Chant), T217.14-224.35 (Chant/Lyons/Willcox); Exhibit E.47, Statement of Mark Spittal (30 April 2024) [5]-[6] [MOH.9999.1202.0001 at 0001-0003].
[268] Transcript of the Commission, 29 November 2023, T220.31-221.11 (Lyons).

episodic care, around a specific condition, and as the demography has changed and people are living with those chronic conditions, as they are frail and elderly now and have difficulty in accessing services, the whole service system needs to shift in its approach.

But examples of where we've done work like shifting the focus is some of the work that has been done around health care hubs, which is where we are focused on delivering a range of services in one place and integrating that with other providers. So where primary care might be working alongside our community health teams, allied health, there might be diagnostic services available as well. We need to see more investment in those types of holistic care in the community setting that enable as much care to be provided for somebody who has a range of different conditions and needs to be accessing a range of different providers and services, who can have their diagnosis made without being referred to an emergency department, who can have arrangements for ongoing care with a specialist arranged outside of a hospital setting.

That's the shift we need to see and we need to see more investment in those sorts of health service delivery arrangements.

247. Part of that response needs to include measures to ensure that the healthcare system is simpler to navigate – for both clinicians and patients – to ensure that care is being delivered in the appropriate setting and in an integrated way.[269] An increased focus on preventative health measures to combat the increasing prevalence of chronic disease accompanied by early interventions to manage and treat those conditions is key to the sustainability of the broader health system. Such measures, however, go beyond system benefits, as they offer obvious advantages to individual patients and society at large, including through increased economic productivity within the population.[270]

248. The response also requires the prioritisation of preventative care across all settings, as well as earlier interventions, to ensure the mix of investment responds to the needs of the community in a sustainable way.[271] Whilst the benefit of increased investment in such measures may not deliver an immediate return or be readily measurable by key performance indicators, there can be no

[269] Transcript of the Commission, 29 November 2023, T221.39-222.25 (Lyons); Exhibit A.1, Joint Report of Dr Nigel Lyons, Dr Kerry Chant AO PSM and Deb Willcox AM (17 November 2023) [136]-[137] [MOH.9999.0001.0001 at 0022]; Exhibit A.53, Joint Report of Alfa D'Amato and Deb Willcox (27 November 2024) [29] [MOH.9999.0005.0001 at 0016].
[270] Transcript of the Commission, 29 November 2022, T223.13-25 (Chant/Lyons/Willcox)
[271] Transcript of the Commission, 29 November 2023, T 222.34-223.5 (Chant/Lyons), T227.33-228.5 (Lyons).

doubt that it is a necessary aspect of ensuring system sustainability into the future.

249. In this respect, over a century ago, Lord Dawson observed that "[p]reventive and curative medicine cannot be separated on any sound principle, and in any scheme of medical services must be brought together in close co-ordination".[272] The need to ensure the mix of preventative and acute services responds appropriately to the needs of the wider population is as important now as it was then. The evidence before the Special Commission supports the conclusion that renewed focus on those matters is now required to ensure that the wider system responds to the needs of the population, is well placed to meet current and future challenges, and remains sustainable.

250. There is also a need for more targeted funding and a consistency of approach when addressing preventative strategies, both within health and more widely across government services and initiatives.

251. The Special Commission has heard that one of the major challenges faced in this area in the past has been the tendency of government to shift its focus toward and away from preventative health and, even within different areas of prevention, from one strategy to another. Acknowledging that decisions relating to the deployment of significant financial resources ultimately lie within the domain of government, the issue is too important for it to be ignored or, worse still, for money devoted to prevention to be wasted by shifting focus, or abandoning initiatives, before their benefits are realised.[273]

252. The evidence before the Special Commission points unequivocally to the importance of prevention to the long-term wellbeing of the New South Wales population and the sustainability of its public health system. Having regard to the proportion of the State's budget devoted to health annually and the significant economic impact that a failure in the prevention space will likely have on the State's economy – not to mention the profound and positive impact that a successful prevention strategy could have on the health and welfare of the population – significant long term investment in this area is clearly warranted.

[272] Exhibit N.3.1, Interim Report on the Future Provision of Medical and Allied Services, Consultative Council on Medical and Allied Services (1920), Section 1 [SCI.0011.0606.0001 at 0004].
[273] See, for example, Transcript of the Commission, 11 December 2024, T6922.34-6923.5 (Mastersson).

253. While NSW Health has a central role to play in driving the State's preventative health strategy, to succeed it must be approached as a whole of government endeavour. Having said that, there are a range of preventative health measures which are classically within the domain of NSW Health and are most effectively delivered through the public health system; including, vaccination strategies and screening programs. While prevention work of this type should remain the responsibility of NSW Health, it is also able to play a leadership role in the coordination and prioritisation of other preventative health strategies. NSW Health is best placed to assess the array of potential prevention strategies available and help to determine which provides "best bang for buck" from a preventative health perspective. It has the skills and data required to assess the outcomes of preventative strategies and the expertise required to determine how long a strategy must be persisted with before it becomes sufficiently embedded to produce what will often be multigenerational benefits.

5.7 Conclusion and key recommendations

254. Preventative health should be identified as a standing, whole of government, priority against which New Policy Proposals brought forward by all branches of government are to be assessed in the sense discussed elsewhere in this outline.

255. All decisions regarding the implementation and advancement of that priority should be informed and coordinated by a multiagency, multidisciplinary body led by NSW Health – ideally by the Chief Health Officer/Population and Public Health Division – with a view to maximising the long-term health benefits achieved through such decisions and insulating them, to the best extent possible, from the vagaries of the political cycle.

6 FUNDING HEALTH SERVICES

256. Although it is the taxpayer that ultimately funds the public healthcare system,[274] the majority of that funding flows through government funding streams, both Commonwealth and State. In this respect, the overall NSW Health Budget is comprised of amounts appropriated from the Consolidated Fund (i.e., State government funding), contributions received from the Commonwealth government pursuant to the National Health Reform Agreement, or other grants, and revenue from other sources, including as patient fees.[275]

257. As a proportion of the New South Wales State budget, the allocation to the health portfolio has consistently been the largest throughout the last decade.[276] For example, for 2024-2025, $35.08 billion was allocated to the health portfolio,[277] representing approximately 28.7% of the overall State budget.[278]

258. The shared nature of the responsibility for funding is a significant driver of the fragmented nature of the wider healthcare system within Australia. It regularly leads to unhelpful debates concerning where ultimate responsibility for funding and delivery of services lies. Those debates can persist even in the context of shrinking or failing private markets in the primary and aged care sectors and the resultant increase in pressure on public hospital services; particularly in the post-pandemic era. Patients, clinicians, and the wider community have little interest in arguments of those kinds; unsurprisingly, their prime interest lies in timely access to appropriate and high quality care of the type required to meet their health needs.

259. That those challenges remain a constant feature of the wider system is somewhat surprising given the repeated commitment by Commonwealth, State, and Territory governments to create and deliver a healthcare system in Australia

[274] Through taxation or private expenditure - whether that be by way of direct payment to the healthcare providers, private health insurance premiums, or philanthropy: See, for example, the discussion in Duckett, S; *The Australian Healthcare System*; 6th Ed; Oxford University Press; p 58.
[275] Exhibit D.4, Statement of Adjunct Professor Alfa D'Amato (9 April 2024) [13] [MOH.9999.0763.0001 at 0003].
[276] Exhibit N3.32, NSW Budget Paper No. 2 2014-2015, p 5.16 [SCI.0011.0741.0001 at 0106]; Exhibit N3.33, NSW Budget Paper No. 1 2015-2016, p 5.20 [SCI.0011.0722.0001 at 0078]; Exhibit N3.34, NSW Budget Paper No. 1 2016-2017, p 5.17 [SCI.0011.0723.0001 at 0057]; Exhibit N3.35, NSW Budget Paper No. 1 2017-2018, p 6.12 [SCI.0011.0724.0001 at 0079]; Exhibit N3 .36, NSW Budget Paper No. 1 2018-2019, p 6.11 [SCI.0011.0730.0001 at 0088]; Exhibit N3.37, NSW Budget Paper No. 1 2019-2020, p 5.16 [SCI.0011.0725.0001 at 0075]; Exhibit N3.38, NSW Budget Paper No. 1 2020-2021, p 5.19 [SCI.0011.0726.0001 at 0100]; Exhibit N3.39, NSW Budget Paper No. 1 2021-2022, p A1.12 [SCI.0011.0727.0001 at 0112]; Exhibit N3.40, NSW Budget Paper No. 1 2022-2023, p A1.12 [SCI.0011.0728.0001 at 0121]; Exhibit N3.31, NSW Budget Paper No. 1 2023-2024, p A1.12 [SCI.0011.0729.0001 at 0110].
[277] $31.87 billion for expenses and $3.20 billion for capital expenditure: Exhibit N3.43, NSW Budget Paper No. 2 2024-2025, [SCI.0011.0570.0001 at 0001].
[278] Exhibit N3.42, NSW Budget Paper No. 1 2024-2025, p 97 [SCI.0011.0545.0001 at 0098].

that is equitable and benefits the population. That commitment can be most clearly seen in the National Healthcare Agreement and the Addendum to the National Health Reform Agreement for the period 2020 to 2025.[279]

260. Those agreements set out the joint aspirations of the Commonwealth, State, and Territory governments, and provide the framework in which they jointly fund public services.

6.1 The National Healthcare Agreement

261. The National Healthcare Agreement defined the objectives, outcomes and performance indicators and sought to outline the roles and responsibilities that guide the Commonwealth and the States and Territories in delivering services across the health sectors.[280] It encompassed the collective aspirations of the Commonwealth, State, and Territory governments in relation to prevention, primary and community care, hospital and related care and aged care.[281]

262. In doing so, it recorded the agreement of all governments that Australia's health system should: be shaped around the health needs of patients, their families and communities; focus on the prevention of disease and injury, the maintenance of health and not just the treatment of illness; support an integrated approach to health promotion, the prevention of illness and injury and the diagnosis and treatment of illness across the continuum of care; and provide all Australians with timely access to quality health services based on their needs, regardless of where they live.[282]

263. In entering into the agreement, the Commonwealth, States and Territories committed to improving the health outcomes for all Australians and to ensure the sustainability of the Australian health system.[283]

264. Significantly, it set out that it was the shared responsibility of the Commonwealth and the States and Territories to fund public hospitals; public health activities; mental health services; subacute care; Aboriginal and Torres Strait Islander

[279] Ex A.28, Addendum to the National Health Reform Agreement 2020-2025 (2020) [SCI.0001.0024.0081]. References to the National Health Reform Agreement are references to its current iteration as reflected in the 2020-2025 addendum unless indicated to the contrary.
[280] Ex A.25, National Healthcare Agreement (2012), p 1 [SCI.0001.0021.0001].
[281] Ex A.25, National Healthcare Agreement (2012), cl 10 [SCI.0001.0021.0001 at 0003].
[282] Ex A.25, National Healthcare Agreement (2012), cl 4 [SCI.0001.0021.0001 at 0002].
[283] Ex A.25, National Healthcare Agreement (2012), cl 12 [SCI.0001.0021.0001 at 0003].

health services; health research; health workforce training; emergency response; and blood and blood products.[284]

265. In addition to those shared funding responsibilities:

a. the States and Territories were obliged to fund community health, capital infrastructure and service planning; ambulance services; food and safety regulation; environmental health and disability services;[285] and

b. the Commonwealth was obliged to fund access to private medical care, access to pharmaceuticals; access to private health insurance; education of health professionals; health services for eligible veterans; residential, community and flexible aged care services; the purchase of vaccines under national immunisation arrangements; and community controlled Aboriginal and Torres Strait Islander primary healthcare.[286]

266. The National Healthcare Agreement also identified the respective responsibilities of the States and Territories beyond direct funding obligations, including: providing public patients with access to all services provided to private patients in public hospitals; service planning, capital works and adequate infrastructure for public hospitals and community health facilities to meet future needs; the funding of patient assistance, travel schemes and ensuring that public patients are aware of how to access those schemes; ensuring that eligible persons who have elected to be treated as private patients have done so on the basis of informed consent; providing and funding pharmaceuticals for public and private patients and for public non-admitted patients in public hospitals (except where Pharmaceutical Reform Agreements are in place); maintaining a public patients hospital charter and an independent complaints body and ensure that patients are aware of how to access these provisions; providing public health, community health, public dental; delivering vaccines purchased by the Commonwealth under national immunisation arrangements and health promotion programs; continuing to provide an agreed

[284] Ex A.25, National Healthcare Agreement (2012), cl 24 [SCI.0001.0021.0001 at 0006].
[285] Ex A.25, National Healthcare Agreement (2012), cl 26 [SCI.0001.0021.0001 at 0007].
[286] Ex A.25, National Healthcare Agreement (2012), cl 29 [SCI.0001.0021.0001 at 0008].

national minimum data set; and providing clinical training programs for undergraduates and specialists.[287]

267. The obligations of the Commonwealth under the National Healthcare Agreement, beyond those directly related to funding, included the obligation to: ensure equitable and timely access to affordable primary healthcare services, predominantly through general practice; assist in reducing pressure on hospital emergency departments through the provision of funding for primary healthcare services; ensure equitable and timely access to affordable specialist services; provide reliable, timely and affordable access to safe, cost-effective and high-quality medicines; ensure that there are sufficient affordable age care services so that people needing this care can access it when it is required, regardless of geographic location; regulate the private health insurance industry and subsidise access to private health insurance; facilitate access by Aboriginal and Torres Strait Islander people to mainstream health services to help close the health equity gap; provide data to the States and Territories on a quarterly basis concerning private health insurance coverage levels, the Medicare benefits schedule and the pharmaceutical benefits scheme by specified geographic area; continue to provide data for an agreed national minimum data set; purchase vaccines for the delivery by states and territories through national immunisation agreements; and provide vocational training programs for general practitioners.

6.2 The National Health Reform Agreement

268. The National Health Reform Agreement set out the parties' commitments in relation to public hospital funding, public and private hospital performance reporting, local governance of elements of the health system, policy and planning for primary healthcare and rearrangement of responsibilities for aged care.

269. It was first entered into in 2012 and has been the subject of subsequent amendments. The current iteration is reflected in the addenda for the period 2020-2025.[288] Following a mid-term review conducted by Rosemary Huxtable

[287] Ex A.25, National Healthcare Agreement (2012), cl 27 [SCI.0001.0021.0001 at 0007-0008].
[288] Ex A.28, Addendum to the National Health Reform Agreement 2020-2025 (2020) [SCI.0001.0024.0001].

AO PSM in 2023,[289] negotiations are currently underway in relation to the content of that agreement for the five-year period between 2025 and 2030. In this respect, on 6 December 2023, National Cabinet endorsed the following objectives to be explored through that negotiation:[290]

a. Increasing Commonwealth National Health Reform Agreement contributions to 45% over a maximum of a 10-year glide path from 1 July 2025, with an achievement of 42.5% before 2030;

b. Replacing the 6.5% national funding cap with a more generous approach that applies a cumulative cap over the period 2025 to 2030, and includes a first year 'catch-up' growth premium; and

c. Commencing the renegotiation of the National Health Reform Agreement Addendum to embed long-term, system-wide structural health reforms, including considering the Mid-Term Review findings.

270. Relevantly for present purposes, the National Health Reform Agreement identifies the three primary means by which the Commonwealth provides funding to the States and Territories in respect of public hospital services, namely:

a. Activity based funding;

b. Block funding; and

c. Public health funding.

271. The criteria for determining the amount of Commonwealth funding pursuant to the National Health Reform Agreement are complex and involve several formulae. What follows is a high-level summary of each category of funding provided for in the National Health Reform Agreement. It is not intended to be exhaustive, or to seek to identify each integer or consideration that applies in that process.

272. In general terms, the State is required to determine the amount it will pay for public hospital services and functions, and in doing so required to fund the

[289] Exhibit N.3.17, Rosemary Huxtable AO PSM, Mid-Term Review of the National Health Reform Agreement Addendum 2020-2025 (24 October 2023) [SCI.0011.0585.0001].
[290] Exhibit N.3.44, National Health Funding Body Annual Report 2023-2024 (September 2024), p 19 [SCI.0011.0745.0001 at 0029].

balance of the cost of those services that is over above the amount of the Commonwealth's contribution.[291]

6.2.1 Activity based funding

273. Activity based funding is the primary mechanism by which the Commonwealth's contribution to funding public hospital services is to be determined, except where that method would be neither practicable nor appropriate.[292] It is "a way of funding hospitals for the number and mix of patients they treat" and is said to "account for some patients being more complex and resource intensive to treat than others".[293]

274. Services that are eligible to attract Commonwealth funding (whether by way of activity based funding, or by block funding) are those that are "in scope". The range of "in scope" activities include:[294]

    a. all admitted services, including hospital in the home programs;

    b. all emergency department services provided by a recognised emergency department service; and

    c. other outpatient, mental health, subacute services and other services that could reasonably be considered a public hospital service.

275. The Independent Hospital and Aged Care Pricing Authority is responsible for maintaining and publishing a list of services that are eligible for Commonwealth funding.[295] The States and Territories and the Commonwealth may also enter into bilaterial agreements which determine the scope of particular activates that will attract Commonwealth funding.[296]

276. As observed above, the formulae applied in arriving at the amount of the Commonwealth funding contribution on an activity basis are complex, and it is beyond the scope of this outline to engage in a detailed consideration of them. However, at a very high level, the Commonwealth funds 45% of the "efficient

[291] Exhibit A.28, Addendum to the National Health Reform Agreement 2020-2025 (2020), cll A.89-A.95 [SCI.0001.0024.0001 at 0028].
[292] Exhibit A.28, Addendum to the National Health Reform Agreement 2020-2025 (2020), cl A.3 [SCI.0001.0024.0001 at 0014].
[293] Exhibit H.2.51, NSW Health Corporate Governance and Accountability Compendium (May 2024) [7.2.2] [MOH.000.0256.0001 at 0078].
[294] Exhibit A.28, Addendum to the National Health Reform Agreement 2020-2025 (2020), cl A.17 [SCI.0001.0024.0001 at 0017].
[295] Exhibit A.28, Addendum to the National Health Reform Agreement 2020-2025 (2020), cll A.18-A.24 [SCI.0001.0024.0001 at 0017].
[296] Exhibit A.28, Addendum to the National Health Reform Agreement 2020-2025 (2020), cll A.25-A28 [SCI.0001.0024.0001 at 0018].

growth of ABF service delivery", subject to the operation of the national funding cap.[297] "Efficient growth" consists of "the national efficient price for any changes in the volume of services provided" and "the growth in the national efficient price of providing the existing volume of services".[298]

277. The Commonwealth's contribution for all activity based funding categories is then determined by adding:[299]

    a. *previous year amount— the Commonwealth's contribution rate for the relevant State in the previous year, multiplied by the volume of weighted ABF Services provided in the previous year, multiplied by the national efficient price in the previous year;*

    b. *price adjustment—the volume of weighted services provided in the previous year, multiplied by the change in the national efficient price relative to the previous year, multiplied by 45 per cent; and*

    c. *volume adjustment—the net change in volume of weighted services provided in the relevant State (relative to the volume of weighted ABF Services provided in the previous year), multiplied by the national efficient price, multiplied by 45 per cent.*

278. The Commonwealth's funding contribution is paid at the "Commonwealth contribution rate".[300] The effect of the national funding cap is that growth in the Commonwealth's total funding contribution is capped at 6.5% per year.[301]

279. It has been suggested that through the application of the national funding cap, "the Commonwealth effectively shifts funding risk to the States irrespective of whether cost growth is within States' control, with the impact being the Commonwealth's contribution rate is effectively reduced."[302]

280. Although it has been the ambition under successive National Health Reform Agreements that the Commonwealth share of funding of public hospital services would increase, it has, in fact declined over time and now accounts for

[297] Exhibit A.28, Addendum to the National Health Reform Agreement 2020-2025 (2020), cl A.6 [SCI.0001.0024.0001 at 0015].
[298] Exhibit A.28, Addendum to the National Health Reform Agreement 2020-2025 (2020), cl A.6 [SCI.0001.0024.0001 at 0015].
[299] Exhibit A.28, Addendum to the National Health Reform Agreement 2020-2025 (2020), cl A.34 [SCI.0001.0024.0001 at 0019].
[300] Exhibit A.28, Addendum to the National Health Reform Agreement 2020-2025 (2020), cl A.35 [SCI.0001.0024.0001 at 0019].
[301] Exhibit A.28, Addendum to the National Health Reform Agreement 2020-2025 (2020), cl A.5 [SCI.0001.0024.0001 at 0015].
[302] Exhibit A.1, Joint Report of Dr Nigel Lyons, Dr Kerry Chant AO PSM, and Deb Willcox AM (17 November 2023) [9] [MOH.9999.0001.0001 at 0002].

approximately 38-39% of the total costs of delivering public hospital services in New South Wales.[303]

6.2.2 Block funding

281. Block funding is provided to support: public hospital functions other than patient services, and public patient services that are not appropriately funded through activity based funding (including small rural hospitals).

282. Where services or functions eligible for Commonwealth funding are more appropriately funded through block grants, the Commonwealth funds 45% of growth in the efficient cost of providing those services or performing those functions. The efficient cost is to be determined annually by the Independent Health and Aged Care Pricing Authority, "taking account of changes in utilisation, the scope of services provided and the cost of those services, to ensure the Local Hospital Network has the appropriate capacity to deliver the relevant block funded services and functions."[304]

283. The amount of the Commonwealth's contribution by way of block funding is the total of the previous year's payment, plus 45% of the growth in the efficient cost of providing the services.[305] Block funding is also subject to the 6.5% cap.

284. The Independent Health and Aged Care Pricing Authority, in consultation with jurisdictions, maintains the criteria for block funding and identifies whether hospital services and functions are eligible for block funding, or a mix of block and activity based funding.[306]

6.2.3 Public Health Funding

285. The Commonwealth provides "public health activity funding" to the states and territories, and the states have "full discretion" over the application of that funding in achieving the outcomes set out in the National Healthcare Agreement.[307]

[303] Transcript of the Commission, 18 November 2024, T6282.1-6 (Kastoun/D'Amato).
[304] Exhibit A.28, Addendum to the National Health Reform Agreement 2020-2025 (2020), cll A.7, A.49 and A.55 [SCI.0001.0024.0001 at 0015, 0022, and 0023]
[305] Exhibit A.28, Addendum to the National Health Reform Agreement 2020-2025 (2020), cl A.50 [SCI.0001.0024.0001 at 0022].
[306] Exhibit A.28, Addendum to the National Health Reform Agreement 2020-2025 (2020), cl A.51 [SCI.0001.0024.0001 at 0022].
[307] Exhibit A.28, Addendum to the National Health Reform Agreement 2020-2025 (2020), cll A.14-A.15 [SCI.0001.0024.0001 at 0017].

6.2.4 Bi-lateral/multi-lateral agreements

286. The National Health Reform Agreement contemplates that State and Territory governments may enter into agreements with the Commonwealth pursuant to which the Commonwealth provides funding that would not otherwise flow under the terms of the National Health Reform Agreement.

6.3 Other sources of Commonwealth funding

287. Although (understandably) much attention was placed on the arrangements set out in the National Health Reform Agreement in the context of the Commonwealth's contribution to the funding of public hospital services, that is not the only other source of Commonwealth funding that is available to be allocated to health.

288. Relevantly, the Commonwealth Grants Commission distributes revenue raised by the Commonwealth from the Goods and Services Tax among the States and Territories.[308]

289. It is not necessary to set out a detailed consideration of the process engaged in by the Commonwealth Grants Commission. For present purposes, it is sufficient to observe that the allocation process undertaken by the Grants Commission takes into account the fact that States differ in their capacity to raise revenue and when assessing a State's ability to pay for a standard set of services (which include public hospital services).[309] In assessing a State's ability to pay for those standard services, "specific purpose payments" received from the Commonwealth – such as those made under the National Health Reform Agreement - are accounted for, such that "[t]o the extent that a State receives above average per capita amounts of PSPs, less GST is required to equalise its fiscal capacity. Conversely, if a State receives below average amounts of PSPs, it requires more GST."[310] Thus, the more a State receives from a specific purpose payment (such as funding under the National Health

[308] See, for example, Exhibit M.20, Report by Professor Stephen Duckett, 'Report on Commonwealth-State financial arrangements in health care' (13 September 2023) [21] ff [SCI.0011.0500.0001 at 0004].
[309] Exhibit M.20, Report by Professor Stephen Duckett, 'Report on Commonwealth-State financial arrangements in health care' (13 September 2023) [42] [SCI.0011.0500.0001 at 0007].
[310] Commonwealth Grants Commission, *Report on GST Revenue Sharing Relativities: 2020 Review. Volume 1 — GST revenue sharing relativities for 2020 21* (Canberra: CGC, 2020), p 15; Exhibit M.20, Report by Professor Stephen Duckett, 'Report on Commonwealth-State financial arrangements in health care' (13 September 2023) [47] [SCI.0011.0500.0001 at 0008].

Reform Agreement), the less Goods and Services Tax revenue it needs to pay for those standard set of services.[311]

290. As a result, it cannot be assumed that increases in funding received from the Commonwealth pursuant to the National Health Reform Agreement (for example, through an increase in activity, or an expansion of "in scope" services) will result in corresponding increases to the overall funding envelope that flows to New South Wales from the Commonwealth.

6.4 Setting the NSW Health budget

291. The budget allocated to the health portfolio is determined through the annual State budget process.

292. That process involves portfolio Ministers preparing budget submissions, which set out the funding requirements and priorities for the years ahead. As related to the health portfolio, budget submissions ordinarily include an analysis of the expenditure base for the forthcoming year, and the extent to which budgeted expenditure growth is sufficient to meet service demand, together with the identification of new policy proposals and an analysis of overall system performance, risks and pressures.[312] The content of budget submissions may also be informed by directions from government; so as to align new policy measures with government priorities or advance proposals that are supported by savings measures.[313]

293. The Ministry is responsible for the preparation of the NSW Health budget submission, which commences in about November and culminates with the submission being provided to Treasury the following February/March.[314]

294. Treasury then prepares advice for Government and, in doing so, proposes a "base" funding requirement for the year ahead.[315]

[311] Exhibit M.20, Report by Professor Stephen Duckett, 'Report on Commonwealth-State financial arrangements in health care' (13 September 2023) [49] [SCI.0011.0500.0001 at 0008]; Transcript of the Commission, 20 November 2024, T6492.32-45, T6493.21-34 (Duckett).
[312] Exhibit A.53, Joint Report of Adjunct Professor Alfa D'Amato and Deb Willcox AM (27 November 2023) [53]-[63] [MOH.9999.0005.0001 at 0011] (although New Policy Proposals can be submitted at any time for consideration by government); Exhibit M.6, Statement of Neville Onley, Alfa D'Amato and Steven Carr (14 November 2024) [41]-[43] [MOH.0011.0091.0001 at 0010]; Transcript of the Commission, 18 November 2024 T6248.9-27 (Cornelius).
[313] Exhibit M.1, NSW Treasury Submission (11 November 2024) [2.7]-[2.11] [TRY.0001.0001.0001 at 0004].
[314] Exhibit M.1, NSW Treasury Submission (11 November 2024) [2.7]-[2.11] [TRY.0001.0001.0001 at 0004].
[315] Transcript of the Commission, 18 November 2024, T6248.22-27 (Cornelius).

295. Treasury also provides advice to government on the level of funding required to support services that are critical to maintain current service outcomes[316], and on the merit of new policy proposals or service enhancements including as to how these proposals align with Government's broader priorities and fiscal capacity.[317]

296. At a general level, the health budget is determined by reference to a "base" level of funding. The historical origins of the base figure – including the size and shape of the heath system that it was at least conceptually supposed to have supported – are unknown by those currently charged with making recommendations as to setting the health budget.[318] As such, and as a matter of practical reality, the adjusted "base" figure cannot be seen as any sort of attempt to deliver to the Ministry the funds required to deliver any particular health service but rather reflects the somewhat arbitrary portion of the annual budget that is to be devoted to the health system; perhaps informed by an understanding of what it would cost for the public health system to continue for another year in its existing form.

297. That "base" reflects an annualised budget, to which adjustment is then made for specific initiatives, activity growth and escalations, and takes into account savings initiatives and any ceasing activities.[319] The "base" component of the budget is set by the application of an "annual escalation rate" – initially set at 4%, comprising 2.5% for cost growth, and 1.5% for service growth - prior to the impact of any particular policy decisions.[320] An allocation for capital works based on identified projects is also made, together with some funding for specific programs.[321]

298. Pausing there, whilst the environment pre-COVID was relatively stable such that system was able to deliver and drive efficiencies simultaneously which were then reinvested to undertake more activity, the post-pandemic

[316] Transcript of the Commission, 18 November 2024, T6260.45-6261.4 (Cornelius).
[317] Transcript of the Commission, 18 November 2024, T6261.6-14 (Cornelius).
[318] Transcript of the Commission, 18 November 2024, T6250.24-38 (Kastoun/Cornelius).
[319] Exhibit A.53, Joint Report of Adjunct Professor Alfa D'Amato and Deb Willcox AM (27 November 2023) [11] [MOH.9999.0005.0001 at 0003]; Exhibit A.1, Joint Report of Dr Nigel Lyons, Dr Kerry Chant AO PSM, and Deb Willcox AM (17 November 2023) [26] [MOH.9999.0001.0001 at 0004]; Transcript of the Commission, 18 November 2024 T6250.6-7 (Cornelius).
[320] Exhibit M.1, NSW Treasury Submission (11 November 2024) [2.1]-[2.4] [TRY.0001.0001.0001 at 0003].
[321] Exhibit A.1, Joint Report of Dr Nigel Lyons, Dr Kerry Chant AO PSM, and Deb Willcox AM (17 November 2023) [28] [MOH.9999.0001.0001 at 0004].

environment is such that it is now doubtful that the "base" on which NSW Health's budget is set remains a reliable foundation or starting point.

299. Obviously enough, in setting the overall State budget, the Expenditure Review Committee considers budget submissions and proposals from each of the portfolios and must consider competing demands for funding. Fundamentally, the allocation of budgets across each of the portfolios (including health) is a matter for the government of the day.[322]

300. Amounts that are ultimately appropriated from the Consolidated Fund in respect of the health portfolio are distributed to the Minister in the annual appropriations legislation and are paid to the Ministry.[323] Those amounts are then distributed across the NSW Health agencies, and together with any Commonwealth or other funding sources, comprise the funding available to those agencies.

6.4.1 Setting the budgets of NSW Health agencies

301. The Minister determines amount (if any) that will be paid from that which is appropriated from the consolidated fund to a public health organisation. As part of that process, as system manager, the Ministry makes recommendations concerning the allocation of the overall budget allocated to the health portfolio.[324]

302. In determining the amount to be paid to a Local Health District from the funds appropriated from the Consolidated Fund, the Minister must have regard to the following matters:[325]

    a. the size and health needs of the resident population of the local health district;

    b. the health services provided to patients from outside the local health district;

[322] Exhibit A.1, Joint Report of Dr Nigel Lyons, Dr Kerry Chant AO PSM, and Deb Willcox AM (17 November 2023) [20] [MOH.9999.0001.0001 at 0002]; Exhibit M.6, Statement of Neville Onley, Alfa D'Amato and Steven Carr (14 November 2024) [44]-[47] [MOH.0011.0091.0001 at 0011].
[323] See, for example, *Appropriation Act 2023* (NSW) s 11; Exhibit D.4, Statement of Adjunct Professor Alfa D'Amato (9 April 2024) [16], [32] [MOH.9999.0763.0001 at 0004 and 0008].
[324] Exhibit D.4, Statement of Adjunct Professor Alfa D'Amato (9 April 2024) [32] [MOH.9999.0763.0001 at 0008]; *Health Services Act 1997* (NSW) s 122(1)(e).
[325] *Health Services Act 1997* (NSW) s 127(1) and (2A).

c. the net receipts and expenditures of the local health district for the financial year;

d. probable capital maintenance and expenditure requirements for the financial year;

e. the National Health Reform Agreement;

f. such other matters as are prescribed by the regulations or as the Minister thinks fit.

303. The extent (if any) to which these factors are actually informing the budget provided to each Local Health District through their annual service agreements is unclear.

304. In determining the amount to be paid to a Statutory Health Corporation from money appropriated from the Consolidated Fund, the Minister may have regard to such matters as the Minister thinks fit.[326] The Minister may also delegate the function of determining the amount of subsidy to be paid to any Affiliated Health Organisation in relation to its recognised services or establishments.[327]

a. Local Health Districts/Specialty Health Networks

305. The Ministry of Health, Local Health Districts and Specialty Health Networks operate as if in a "purchaser/provider relationship" with the Ministry allocating budget to these organisations through the Annual Service Agreements.[328] It is through those agreements that the Ministry "purchases" activity and services (that attract activity based funding contributions) and provide block or other funding.[329]

306. The process by which the levels of activity are set begins in around October, at which point the Ministry of Health reviews the current years' Service Agreements.[330] That review includes meetings with each of the public health organisations.[331]

[326] Health Services Act 1997 (NSW) s 127(2)
[327] Health Services Act 1997 (NSW) s 129.
[328] Exhibit A.1, Joint Report of Dr Nigel Lyons, Dr Kerry Chant AO PSM, and Deb Willcox AM (17 November 2023) [30] [MOH.9999.0001.0001 at 0004].
[329] Exhibit A.1, Joint Report of Dr Nigel Lyons, Dr Kerry Chant AO PSM, and Deb Willcox AM (17 November 2023) [31] [MOH.9999.0001.0001 at 0004]; Exhibit H.2.51, NSW Health Corporate Governance and Accountability Compendium [7. 3] [MOH.0010.0256.0001 at 0080].
[330] Transcript of the Commission, 21 November 2024, T6508.28-34 (Daly).
[331] Transcript of the Commission, 21 November 2024, T6509.6-28 (Portelli).

307. The State Purchasing Branch within the Ministry commences the annual "purchasing process" in December through a series of workshops with the Local Health Districts, Specialty Health Networks, pillars and statewide services.[332] Through those workshops, the Ministry conveys detail concerning the prevailing fiscal environment and current and future NSW Health priorities. Following the workshop, the Ministry finalises the purchasing model to be applied in the purchasing process.[333] The Ministry's intent behind those workshops is to provide context for later discussions and to manage expectations.[334]

308. Early in the calendar year, a series of "Purchasing Roadshows" are held with each public health organisation.[335] The purpose of those "Roadshows" is to explore key elements of the service agreements for the forthcoming year, including activity targets, service mix, funding models, strategic priorities, policy proposals, and key performance indicators.[336]

309. The starting point for the allocation of budget is the previous financial year's activity targets.[337] Growth, in terms of equity, ageing population, and total population size, is also considered. In this respect, in determining the levels of activity and mix of services to be "purchased", data relating to system performance and service utilisation is then applied.[338] An opaque series of "equity adjustors" are then applied and are intended to account for particular demographic and socio-economic features of the relevant segment of the population.[339] Factors specific to a particular Local Health District or Specialty Health Network, such as new builds, statewide services, or highly specialised services are also considered.[340]

[332] Exhibit M.4, Statement of Matthew Daly, Joe Portelli and Sharon Smith (14 November 2024) [29], [32]-[33] [MOH.0011.0089.0001 at 0003, 0008]; Transcript of the Commission, 21 November 2024 T6513.20-25 (Portelli).
[333] Exhibit M.4, Statement of Matthew Daly, Joe Portelli and Sharon Smith (14 November 2024) [32]-[33] [MOH.0011.0089.0001 at 0008]; Transcript of the Commission, 21 November 2024 T6513.10-14 (Portelli), T6527.13-18 (Carr).
[334] Transcript of the Commission, 21 November 2024, T6527.42-47 (D'Amato).
[335] Exhibit M.4, Statement of Matthew Daly, Joe Portelli and Sharon Smith (14 November 2024) [34] [MOH.0011.0089.0001 at 0008].
[336] Exhibit M.4, Statement of Matthew Daly, Joe Portelli and Sharon Smith (14 November 2024) [34]-[35] [MOH.0011.0089.0001 at 0008].
[337] Exhibit A.1, Joint Report of Dr Nigel Lyons, Dr Kerry Chant AO PSM, and Deb Willcox AM (17 November 2023) [30] [MOH.9999.0001.0001 at 0004].
[338] Exhibit M.4, Statement of Matthew Daly, Joe Portelli and Sharon Smith (14 November 2024) [10]-[11] [MOH.0011.0089.0001 at 0003].
[339] Exhibit M.4, Statement of Matthew Daly, Joe Portelli and Sharon Smith (14 November 2024) [13] [MOH.0011.0089.0001 at 0003].
[340] Exhibit A.1, Joint Report of Dr Nigel Lyons, Dr Kerry Chant AO PSM, and Deb Willcox AM (17 November 2023) [30] [MOH.9999.0001.0001 at 0004].

310. Approximately, 70% of the total State health budget is allocated through activity based funding, around 20% through block funding, with the remainder made up of grants related to specific programs.[341]

311. In New South Wales, 100 hospitals are eligible for activity based funding.[342] To be eligible for this funding type, a hospital must have more than 3500 National Weighted Activity Units per annum in a rural hospital, or more than 1800 admitted patient National Weighted Activity Units per annum in metropolitan hospital.[343] In funding Local Health Districts and Specialty Health Networks on an activity basis, the Ministry "purchases" that activity at the State Efficient Price.[344] The State Efficient Price reflects the average cost of providing the weighted unit of care – i.e., the NWAU – within New South Wales.[345]

312. The rationale for adopting the State Efficient Price was "to drive the best, most optimal amount of volume of activity" with the resources available[346], and it was described as "one of the levers to support people looking for new ways and innovative ways to deliver services, maintain their quality at the highest possible level, and keep that sustained, but look for more efficient and effective ways of delivering care."[347]

313. However, in many parts of the State, the cost of delivering care exceeds the State Efficient Price. In an attempt to address that reality, and the fact that some Local Health Districts do not have the benefit of the "swings and roundabouts" of being able to provide care in some locations below that price that offsets those locations which cost more,[348] certain adjustors are applied.[349] However, the evidence received by the Special Commission suggests that the various adjustors applied, including in the budget setting process at the State level, are

[341] Transcript of the Commission, 28 November 2023, T138.14-25 (Lyons).
[342] Exhibit A.1, Joint Report of Dr Nigel Lyons, Dr Kerry Chant AO PSM, and Deb Willcox AM (17 November 2023) [14] (MOH.9999.0001.0001 at 0003].
[343] Exhibit A.1, Joint Report of Dr Nigel Lyons, Dr Kerry Chant AO PSM, and Deb Willcox AM (17 November 2023) [14] (MOH.9999.0001.0001 at 0003].
[344] Exhibit H.2.51, Corporate Governance and Accountability Compendium, NSW Health (May 2024) [7. 2.2] [MOH.0010.0256.0001 at 0078]; Transcript of the Commission, 28 November 2023 T151:14-20 (Lyons).
[345] Transcript of the Commission, 28 November 2023 T151.14-20 (Lyons).
[346] Transcript of the Commission, 28 November 2023 T151.26-28 (Lyons).
[347] Transcript of the Commission, 28 November 2023 T152.18-23 (Lyons).
[348] Transcript of the Commission, 20 November 2024, T6480.28-47, T6487.3-21 (Duckett).
[349] Exhibit M.6, Statement of Neville Onley, Alfa D'Amato and Steven Carr (14 November 2024) [20] [MOH.0011.0091.0001 at 0004-0005].

not meeting the rising cost of delivering services in some parts of the State, or offsetting other limitations of the funding model.[350]

314. There are 110 small rural hospitals which are block funded; because their volume is too low for activity based funding.[351] These hospitals are funded on a block basis in accordance with the small hospitals funding model.[352] There are a further 17 facilities in the state that are also block funded, including specialist standalone mental health facilities and standalone major city hospitals providing specialist services.[353] These include the Sydney Eye Hospital, for example, which has a limited range of patients.[354]

315. The budgets for Local Health Districts and Specialty Health Networks are then finalised, with funding allocated by reference to a mix of funding streams, such as: activity based funding (acute admitted, emergency department, non-admitted, sub-acute admitted and non-admitted); small rural hospitals; block funded hospitals and services; and teaching, training and research.[355] That should ordinarily conclude in about June.[356]

316. There were, however, several examples in evidence before the Commission of statements of service or service agreements which were executed well into the year in respect of which they applied.[357] Some of that delay is likely attributable to recent delays in the delivery of the State budget. However, it is inherently undesirable - from a governance perspective - that the agreements which form the basis of budget allocations and performance monitoring are executed well into (or in unusual circumstances, shortly after) the period during which the relevant services are to be provided.

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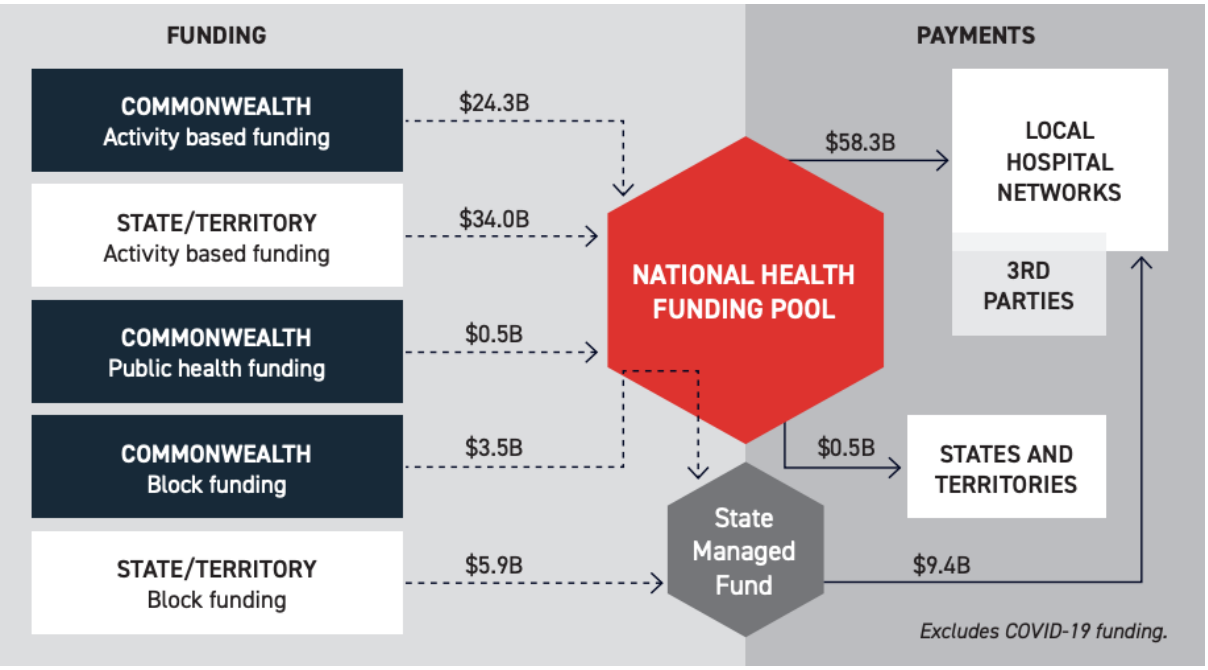
[350] See, for example, Exhibit K.49, Statement of Stuart Dowrick (12 September 2024) [17]-[18] [MOH.0011.0069.0001 at 0005]; Transcript of the Commission, 21 November 2024 T6568.32-37 (D'Amato).
[351] Exhibit A.1, Joint Report of Dr Nigel Lyons, Dr Kerry Chant AO PSM, and Ms Deb Willcox AM (17 November 2023) [15] [MOH.9999.0001.0001 at 0003].
[352] Exhibit A.53, Joint Report of Adjunct Professor Alfa D'Amato and Ms Deb Willcox AM (27 November 2023) [98] [MOH.9999.0005.0001 at 0018-0019].
[353] Exhibit A.1, Joint Report of Dr Nigel Lyons, Dr Kerry Chant AO PSM, and Ms Deb Willcox AM (17 November 2023) [17] [MOH.9999.0001.0001 at 0003].
[354] Transcript of the Commission, 28 November 2023 T137:21-31 (Lyons).
[355] Exhibit H.2.51, Corporate Governance and Accountability Compendium, NSW Health (May 2024) [7.2.4] [MOH.0010.0256.0001 at 0079].
[356] Exhibit A.53, Joint Report of Adjunct Professor Alfa D'Amato and Ms Deb Willcox AM (27 November 2023) [33] [MOH.9999.0005.0001 at 0006].
[357] See, for example, Exhibit B.23.129, HealthShare Statement of Service 2023-24 (9 February 2024) [MOH.9999.0010.0001]; Exhibit B.23.181, Southern NSW Local health District Service Agreement 2023-24 (26 October 2023) [MOH.0001.0456.0001]; Exhibit D.1.20, Nepean Blue Mountains Local Health District Service Agreement 2023-24 (31 October 2023) [MOH.9999.0794.0001].

317. Funding ultimately flows to each Local Health District/Specialty Health Network in accordance with processes established under the National Health Reform Agreement. It is not necessary to explore the detail of those arrangements here, however, they are broadly demonstrated in the in the following diagram (which summarises the flow of funding at the national level for the 2023-2024 year).[358]



318. Local Health Districts and Specialty Health Networks (like all public health organisations) can also submit funding requests for new services or expansions of existing services beyond the base amount at any stage.[359] These submissions are assessed by the Ministry.[360] They may also require supplementation of their budgets throughout the year.

b. Shared services

319. The Secretary issues statements of service to each of the shared services organisations, namely, HealthShare NSW, eHealth NSW and NSW Health Pathology.[361] The shared services organisations operate on a cost recovery model through internal charges to the Local Health Districts or Specialty Health

[358] Exhibit N.3.44; National Health Funding Body Annual Report 2023-2024 (September 2024), p 22 [SCI.0011.0745.0001 at 0032]; Exhibit D.4, Statement of Adjunct Professor Alfa D'Amato (9 April 2024) [33] [MOH.9999.0763.0001 at 0008].
[359] Exhibit M.4, Statement of Matthew Daly, Joe Portelli and Sharon Smith (14 November 2024) [39] [MOH.0011.0089.0001 at 0009].
[360] Exhibit M.4, Statement of Matthew Daly, Joe Portelli and Sharon Smith (14 November 2024) [40] [MOH.0011.0089.0001 at 0009].
[361] Exhibit D.4, Statement of Adjunct Professor Alfa D'Amato (9 April 2024) [36], [40] [MOH.9999.0763.0001 at 0009-0010].

Networks.[362] NSW Health Shared Services' budgets are determined as part of the annual budget cycle and are prepared by reference to considerations specific to the service, such as charges they levy to other NSW Health entities.[363]

c. NSW Ambulance

320. NSW Ambulance enters into a Service Agreement, pursuant to which it receives block funding.[364] Its budget reflects a base level of funding that is adjusted annually to account for escalations, including in the cost of delivering services, but does not include adjustments that take into account the increased demand for Ambulance services.[365]

d. The Pillars

321. The pillar organisations enter into performance agreements with the Secretary.[366] They are relevantly similar to the service agreements entered into by the Local Health Districts, but as those organisations do not provide clinical services, they do not include a section concerning purchased volumes and services.[367]

322. The NSW Health Pillar organisations operate on a traditional salaries and wages and goods and services budget, in which escalations for wages are consistent with applicable industrial agreements.[368]

6.5 Benefits and limitations of current funding models

323. The Mid-Term Review of the Addendum to the National Health Reform Agreement considered, among other matters, the various benefits and limitations of the current approaches to funding that emerge from it. That review made a series of recommendations for improvements or adjustments to existing models. For example, the review recommended:

[362] Exhibit A.53, Joint Report of Adjunct Professor Alfa D'Amato and Deb Willcox AM (27 November 2023) [38] [MOH.9999.0005.0001 at 0007-0008].
[363] Exhibit A.53, Joint Report of Adjunct Professor Alfa D'Amato and Deb Willcox AM (27 November 2023) [38] [MOH.9999.0005.0001 at 0007-0008].
[364] Exhibit D.4, Statement of Adjunct Professor Alfa D'Amato (9 April 2024) [36], [40] [MOH.9999.0763.0001 at 0009-0010]; Transcript of the Commission, 18 November 2024 T6363.38-39, T6392.16-18 (Morgan).
[365] Transcript of the Commission, 18 November 2024 T6392.4-18, T6365.18-29 (Morgan).
[366] Exhibit D.4, Statement of Adjunct Professor Alfa D'Amato (9 April 2024) [36] [MOH.9999.0763.0001 at 0009].
[367] Exhibit D.4, Statement of Adjunct Professor Alfa D'Amato (9 April 2024) [39] [MOH.9999.0763.0001 at 0010].
[368] Exhibit A.53, Joint Report of Adjunct Professor Alfa D'Amato and Deb Willcox AM (27 November 2023) [42] [MOH.9999.0005.0001 at 0008].

a. the creation of a funding pathway to support innovation;[369]

b. the development of bundled and blended payment models under the National Health Reform Agreement;[370]

c. an increase in the Commonwealth's contribution to 45% of nationally efficient public hospital activity and reframing the existing 6.5% national funding cap;[371] and

d. a further review of the calculation of the National Efficient Price to reduce calculation complexity.[372]

324. As will be seen below, the focus of those recommendations is consistent with some of the limitations in the current funding models that have been identified in the evidence. Given that the review supported the continued use of the activity based and block funding methodologies, any consideration of how healthcare funding models used within New South Wales can be improved to overcome those limitations should pragmatically assume these methods will remain central to funding arrangements into the future.[373]

325. However, there remains a need to review how those models are best utilised – in combination with other funding streams and approaches – to support a long-term sustainable public health system.

6.5.1 The benefits

326. Most of the benefits of the current funding models – and in particular the centrality of activity based funding to that model - identified in the evidence relate to the promotion of technical efficiency and transparency.[374] In this respect, through the implementation and adherence to those models, the New South Wales public health system has become, by world standards, highly

[369] Exhibit N3.17, Rosemary Huxtable AO PSM, Mid-Term Review of the National Health Reform Agreement Addendum 2020-2025 (24 October 2023) pp 7-8, 11 [SCI.0011.0585.0001 at 0012-0013, 0016].
[370] Exhibit N3.17, Rosemary Huxtable AO PSM, Mid-Term Review of the National Health Reform Agreement Addendum 2020-2025 (24 October 2023) p 8 [SCI.0011.0585.0001 at 0013].
[371] Exhibit N3.17, Rosemary Huxtable AO PSM, Mid-Term Review of the National Health Reform Agreement Addendum 2020-2025 (24 October 2023) p 9 [SCI.0011.0585.0001 at 0014].
[372] Exhibit N3.17, Rosemary Huxtable AO PSM, Mid-Term Review of the National Health Reform Agreement Addendum 2020-2025 (24 October 2023) p 8 [SCI.0011.0585.0001 at 0013].
[373] Exhibit N3.17, Rosemary Huxtable AO PSM, Mid-Term Review of the National Health Reform Agreement Addendum 2020-2025 (24 October 2023) pp 8, 10 [SCI.0011.0585.0001 at 0013, 0015].
[374] Exhibit A.53, Joint Report of Adjunct Professor Alfa D'Amato and Deb Willcox AM (27 November 2023) [93] [MOH.9999.0005.0001 at 0012]; Transcript of the Commission, 30 November 2023 T310.29-311.35 (D'Amato); Exhibit E.47, Statement of Mark Spittal (30 April 2024) [103] [MOH.9999.1202.0001 at 0020-0021];Transcript of the Commission, 20 November 2024 T6478.25-6479.8 (Duckett);

technically efficient.[375] Accordingly, while the system should always aim for further improvement, there are arguably limited material gains in technical efficiency to be achieved into the future.[376]

327. The existing funding models have also enabled the system to collect valuable data on the activity performed across the system. Given the importance of data (referred to elsewhere in this outline), ancillary benefits of that kind that flow from existing funding models are significant.[377]

6.5.2 The limitations

328. Several limitations in the current funding models were identified, some of which include how those models are applied in setting the budgets of NSW Health agencies. Set out below are some of those that have been identified in the evidence. There were several others that were also identified, and which are relevant to the overall consideration of this issue, but which are not necessary to explore here for the purpose of the analysis.[378]

a. Allocative efficiency

329. While existing funding models are recognised as supporting technical efficiency, the broad consensus that emerges from the evidence is that they do not drive allocative efficiency, focusing on activity throughput rather than health outcomes.[379] Those limitations were effectively summarised by Mark Spittal, Chief Executive of Western NSW Local Health District, in the following way[380]:

> *The critical deficiency in the model, however, is that it does not equally balance the public policy tensions between compassion, social justice and the efficient stewardship (productive efficiency) of taxpayer resources. The current focus is almost solely on productive efficiency at the expense of both allocative efficiency (investing in the*

[375] Transcript of the Commission, 10 December 2024, T6826.6-21 (Eagar).
[376] Transcript of the Commission, 10 December 2024 T6826.26-45 (Eagar). Cf: Transcript of the Commission, 18 November 2024, T6286.22-37 (Cornelius).
[377] See, for example, Transcript of the Commission, 30 November 2023 T310.29-311.35 (D'Amato); Exhibit M.6, Statement of Neville Onley, Alfa D'Amato and Steven Carr (14 November 2024) [80] [MOH.0011.0091.0001 at 0024].
[378] See, for example, Transcript of the Commission, 20 November 2024 T 6523.42-6524.3 (Daly); Transcript of the Commission, 21 November 2024 T6523.42-6524.1, T6524.5 (D'Amato); Transcript of the Commission, 10 December 2024, T6808.20-6809, 6848.14-28 (Eagar).
[379] Exhibit A.1, Joint Report of Dr Nigel Lyons, Dr Kerry Chant and Deb Willcox AM (17 November 2023) [156] [MOH.9999.0001.0001 at 0024]; Transcript of the Commission, 29 November 2023 T227.16-27 (Lyons); Transcript of the Commission, 30 November 2023 T278.39-40 (Willcox).
[380] Exhibit E.47, Statement of Mark Spittal (30 April 2024) [104]-[105] [MOH.9999.1202.0001 at 0021].

interventions that deliver the greatest benefit) and considerations of social equity (distributive justice).

In my view the current funding system pays marginal attention to issues of allocative efficiency and social equity. The system itself has largely evolved from an a-priori assumption that the distribution of healthcare resources across NSW that existed prior to the introduction of ABF was both equitable and optimal. The evidence of profound differences in health outcomes and access to services provides very little support for that assumption.

330. Similarly, Anna McFadgen, Chief Executive Officer, St Vincent's Hospital Sydney described the limitation of the funding model as it relates to driving allocative efficiency as follows[381]:

> *… activity based funding, by its nature, is designed to incentivise activity, right, throughput, as opposed to a bundle of care, if you will. So I think there's an opportunity through some different funding models – block funding, bundled care, however you kind of want to term it - that you could provide to a health service and LHD, a network, for more flexible use, which would then enable that health service to either deliver care where it's appropriate to do so in a hospital setting, but actually also potentially deliver care in other settings, which, as I say, is more cost effective. So that's - I don't think - I think whilst we've - you know, we've certainly explored those sorts of models, I think there's much more opportunity to do that.*

331. Stuart Dowrick, then Chief Executive of the Mid North Coast Local Health District, also expressed the view that there was a need to craft funding models to promote activity that addresses the socioeconomic factors affecting health outcomes (i.e., the social determinants of health). In this respect, he gave evidence that:[382]

> *The ABF model, as a mechanism for funding LHDs based on type and volumes of services provided, is primarily a hospital acute service model and does not effectively address the financial burden imposed on LHDs as a consequence of broader socioeconomic factors impacting healthcare and importantly health outcomes. The inflexible application of ABF in NSW Health does not always ensure that LHDs are funded adequately to support innovation and meet community needs. The ABF model needs to accommodate the application of some discretion to ensure that LHDs with*

[381] Transcript of the Commission, 13 June 2024, T3624.28-42 (McFadgen).
[382] Exhibit K.49, Statement of Stuart Dowrick (12 September 2024) [17] [MOH.0011.0069.0001 at 0005].

> *considerable population disadvantage, such as MNCLHD, receive an appropriate share of the State health budget.*

332. Other witnesses expressed similar views.[383]

b. Support for innovation

333. It has been suggested that the current funding model – and in particular the activity based funding component of that model – does not support the development of innovative models of care, in circumstances where those models are not immediately recognised as being "in-scope" and thus eligible to attract a Commonwealth funding contribution.[384]

334. There are funding streams under the National Health Reform Agreement that support innovation outside of activity based funding.[385] However, the limitation referred to in the evidence is perhaps more immediate in circumstances where care is to be delivered outside of the hospital environment and may not be what would have been considered as a traditional hospital service.[386] Care of that kind is not immediately compatible with the premise of activity based funding.

335. There is – of course – nothing preventing NSW Health agencies from developing and implementing innovative models of care, even if they do not immediately attract a funding contribution from the Commonwealth.[387] Indeed, they should do so whilst pursing a Commonwealth funding contribution towards the delivery of those models, where appropriate.[388] As Adjunct Professor Jéan-Fredéric Levesque, Deputy Secretary for Clinical Innovation and Research and Chief Executive of the Agency for Clinical Innovation, rightly said:[389]

> *What we don't want is for a new model not to be adopted because implementing it would reduce the activity that is actually the way to generate reimbursement in health care. That's a well-known issue around the world,*

[383] See, for example, Exhibit K.34, Statement of Tracey Maisey (9 September 2024) [130]-[131] [MOH.0011.0064.0001 at 0026]; Transcript of the Commission, 10 December 2024, T6823.39-43, T6826.6-21 (Eagar).
[384] Transcript of the Commission, 28 November 2023., T133.11-28 (Willcox); Transcript of the Commission, 29 November 2023 T241.2-35 (Lyons).
[385] Transcript of the Commission, 26 February 2024 T1131.7-14 (Levesque).
[386] See, for example, Exhibit A.1, Joint Report of Dr Nigel Lyons, Dr Kerry Chant and Deb Willcox AM (17 November 2023) [201] [MOH.9999.0001.0001 at 0028]; Transcript of the Commission, 29 November 2023 T241.37-242.9 (Willcox); Exhibit B.3, Statement of Adjunct Professor Jéan-Fredéric Levesque (30 January 2024) [87], [113] [MOH.0001.0435.0001 at 0034, 0041]; Transcript of the Commission, 26 February 2024 T1108.1–20 (Levesque);
[387] Transcript of the Commission, 26 February 2024, T1131.7-14 (Levesque).
[388] Transcript of the Commission, 18 November 2024, T6264.32-41 (Cornelius).
[389] Transcript of the Commission, 26 February 2024, T1107.1-6 9 (Levesque). However, it appears that the focus on activity generation that flows from the exiting model, including activity targets given to Local Health Districts, is having that practical effect: see, for example, Exhibit K.40, Statement of Tracey McCosker PSM (13 September 2024) [50] [MOH.0011.0062.0001 at 0013]; Transcript of the Commission, 19 September 2024, T5442.11-17 (McCosker); Transcript of the Commission, 19 November 2024 T6392.33-6393.1 (Wilson).

and therefore it's something we need to address through those negotiations with the Commonwealth and the health reform agenda.

c. Promoting or incentivising Preventative care

336. For similar reasons to those related to the implementation of innovative models of care, it has been suggested that existing funding models do not support or incentivise the delivery of preventative care within the New South Wales public health system.[390]

d. The ability of the model to capture the cost of complex care and rural and regional services

337. Another criticism of the current funding model is that the funding that flows through it does not reasonably reflect the cost of delivering complex care, or care in rural and regional locations.[391]

338. For example, in July 2024, NSW Health conducted a review of the Small Hospitals Funding Model.[392] That review found that the current approach to funding small hospitals is not sufficiently responsive to changes in structural costs like patient transport and workforce, inflation, and capital funding and asset management in small hospital settings[393], and that funding for rural local health districts did not adequately support the implementation of innovative models of care.[394]

339. The review also found that the Commonwealth's funding contribution has not kept pace with the increasing costs of providing care in small hospitals[395] and aged care in multi-purpose services.[396]

[390] See, for example, Transcript of the Commission, 28 November 2023 T128.21-25 and 33-34 (Chant); Transcript of the Commission, 29 November 2023, T226.40-227.14 (Lyons); Exhibit C.33.1, Statement of Jill Ludford (12 March 2024) [124] [MLH.0001.0016.0001 at 0025]; Transcript of the Commission, 22 March 2024 T1725.3-25, T1726.21-39 (Ludford).
[391] Transcript of the Commission, 30 November 2023 T322.42-324.2 (D'Amato); Transcript of the Commission, 20 March 2024 T1487.42-1488.21 (Lawrence); Exhibit F.1, Statement of Bradley David Astill (8 May 2024) [63] [MOH.9999.1258.0001 at 0010]; Exhibit K.40, Statement of Tracey McCosker PSM (13 September 2024) [48]-[49] [MOH.0011.0062.0001 at 0012]; Transcript of the Commission, 18 September 2024 T5338.41-5339.11 (McCosker); Transcript of the Commission, 19 November 2024 T6396.2-11, T6396.22-6397.20 (Collins); Transcript of the Commission, 21 November 2024 T6580.17-21 (D'Amato); Transcript of the Commission, 10 December 2024 T6805.28 – 6806.30 (Eagar).
[392] Exhibit M.9, Small Hospitals Funding Model Review (July 2024) [MOH.0100.0294.0001].
[393] Exhibit M.9, Small Hospitals Funding Model Review (July 2024) pp 18-22 [MOH.0100.0294.0001 at 0019-0023].
[394] Exhibit M.9, Small Hospitals Funding Model Review (July 2024) p 28 [MOH.0100.0294.0001 at 0029].
[395] Exhibit M.9, Small Hospitals Funding Model Review (July 2024) p 22 [MOH.0100.0294.0001 at 0023].
[396] Exhibit M.9, Small Hospitals Funding Model Review (July 2024) p 23 [MOH.0100.0294.0001 at 0024].

e. Short term budget cycles

340. The annual budget cycle can create challenges for effective longer-term planning for Local Health Districts, Affiliated Health Organisations and non-government organisations.[397]

341. While in the past, when the budgetary environment was more stable, NSW Health agencies could project likely future funding flows (including growth) with some reliability, in the current environment their ability to do so is compromised.[398] In this respect, longer budget cycles are said to support robust service design and planning, support the development, implementation and assessment of new or innovative models of care, and support workforce planning.[399]

342. In apparent recognition of the challenges associated with short term budget cycles, consideration is currently being given to longer term arrangements that focus on improving health outcomes to compliment the annual cycles that flow from the arrangements under the National Health Reform Agreement.[400]

6.6 The "constrained financial environment"

343. Despite the overall size of the health budget, the evidence clearly demonstrates that the system is under severe budgetary pressure. Whatever may have been the case prior to the pandemic, it is now clear that in the "post-pandemic environment", it can no longer be assumed that the funding envelope available to NSW Health is (or will, in the future, be) sufficient to meet the existing demands placed on it – whether they be in relation to service demand, or those associated with the costs of delivering services.

344. Prior to the COVID-19 pandemic, the level of funding available to NSW Health had generally been predicated on historical 4-5% growth, together with funding to support new policies.[401] That model was utilised to "provide greater funding

[397] See, for example, Transcript of the Commission, 20 March 2024 T1507:15-1508:44 (Lawrence); Transcript of the Commission, 23 May 2024 T3236:13-3264:25 (Files/Pearce); Exhibit N.1.1, Expert Report 1 – Resource Management in NSW health, Sax Institute (29 November 2024) [36] [SCI.0011.0607.0001 at 0009].
[398] See, for example, Transcript of the Commission, 23 May 2024 T3236.13-3264.25 (Files/Pearce).
[399] Transcript of the Commission, 23 May 2024 T3263.36-3264.2 (Pearce).
[400] Exhibit M.6, Statement of Neville Onley, Alfa D'Amato and Steven Carr (14 November 2024) [79] [MOH.0011.0091.0001 at 0024]; Transcript of the Commission, 30 November 2023 T305.7-10 (D'Amato).
[401] Exhibit A.1, Joint Report of Dr Nigel Lyons, Dr Kerry Chant AO PSM, and Deb Willcox AM (17 November 2023) [22] [MOH.9999.0001.0001 at 0002].

certainty and improve the sustainability of growth".[402] Despite a spike in growth during the COVID-19 pandemic, from the 2023-24 financial year the growth rate was anticipated to be much lower.[403]

345. The confluence of factors presently impacting on the public health system – many of which are out of the system's direct control – have produced what was described by many (in the most neutral of ways) as a "constrained financial environment". In this respect, the joint statement of Adjunct Professor D'Amato, Mr Carr and Mr Onley describes the difference in the pre and post pandemic environment in the following way:[404]

> *The existing model functioned relatively well in allocating funding for the delivery of public health services across NSW in a stable growth environment, where there was sufficient funding for additional activity or new initiatives through the purchasing process and new policy proposals.*
>
> *However, this is not the case in the post COVID-19 environment with limited growth funding available and challenges with attraction and retention of workforce, escalation of costs for goods and services and the bringing on line of a large number of new facilities through the capital program*

346. As a result (and although the historical origins of the "base" from which the health budget have been set remain elusive)[405] it is now doubtful that the "base" on which the funding model is built reflects a reliable starting point.[406] In this respect, Adjunct Professor D'Amato succinctly explained the effect prevailing circumstances as follows[407]:

> *Yes, look, I agree. Perhaps we need to make a distinction from what happened after COVID, because I think COVID kind of created more challenges.*
>
> *Before COVID, in a relatively, you know, stable environment, when wages or even, you know, CPI was relatively under control, we were able to deliver*

[402] Exhibit A.1, Joint Report of Dr Nigel Lyons, Dr Kerry Chant AO PSM, and Deb Willcox AM (17 November 2023) [23] [MOH.9999.0001.0001 at 0003].
[403] Exhibit A.1, Joint Report of Dr Nigel Lyons, Dr Kerry Chant AO PSM, and Deb Willcox AM (17 November 2023) [25] [MOH.9999.0001.0001 at 0003].
[404] Exhibit M.6, Statement of Neville Onley, Alfa D'Amato and Steven Carr (14 November 2024) [77]-[78] [MOH.0011.0091.0001 at 0024].
[405] Transcript of the Commission, 18 November 2024, T6250.24-46 (Cornelous/Kastoun).
[406] Transcript of the Commission, 18 November 2024, T6257.22-6258.28 (Kastoun/D'Amato); Transcript of the Commission, 20 November 2024 T 6523.42-6524.3 (Daly); Transcript of the Commission, 21 November 2024 T6523.42-6524.5 (D'Amato).
[407] Transcript of the Commission, 21 November 2024 T6524.5-18 (D'Amato).

> *and drive efficiencies at the same time. So those efficiencies were reinvested to do more activity, but that was the key, the stability in the economic and fiscal environment.*
>
> *Now, we are in a different situation, and I think that's where the challenge is at the moment. I don't know whether we're ready to set the new base at this stage.*

347. Coupled with a reduction in the growth funding applied to that base,[408] that the system is subject to budget pressures is perhaps unsurprising. As a consequence, NSW Health agencies presently do not have the same levels of headroom within their budgets to develop and expand services that may have existed in the past.[409]

348. There are other features of a public health system that add to the complexity of those issues. Even if the overall funding envelope available were to increase significantly, reasonable arguments could be made for yet further investment. As much is demonstrated by the fact that over the last decade, some Local Health Districts have seen their expense budgets increase by over 100%, yet many compelling examples of the use to which additional funding could be put emerged in the evidence.[410] In that context, it is a truism the health system has the capacity to absorb any increase in funding it may be given.[411]

349. However, the size of the overall health budget cannot be viewed in isolation. Although the health portfolio is a vital and important aspect of government services, it reflects but one aspect of government spending that must be balanced against many others.[412] Unless there is to be a significant expansion in the taxation base (whether at the Commonwealth or State level), the challenges associated with that necessary task of balancing competing demands on finite budget will remain significant, particularly in an environment of rising costs and workforce challenges across the public sector generally.

350. It is in that context that the question of whether the overall levels of funding available for healthcare is "adequate" or "sufficient" must be considered. It is,

[408] Exhibit M.6, Joint statement of Adjunct Professor Alfa D'Amato, Neville Onley and Steven Carr, 14 November 2024, [77]-[82] [MOH.0011.0091.0001 at 0024-0025].
[409] Transcript of the Commission, 21 November 2024 T6597.47-6598.13 (Portelli).
[410] See, for example, Exhibit M.6, Statement of Neville Onley, Alfa D'Amato and Steven Carr (14 November 2024) [57] [MOH.0011.0091.0001 at 0017].
[411] Transcript of the Commission, 19 November 2024, T6409.44-47 (Mains).
[412] See, for example, Transcript of the Commission, 18 November 2024, T6254.39-6256.18 (Kastoun).

perhaps, superficially attractive to respond to such a question by pointing to the fact that, if more funding were allocated, it could undoubtedly be put to good use within the system. However, such an approach would fail to engage with the realities of the funding and delivery of public services outlined above.

351. Some have suggested that the present level of funding is adequate.[413] The ability of NSW Health agencies to operate within their budgets is sometimes cited as supporting that view. However, the ability of an agency to operate within its budget is a blunt measure of whether the level of funding allocated to that agency is "enough" or "sufficient" to enable it to fulfil its function and purpose. It says much more about the financial management of the entity than the capacity of that entity to produce any particular outcome through the application of the available funding.

352. Many others would say that the current funding envelope is insufficient. Many individual clinicians have – understandably – highlighted their inability to obtain funding for a particular service, or for additional staff to support a service, as indications of the inadequacy of funding available. They view that inability to attract funding as reflective of an insufficiency of funding within the wider system generally; in some cases, they may be right.

353. Within some parts of the system a conclusion can readily be drawn that the funding available to it is insufficient. For example, the Southern New South Wales Local Health District has a range of characteristics which make the delivery of services, and the maintenance of its infrastructure, challenging and costly. The funding available to it does not presently enable the district to meet those challenges.[414] Other Local Health Districts have experienced significant budgetary challenges when opening and operating new facilities in circumstances where the ongoing funding made available to them does not meet the cost of doing so.[415]

354. However, whether the funding envelope available to the system as a whole is sufficient is a more nuanced question. It is not one that can be addressed by pointing to the things that could be done if more funding were available. As

[413] Exhibit M.1, Submission of NSW Treasury (undated) [2.30] [TRY.0001.0001.0001 at 0007].
[414] Transcript of the Commission, 16 August 2024, T5064.12-5069.20 (Hoskins/Clout), T5070.31-5071.3 (Bennett).
[415] Transcript of the Commission, 18 September 2024, T5355.45-5358.42 (Maisey).

observed above, it may be readily assumed that if more funding were available (even in vast quantities), it would be put to good use in delivering health outcomes for the population.

355. In this respect, Adjunct Professor D'Amato, when asked to express a view as to whether the current level of funding available to NSW Health is adequate[416] gave evidence that (emphasis added):[417]

> *Okay, I feel that it's a bit* ***difficult for me to make a call whether we're adequately funded. We do the best we can with what has been allocated to us*** *and we always try to do our best for our patients and our workforce. Ultimately, that's what we do.*
>
> *Admittedly, I think we've done relatively well compared to the other states and other territories, and perhaps also internationally, but I do think that* ***we're now stepping into a different environment and it is challenging. It is challenging to maintain the level of performance*** *and it is challenging because, in my opinion,* ***we need to start thinking more about medium and long term outcomes, investment in prevention****, which before – we probably tried to get there, just before COVID, as we were working with other policies, treasury policies, with outcome budgeting and then, all of a sudden, we interrupted the whole process.*
>
> *I think there was an evolution in our ABF moving towards more of an outcome framework. We had investment in value-based health care, but during COVID, obviously, all of these had been paused. So for me to answer your question,* ***I feel that it's a bit premature. I think we need to acknowledge that the environment's changed now****.*

356. That answer – from the Chief Financial Officer of NSW Health – serves to highlight the fact that a proper assessment of whether the funding available to the public health system as a whole is "adequate" or "sufficient" inherently depends on an identification of the nature and extent of the services that the system should be delivering and where those services are to be delivered. It is an assessment that must, necessarily, recognise the fundamental reality that resources are finite, and the need to make (frequently difficult) decisions about how those resources are to be deployed – and how they will not – will always be present.

[416] As suggested by Treasury: see Exhibit M.1, Submission of NSW Treasury (undated) [2.30] [TRY.0001.0001.0001 at 0007].
[417] Transcript of the Commission, 18 November 2024 T6291.19-43 (D'Amato).

357. All of the above factors highlight the critical importance of a system wide, strategic approach to service design and planning, that ensures that the resources available are most effectively and efficiently deployed. As will be explored below – part of that process must include an assessment of what can reasonably be expected of a public health system with finite resources (of all kinds). If such an approach is not adopted, and in doing so the challenges that have emerged in the post pandemic environment addressed, the sustainability of the wider system is at risk.[418]

358. That is not a new idea. In one of many parallels that have emerged in the work of this Special Commission with those considered by Commissioner Garling (as his Honour then was) in 2008, he relevantly concluded that:[419]

> *In my view, there needs to be a complete state-wide review undertaken by NSW Health which involves:*
>
> *(a) the identification of a set of criteria, which relate to at least, patient safety, necessary workforce skills, and the volume and quality of services regarded as an appropriate critical mass for the services provided across NSW in public hospitals;*
>
> *(b) a determination of whether each hospital, having regard to its location, the available workforce determined on a long term basis, the size of the population which it services, the alternative locations within an appropriate distance (measured by time or distance) and the age and state of repair of the facilities and equipment, is (or can become) a location for the delivery of safe patient care;*
>
> *(c) a clear delineation of the role of each hospital – what it can and can't do;*
>
> *(d) clear communication of the role of a local hospital to its community, and community understanding of the limitations of the local hospital;*
>
> *(e) re-allocation of specialist medical services to hospitals in NSW best placed to deliver those services; and*
>
> *(f) the consideration of the availability of an efficient transport and retrieval system state-wide to transport patients to the hospital best*

[418] Exhibit M.6, Statement of Neville Onley, Alfa D'Amato and Steven Carr (14 November 2024) [52] [MOH.0011.0091.0001 at 0012].
[419] Final Report of the Special Commission of Inquiry into Acute Care Services in New South Wales Public Hospitals, (27 September 2008) Vol 3, [26.96].

placed to provide the medical service required, and return the patient to their original locations.

359. Although the prevailing circumstances are now very different to those that existed in 2008, several of the concepts highlighted in the extracted passage are as relevant then now as they were then, and perhaps even more so.

360. It is through that process that the optimal funding model – including through blended or bundled funding – can be identified. As part of that process, the funding model should not be the tail that wags the dog but rather should be formulated to compliment and support the objectives of the health system NSW Heath aspires to deliver at the conclusion of the planning process described below.[420]

6.7 Conclusion and key recommendations

361. As will be apparent from other sections of this outline, the public health system which is – and is required to be – delivered by NSW Health extends well beyond the provision of acute care in New South Wales public hospitals. Existing funding arrangements are an inadequate means of distributing the funds available with a view to funding the delivery of that system.

362. Having identified through, the collaborative planning process described below, the health system that NSW Health aspires to deliver to the people of New South Wales, the Ministry should – with expert guidance – reformulate its approach to funding so as to devise a funding structure which will ensure that the Local Health Districts and Specialty Networks are sufficiently resourced to deliver *that* system. That might include blended, bundled or other funding mechanisms to support that system.

363. Doing so will enable a considered assessment to be made of whether the present funding envelope available is “adequate” to sustain that system, or whether it needs to be expanded and if so, by how much.

[420] Transcript of the Commission, 12 December 2024, T6969.32-6971.9 (Wilson).

7 THE PLANNING AND DELIVERY OF HEALTH SERVICES IN NEW SOUTH WALES

364. A robust health service planning function is critical to the delivery of healthcare within New South Wales.

365. In a "constrained financial environment", the capability of NSW Health to design and implement a feasible and successful system-wide approach to health service planning relies on decision-making within NSW Health as to what the public health system is, and the boundaries of "the civil contract … between taxpayers and the government about what [public health services] might be received in a particular community".[421]

366. The current approach to health service and workforce planning in New South Wales does not have the benefit of this kind of statewide vision for public health services. Nor is it built upon a robust understanding of population health needs from the bottom-up.

367. The evidence before the Special Commission supports the desirability of a refocused approach to service and workforce planning in New South Wales which would enable services to be spread across the State in a manner that best responds to local population need and community expectations regarding service availability, within the confines of the finite NSW Health budget.

7.1 The current approach to service planning and its drivers

368. Healthcare service planning in New South Wales is presently devolved from the Ministry of Health to Local Health Districts and Specialty Health Networks, which have the primary responsibility for service planning in response to the health needs of their designated populations.[422] This responsibility, in both the short and long term, includes:

    a. undertaking detailed service planning and workforce planning to ensure a sound foundation for investment decisions, both capital and recurrent;

    b. any planning considered necessary at the local level to respond to particular health issues, emergencies or service needs; and

[421] Transcript of the Commission, 16 April 2024 T2907.32-42 (Spittal)
[422] Exhibit H2.51, NSW Health Corporate Governance and Accountability Compendium (May 2024) [6.1.1] [MOH.0010.0256.0001 at 0066].

c. developing plans to improve health outcomes in response to national, state and local health priority areas.

369. At a supervisory level, the Ministry of Health has responsibility for coordinating the planning of *system-wide* services, workforce, population health, asset planning and portfolio management, and providing advice to the Minister, Minister for Regional Health, and the Minister for Mental Health on these matters.

370. The clinical service planning framework, and the way in which the responsibilities of the Ministry and Local Health Districts with respect to service planning are supposed to interact, are set out in a number of cascading policy documents which reflect a top-down approach to service planning.

371. At the top of the policy hierarchy are the policies developed at the NSW Health level, spearheaded by the New South Wales Future Health Strategic Framework, which "is the roadmap for the health system to achieve NSW Health's vision" between 2022 and 2032.[423] The framework includes six key strategic objectives relating to patient experience, safe care, population health, workforce, sustainability, and research and innovation.[424] It is complemented by three other NSW Health-wide strategic plans relating to regional health, health workforce and Aboriginal health.[425]

372. The Future Health Strategy is intended to reflect "guiding, overarching strategies and objectives" that will then flow through into the plans generated by Local Health Districts, the service agreements entered by the Ministry of Health, and arrangements for statewide services.[426] It was developed in consultation with the Local Health Districts, as well as consumers and clinicians directly.[427]

373. Through its policies, as well as centralised planning approaches and Service Agreements, the Ministry of Health strives to guide the development of services

[423] Exhibit H2.51, NSW Health Corporate Governance and Accountability Compendium (May 2024) [6.2.2] [MOH.0010.0256.0001 at 0067-0068].
[424] Exhibit H2.51, NSW Health Corporate Governance and Accountability Compendium (May 2024) [6.2.2] [MOH.0010.0256.0001 at 0068].
[425] Exhibit H2.51, NSW Health Corporate Governance and Accountability Compendium (May 2024) [6.2.3]-[6.2.5] [MOH.0010.0256.0001 at 0068-0069].
[426] Transcript of the Commission, 28 November 2023, T76.10-30 (Lyons).
[427] Transcript of the Commission, 28 November 2023, T76.36-77.1 (Lyons).

and investments in the New South Wales public health system.[428] The Ministry of Health also monitors and reviews data to inform its planning around gaps in service provision and changes in population demographics.[429]

374. The role of Local Health Districts is to translate the Ministry's strategy and directions into organisational plans developed at the Local Health District level,[430] including:

a. Strategic Plans;

b. Health Care Services Plans;

c. Corporate Governance Plans;

d. Strategic Asset Management Plans / Asset Management Plans; and

e. Operations/Business plans at all management levels of the local health district or specialty network.

375. Of the above organisational plans, the most comprehensive plan with respect to the service direction of a Local Health District is its Health Care Services Plan. This plan is intended to include detail of priorities for a Local Health District or specialty network over a five to ten year horizon, with specific focus on those issues which affect the health of the catchment population and the delivery of services.[431] As acknowledged by the Ministry of Health:[432]

> *the value and quality of a Health Care Services Plan will depend on the quality of a number of separate, but inter-dependent foundation planning processes, which focus more specifically on areas such as health improvement, clinical services, clinical and non-clinical support services, assets, resource implications and sustainability (workforce, financial and environmental).*

376. Local Health Districts and Specialty Networks are also supposed to undertake more detailed local workforce plans that identify the numbers and types of staff required to meet service needs. In developing these plans, a long lead time is important in order to provide advice to the Ministry and education and training

[428] Transcript of the Commission, 28 November 2023, T75.45-76.24 (Lyons).
[429] Transcript of the Commission, 28 November 2023, T77.5-13 (Chant).
[430] Transcript of the Commission, 28 November 2023, T80.40-46 (Lyons).
[431] Exhibit H2.51. NSW Health Corporate Governance and Accountability Compendium (May 2024) [6.3.1] [MOH.0010.0256.0001 at 0069].
[432] Exhibit H2.51. NSW Health Corporate Governance and Accountability Compendium (May 2024) [6.3.1] [MOH.0010.0256.0001 at 0069].

agencies on the numbers and types of health service staff required to meet population demand in the future.[433]

377. At the bottom of the top-down policy hierarchy are the facility plans at each site within a district, which are influenced by the nature of the service under consideration and the objectives of the particular planning exercise. These plans, accompanied by service agreements, are intended to provide "clear direction for the provision of health services to achieve measurable health improvements and outcomes and are undertaken within a broader framework of system-wide goals, objectives and priorities".[434]

378. From the perspective of the Ministry, the devolved planning structure recognises that the Local Health Districts are "the best people to make a decision about what services should be provided".[435] This is because:[436]

> *[d]ecisions that are made as close as possible to where patients receive their care or where communities receive a service are seen to be better decisions because people can be involved in those decisions, can understand them, be involved in processes that support the decision-making, and understand who is making the decision again, and ask why. When the decision is made a long way away, that is more difficult to achieve…*

379. In this regard, Local Health Districts will undoubtedly have a "greater understanding of the service configuration locally, the relationship to other service providers … and for much of [their] care, it is around how [they] work in partnership with … primary care, aged care sector or other non-government organisations".[437] As a result, when planning services for their communities, Local Health Districts are expected to use the Ministry-level policies as a framework for consideration. However, they are also required to make any adaptations necessary to ensure that the services provided are in accordance with their local needs and local planning.[438]

[433] Exhibit H2.51. NSW Health Corporate Governance and Accountability Compendium (May 2024) [6.3.4] [MOH.0010.0256.0001 at 0071].
[434] Exhibit H2.51. NSW Health Corporate Governance and Accountability Compendium (May 2024) [6.3.3] [MOH.0010.0256.0001 at 0070-0071].
[435] Transcript of the Commission, 21 November 2024, T6542.39-6544.38 (Smith/Portelli).
[436] Transcript of the Commission, 28 November 2023, T70.1-19 (Lyons).
[437] Transcript of the Commission, 28 November 2023, T70.28-34 (Chant).
[438] Transcript of the Commission, 28 November 2023, T84.23-35 (Willcox).

380. While the Ministry retains statewide oversight of the services offered at different locations, including the overall equitability and accessibility of the various services, the funding allocation provided to the Local Health District is largely untied to enable districts to enact and bring their clinical services plan to life and address the needs of their population in a responsive manner.[439]

381. In addition to the policy framework outlined above, there are implementation processes and mechanisms that are also devolved from the Ministry to Local Health Districts.

382. At the Ministry level, there are planning teams which review populations – including demographics, ageing, housing, public transport, and "macro government measures" – which impact on that population and its needs, as well as any specific needs of priority populations, for the purpose of macro level planning.[440] With respect to equity, the Ministry strives for "the same outcomes" for the people of New South Wales, but acknowledges that achieving the same outcomes in relation to the same underlying health need requires different approaches between Local Health Districts.[441] In the rural and regional setting, this involves conducting "place-making work", which, according to the Ministry, brings together relevant people within a community such as community leaders, local government, community members and non-government organisations, to "collectively make decisions around what sorts of health services they're going to need now and into the future".[442]

383. At the Local Health District level, population health planning and clinical service planning is informed by a range of inputs, including Australian Bureau of Statistics data and local government, which is then translated into plans outlining "where their services need to be developed, either location or complexity, to … care for their population". Hospitals and other services will also generate operational plans on the basis of the overarching local and state-level strategic plans to determine how they run their operational services in a

[439] Transcript of the Commission, 21 November 2024, T6542.39-6544.38 (Smith/Portelli).
[440] Transcript of the Commission, 28 November 2023, T159.17-32 (Willcox).
[441] Transcript of the Commission, 28 November 2023, T84.13-17 (Chant).
[442] Transcript of the Commission, 28 November 2023, T162.19-41 (Willcox).

way that is "supporting the population needs that are being described at a macro level".[443]

384. The Ministry, under the guidance of the Secretary, is presently working on strengthening service planning capability within the Ministry, however only to the extent that it informs capital programs, not better clinical service planning.[444]

7.1.1 Drivers of service planning

385. Whilst the above policy and policy implementation framework notionally governs how service planning should occur as between the Ministry and Local Health Districts, it does not necessarily reflect the reality of the planning processes undertaken by each of them, nor the effectiveness of those processes. Rather, the evidence suggests that the reality of service planning is different from the cohesive approach contemplated by the above policies.

386. At a general level, the Special Commission heard evidence that the devolved clinical service planning framework has eroded robust place-based service planning capability within both the Ministry and Local Health Districts. Relevantly, the widespread disinvestment in planning resources within NSW Health and dissolution of its service planning branches following the devolution to Local Health Districts in 2010, as well as ongoing underinvestment in retaining planning skill at the Local Health District level, has fostered a "patchy" approach to service and workforce planning.[445]

387. The top-down devolved service planning structure also means that local needs analysis at the Local Health District level is not driving, and cannot drive, service and workforce planning strategy at the Ministry level. To the contrary, the limited collaboration between the Ministry and Local Health Districts in relation to the implementation of the top-level, principle-based policy documents, means that all strategic decision making effectively sits at the local level.[446] Within a constrained fiscal environment however, the plans do not offer any significant

[443] Transcript of the Commission, 28 November 2023, T159.33-160.9 (Willcox).
[444] Transcript of the Commission, 21 November 2024, T6575.21-37 (Daly).
[445] Transcript of the Commission, 21 November 2024, T6574.34-45 (Daly).
[446] Transcript of the Commission, 19 November 2024, T6356.1-7 (Cox); Transcript of the Commission, 14 October 2024, T5614.18-28 (Griffiths).

guidance with respect to the prioritisation, and where the service priority lies in terms of investment.[447]

388. In these circumstances, the drivers of service planning and delivery have strayed from the Ministry strategic plans toward other, more tangible, considerations at the Local Health District level; namely, the immediate need to continue delivering the current array of services in the context of a highly constrained budgetary environment.

7.1.2 Funding availability

389. The availability of funding is presently, and has historically been, a key driver in decision-making and planning with respect to services that are delivered by Local Health Districts in New South Wales.

390. As outlined elsewhere in this outline, Local Health Districts are primarily funded pursuant to service level agreements with the Ministry. This funding may take on a number of different forms with respect to whether the funding is tied to activity, programs or is available for Local Health Districts to spend as they see fit. However, the Ministry exercises limited oversight of Local Health Districts with respect to the strategic spending of their budgets.

391. Many Local Health Districts are regularly overbudget in their annual service agreements with the Ministry.[448] This suggests that the current base budgets of Local Health Districts are not sufficient to meet the demand placed upon existing services. In these circumstances, there can be no expectation of budget availability for Local Health Districts to invest in the evolution of services in accordance with local population need and demand.

392. It is inevitable that Local Health Districts under these constraints will become overstretched if they attempt to continue meeting need without disinvesting in existing services. However, in the absence of any clear planning about service need more broadly, including how that service need may already be met in surrounding Local Health Districts or other locations, Local Health Districts and the public health system more broadly is forced to continue to attempt to deliver

[447] Transcript of the Commission, 19 November 2024, T6350.1-10 (Mains).
[448] See, for example, Transcript of the Commission, 16 April 2024, T2961.46-2962.17 (Spittal).

a full range of services from multiple locations (despite limited demand and cost inefficiencies).[449]

393. Whilst Local Health Districts can receive program-based funding from the Ministry in a manner which directs them to spend funding in a certain manner, this manner of driving decision-making is not done in a way which is strategic and instead focuses on the resolution of discrete problems.[450]

394. Further, whilst Local Health Districts are subject to a list of standardised key performance indicators in implementing their services,[451] these key performance indicators are largely disconnected from any planning activity in the sense that they are not crafted to measure achievement of whatever objectives a Local Health District may be seeking to achieve through the implementation of its plans. Rather, in a practical sense, these key performance indicators can incentivise Local Health Districts to divert their funding toward particular services.[452] This can come at the expense of community-based services not generally subject of reporting obligations, or a key performance indicator.[453]

395. Ultimately, while it will always be necessary to operate within a confined budgetary envelope, in the absence of structured service planning that commences with an identification of the health need of the community, and the services required to meet that need, it is not possible to reach an informed and objective view as to the adequacy of that budget envelope.

7.1.3 Historical considerations

396. Similarly to funding availability, historical funding commitments have largely underpinned the growth of the public health system, with a focus on maintaining existing services, and creating new services ad hoc when population need, political motive or funding availability arise.

397. The “starting position” for many Local Health Districts is the funding of existing services, which they have committed to fund and the community expects them

[449] Transcript of the Commission, 15 October 2024, T5706.41-5707.2 (Minns).
[450] Transcript of the Commission, 23 May 2024, T3366.1-12 (Astill).
[451] Transcript of the Commission, 28 November 2023, T96.11-21 (Lyons).
[452] Transcript of the Commission, 21 November 2024, T6542.39-6544.38 (Smith/Portelli).
[453] Transcript of the Commission, 21 November 2024, T6547.25-6548.39 (Daly/Smith).

to provide, which can make divesting from services very challenging.[454] In this way, these historical "precedents" effectively limit the discretion of Local Health Districts with respect to the services they can fund and deliver within their allocated budgets.[455] Accordingly, funding of new services or altering the locations of services based on community need largely relies on Local Health District efficiency offsets or other reductions to costs.[456]

398. The tendency for the budgets of Local Health Districts to be set in accordance with historical funding and service precedents reflects several different challenges with divesting, adding or changing services in a reactive, rather than planned, manner. For example, the care delivered can be dictated to some extent by the staff, including clinicians, working within a facility and their particular skill set.[457] Further, in the absence of a longer-term plan outlining service priorities, Local Health Districts cannot always respond appropriately when opportunities for beneficial service change present themselves.[458] Given that changes in service delivery will inevitably affect staff and job security, change management must occur progressively.

399. The retention of services for historical reasons (until such a time as change can progressively be made to re-adjust priorities) also means that any increased costs associated with providing any those services spreads the available funding even thinner across the array of services within the Local Health District.[459]

400. Most importantly, the reality that service delivery is a product of history rather than a careful forward-looking planning process, impedes health care delivery from keeping pace with vast shifts in the community and burden of disease.[460] For example, the Special Commission heard evidence that Cooma Hospital and Health Service was "suffering" from the lack of "any kind of lead or governance program or plan to move it forward", when planning conversations to meet its current demographic should have started 10 years prior.[461] Evidently, the

[454] Transcript of the Commission, 19 November 2024, T6330.3-15 (Wilson).
[455] Transcript of the Commission, 19 November 2024, T6332.11-21 (Wilson), 6334.4-14 (Collins).
[456] Transcript of the Commission, 19 November 2024, T6330.3-15 (Wilson).
[457] Transcript of the Commission, 19 November 2024, T6331.28-47 (Wilson).
[458] Transcript of the Commission, 19 November 2024, T6332.23-42 (Wilson).
[459] Transcript of the Commission, 19 November 2024, T6332.44-6333.11 (Wilson).
[460] Transcript of the Commission, 16 May 2024, T2973.30-43 (Spittal).
[461] Transcript of the Commission, 15 August 2024, T4954.31-44 (Clarke).

current approach has not allowed "sensible reinvestment or evolution of the ways in which [Local Health Districts are] investing to improve health outcomes for [their] community".[462]

7.1.4 Workforce considerations

401. The availability and presence of a workforce to deliver the services offered and prioritised by a Local Health District also influences service planning.

402. For instance, whilst there may be certain services which a Local Health District would prioritise if the required workforce were available, the reality of workforce maldistribution issues means that certain Local Health Districts are unable to attract and retain a workforce in the short-term to staff certain services.[463]

403. To the contrary, where a workforce is available to deliver services that are not necessarily a priority for the population need within a certain community, the mere presence of that workforce alone can drive service planning. For example, Jude Constable, then Acting Chief Executive of Central Coast Local Health District, gave evidence that when she had previously been involved in rural health districts, individual clinicians who lived in the district and developed or brought in highly specialised skills were funded and supported by the Local Health District to offer specialised services that would not otherwise be located within the district. When those clinicians then left the district, the community expected the continued delivery of the specialised service, which became highly political and challenging for the district to manage.

404. The emphasis on workforce availability, rather than population need, as a driver of service planning to some extent reflects the deficiencies in the current workforce planning processes, as well as the limited integration of workforce and service planning.[464] In particular, New South Wales has not "done a very good job of predicting ahead of time how many doctors [it will] need, [and] how many nurses [it will] need", nor facilitating collaboration between educational institutions and medical colleges for the delivery of that workforce.[465]

[462] Transcript of the Commission, 16 May 2024, T2974.17-34 (Spittal).
[463] Transcript of the Commission, 19 November 2024, T6339.32-6340.5 (Constable).
[464] Transcript of the Commission, 20 November 2024, T6448.28-6449.15 (Braithwaite).
[465] Transcript of the Commission, 20 November 2024, T6448.37-6449.15 (Braithwaite).

405. This may, at least in part, reflect the fact that that under the current framework there are too many entities with input into, and influence over, the potential planning approach and its outcomes, including the Commonwealth and State governments, administrators of training placements, medical specialty Colleges, and universities.[466]

7.1.5 Facility-focused

406. Service Agreements between Local Health Districts and facilities for the provision of services are the primary mechanism for the distribution of Local Health District budgets. Because Local Health Districts have traditionally delivered facility-based services, planning processes have had a tendency to be driven by the needs of capital processes, infrastructure and prioritisation of limited capital funds.[467] This facility centric approach is problematic in circumstances where the "real planning need or the needs of [a] community [have] nothing to do with a facility", and instead demand the provision of services in a community in a different way, for example through extended general practice or extended scope of practice for nurses or allied health.[468] The latter kind of planning does not fit easily into the traditional planning process.[469]

407. The Ministry has acknowledged that the focus on "delivering bigger and better, and more beds" should be realigned to a focus on the needs of the community, which may take the focus of health service planning "out of hospital". This would present greater opportunity for "more investment in community-based services rather than continually building bigger and larger hospitals with more beds".[470] It would also allow the reallocation of capital build resources in circumstances where the building and operating costs of those facilities are going to present a "real challenge" for the NSW Health budget into the future.[471]

408. Facility-focused planning, which seeks to continuously upgrade the services available in facilities, particularly those in rural and remote locations, has also encouraged Local Health Districts to invest in facility-based maintenance and

[466] Transcript of the Commission, 20 November 2024 T6502.27-44 (Duckett).
[467] Transcript of the Commission, 16 May 2024, T2958.2-19, 2972.11-22 (Spittal).
[468] Transcript of the Commission, 16 May 2024, T2973.6-22 (Spittal).
[469] Transcript of the Commission, 16 May 2024, T2973.15-20 (Spittal).
[470] Transcript of the Commission, 28 November 2023, T107.1-16 (Lyons).
[471] Transcript of the Commission, 28 November 2023, T107.37-44 (Lyons).

upgrades for the purpose of service planning rather than appropriate patient transport which could connect patients to a broader network of available health care.

409. At present, in addition to Local Health District patient transport vehicles conducting interhospital transfers, HealthShare NSW's Patient Transport Service is available to non-emergency patients who require transport to, or from, a health facility such as a hospital, rehabilitation unit or aged care facility and are assessed as medically unsuitable for community, public or private transport by a medical practitioner or registered nurse. Transports are undertaken within greater metropolitan Sydney (including the Central Coast, Illawarra Shoalhaven and Hunter New England areas), and in other parts of NSW non-emergency patient transport is managed locally.[472] There is also the Isolated Patients Travel and Accommodation Assistance Scheme (IPTAAS), which has associated eligibility criteria and conditions.

410. Notwithstanding the existence of these programs, there remain accessibility issues for patients in rural and remote areas,[473] because HealthShare's Patient Transport Service either does not operate in those areas or applies increased costs for travelling the large distances required,[474] and there is limited community knowledge of, and capability to apply for, the Isolated Patients Travel and Accommodation Assistance Scheme.[475] The gaps in patient transport extend to interhospital transfers, returning patients home after they have received hospital treatment,[476] medical retrieval, and transport to and from outpatient services.[477]

411. As a result of accessibility issues, patients may forego the care they need, [478] or rely on other community services,[479] such as Aboriginal Medical Services for First Nations people,[480] to provide non-emergency transport. Similarly, where there are no other transport options available, ambulances can be forced to

[472] Exhibit B.11. Statement of Carmen Rechbauer (12 February 2024) [77]-[80] [MOH.9999.0009.0001 at 0023].
[473] Transcript of the Commission, 22 May 2024 T3137.15-18 (Bottell); Transcript of the Commission, 16 August 2024 T5109.23-34 (Bennett).
[474] Exhibit K.44, Statement of Tony Gilbertson (9 September 2024) [22]-[23] [MOH.0011.0065.0001 at 0005].
[475] Transcript of the Commission, 22 May 2024 T3135.16-33 (Nott).
[476] Transcript of the Commission, 15 August 2024 T4997.5-19 (Cawthorne).
[477] Transcript of the Commission, 14 May 2024 T2747.18-38 (Mason).
[478] Transcript of the Commission, 22 May 2024 T3135.16-33 (Nott).
[479] Transcript of the Commission, 23 May 2024 T3318.24-30 (Bottrell).
[480] Transcript of the Commission, 14 May 2024 T2739.14-22 (Hampton).

assume the role of non-emergency patient transport, at the expense of attending and completing emergency jobs.[481] It is not acceptable for community services to bear the costs of transporting patients long distances as a result of an inadequate statewide transport offering, nor should Local Health Districts permit the use of ambulances for patient transport which could appropriately utilise a Local Health District patient transport vehicle.[482]

7.1.6 Political considerations

412. It has been suggested that every Chief Executive of a Local Health District likely has a list of services that they would like to cease providing so as to reinvest the moneys liberated into services which would provide better benefit to their particular communities.[483] It is said that disinvestment of this type "is really, really hard and it requires an enormous amount of will and political acumen to actually secure ... not just through the medical politics but also the community politics and then macro politics"; particularly within rural areas.[484] These obstacles are by no means new; they were expressly identified in paragraphs 26.133-26.159 of the Garling Report[485] and very little would appear to have changed since that report was prepared; despite the recommendations it contained, those paragraphs are equally apt to describe the current situation.

413. Political drivers and decision-making also inevitably shape the public health service and the way in which services are planned and provided. Whilst political considerations sometimes arise in circumstances where a new service is negotiated and advocated for by a local Member of Parliament, or where the government is persuaded of a need for a particular service in circumstances where there has been a service failure, political drivers of service planning are most often seen in decisions (or lack thereof) to withdraw services from a particular community or location.

414. Regardless of community need for particular services, there is often a lack of political will to cease inefficient and uneconomic investments and ways of delivering services where there is an expectation that those divestments will be

[481] Transcript of the Commission, 19 November 2024, T6369.17-26, T6370.38-46 (Morgan).
[482] Transcript of the Commission, 16 August 2024, T5109.23-34 (Bennet).
[483] Transcript of the Commission, 21 November 2024, T6560.29-6561.9 (Daly).
[484] Transcript of the Commission, 21 November 2024, T6560.29-6561.9 (Daly).
[485] Final Report of the Special Commission of Inquiry into Acute Care Services in New South Wales Public Hospitals, (27 September 2008) [26.133]-[26.159].

highly resisted and difficult to work through within the affected communities.[486] It is problematic, particularly where such decisions are made during times of austerity, as they deprive Local Health Districts of the ability to meaningfully reinvest the moneys liberated through disinvestment into alternative services which are needed to meet the evolving health needs of a particular community.[487]

415. Parliament, political parties, and bureaucrats recognise the complexity of exploring real and genuine ways to realign the health system, which includes planning with communities and allowing them to understand a transition which will produce the best outcomes for that community.[488] Where community understanding and involvement requires significant planning, investment and consultation, there can be political motivations to maintain services which are unnecessary, or which would be better delivered elsewhere in the State.

416. The political cycle, by which governments realign their priorities or are replaced, can also impact funding, particularly program funding, according to what the government of the day views as a priority. This can force Local Health Districts, as publicly funded organisations, to "pivot" toward the government's priorities at any given time, though this can be costly and time-consuming.[489]

417. Regrettably, these forces will continue to obstruct the necessary evolution of the public health system and, accordingly, its capacity to best meet the changing health needs of communities within New South Wales. While it would be unrealistic to think that these obstructions can be removed entirely, it is possible for the public health system to operate in a manner which reduces the impact that they have.

418. What is required is a greater level of genuine community engagement and transparency around decision making within health. It is understandable that a community will fall prey to political posturing around disinvestment in a service where there is no proper understanding of the decision making process which lies behind that proposal or, particularly, the benefits that are to be obtained by that community through the redeployment of the liberated resources. This lack

[486] Transcript of the Commission, 16 May 2024, T2974.17-34 (Spittal).
[487] Transcript of the Commission, 16 May 2024, T2974.5-39 (Spittal).
[488] Transcript of the Commission, 16 May 2024, T2975.26-44 (Spittal).
[489] Transcript of the Commission, 20 March 2024, T1509.6-18 (Lawrence).

of understanding will inevitably be a feature of any system which lacks transparency and makes decisions “for” rather than “with” the community it is intending to serve.

7.2 The importance of place-based planning

419. The absence – at least at a practical level – of strong systematic planning has fostered the organic development of services in response to other drivers, such as funding and workforce availability, political considerations and historical service commitments. This method of growth has been ineffective in promoting patient safety and fiscal responsibility,[490] and has culminated in a public health system which is increasingly being stretched unsustainably in an attempt to deliver as many services, in as many locations, as possible. No doubt this fact has contributed to the genuine perception within certain areas of the public health system that funding and workforce shortages have driven the system to a “crisis” point.

420. In large part, this reflects the devolved nature of the current service planning framework and the resultant loss of planning capability within both the Ministry of Health and Local Health Districts; it is also a product of the somewhat isolationist approach taken to service planning by those Local Health Districts.

421. At the Local Health District level, service planning has taken on a facility-centric view, whilst inadequate overarching opportunities for coordinating services with surrounding Local Health Districts has limited potential for networked or system-wide planning. Planning of this type is seen – and treated – as the business of NSW Health and executed accordingly. At the Ministry level, a very broad principle-based service planning strategy provides little guidance to Local Health Districts in their distribution and prioritisation of services.

422. In these circumstances, there is a clear need to approach the practice of system-wide health planning in New South Wales in a way which better combines the local knowledge and assessment of Local Health Districts in relation to their population health needs, more genuine collaboration with (and information sharing between) Local Health Districts and other providers of health care within their catchments and overarching systemwide coordination

[490] Transcript of the Commission, 19 November 2024, T6343.19-24 (Mains).

delivered through the Ministry. Greater central involvement in planning is essential in leveraging the whole of NSW Health in the provision of the public health system, including with respect to identifying the most optimal and equitable distribution of services across the State.

423. There is broad acceptance that the approach to place-based planning should involve the following steps:

a. Identification of the health needs of the relevant community. This must be done in genuine collaboration with the community, including other providers of health care within the relevant place;

b. Identification of other entities, including Local Health Districts, which are already (or are capable of) delivering services meet the identified needs;

c. Identification of gaps or areas of need which are not being met;

d. Identification of which of those gaps the public health system 'should' fill and how, both generally and within the relevant community. Once again, this is something that must be done in an open collaboration with the community and all other providers of health care within the relevant place;

e. Ongoing collaboration with the community and other providers of health services to:

i. Determine how emerging gaps are to be filled and what funding is available to enable that to occur;

ii. Generate a strategy which is forward looking and has a reasonable planning horizon;

iii. Incorporate regular and genuinely collaborative processes of monitoring to ensure the plan is delivering on its intended objectives and enables adjustment to be made where required.

424. Each of these steps, and the reason for their respective importance, is outlined below.

7.2.1 Identifying and prioritising health needs and services

425. In developing robust place-based service planning, the steps outlined above reflect an interconnected need to base planning decisions on informed

conclusions about a population's health needs, whether the public health system should be responsible for meeting those needs, and if so, how those needs can be met in the most optimal and equitable manner.

7.2.2 Identification of the health needs of the relevant community

426. As noted above, the first step in this process must be the identification of the health needs of the local community. It is important that this be the first step in the planning process, because unless community needs are identified, there will potentially be large gaps in service provision, including gaps which are invisible to service planners.[491] It also recognises that the health needs of a community should be the core consideration in place-based planning, and "the infrastructure requirements or the service provider requirements to meet that need are secondary to the core purpose of planning".[492]

427. The identification of need, for the purpose of service planning, should involve population needs analysis, demand analysis and analysis of socio-demographic factors,[493] as well as community engagement.[494] In recognising that Local Health Districts are but "a single organisation in a health ecosystem", it should also involve engagement with other local organisations delivering services, in both the primary care and acute care sector,[495] to determine both the quantitative and qualitative needs of the community.[496] This is essential for understanding the entire patient journey, not just their experience in a hospital,[497] and overcoming the "hyper-fragmentation" of healthcare.[498]

428. The 'needs-identification' step of the process will inevitably be best informed by a ground-up approach, whereby Local Health Districts with intimate knowledge of their local communities and the associated health matrix, can feed information into the planning process while also utilising information flowing down from the Ministry, which has a broader understanding of service availability within the State. Local Health Districts can also distil and indicate where regional health needs differ from the needs of specific communities

[491] Transcript of the Commission, 12 December 2024 T6992.37-6994.33 (Wilson/Huckel Schneider).
[492] Transcript of the Commission, 16 April 2024 T2958.2-19 (Spittal).
[493] Transcript of the Commission, 19 November 2024 T6341.25-41 (Mains).
[494] Transcript of the Commission, 15 May 2024 T2893.5-7 (Hawthorn).
[495] Transcript of the Commission, 14 May 2024 T2681.3-13 (Chua).
[496] Transcript of the Commission, 18 September 2024 T5341.15-24 (Maisey).
[497] Transcript of the Commission, 22 March 2024 T1691.35-41 (Ludford).
[498] Transcript of the Commission, 15 August 2024 T4899.9-28 (Gow).

within a region.[499] In this regard, in deciding whether a particular location has a need for a particular service, there is a requirement to "marry the local knowledge and understanding as well as the technical support … from [M]inistry to make those sorts of decisions".[500]

429. Without first identifying health and service needs, there cannot be any valuable exercise in prioritisation with respect to the services that can feasibly be delivered within a Local Health District's budget envelope.[501] In other words, the needs of the community will inevitably form the basis of all subsequent service planning decisions. This is far more productive than attempting to design services to suit funding arrangements.[502]

7.2.3 Identification of what the public health system 'should' deliver and where

430. The next step in developing an approach to service planning is deciding what services should in fact be delivered by the public health system in order to meet the identified need. This involves a broader consideration of what the public health system is and what it can deliver in an economic and safe way.[503]

431. At present, there is a finite budgetary envelope allocated to NSW Health and it is not possible for the public health system to deliver every health service within every Local Health District. This is complicated by the fact that "[d]ifferent people have different expectations of what health services should be provided, where, and by whom".[504] Accordingly, there is a need for NSW Health to consider, first, what services fall within the ambit of the 'public health system', and second, how the public health system can operate to offer those in-scope services to the people of New South Wales in an optimal and equitable way. This must be done as part of an open collaboration with community and other providers of healthcare to that community.

432. With respect to the determination of what the public health system is at its core, and what services it should offer at a statewide level, the Special Commission heard evidence that NSW Health should give consideration to whether the

[499] Transcript of the Commission, 15 May 2023 T2884.23-40 (Hawthorn).
[500] Transcript of the Commission, 20 November 2024 T6485.37-6486.10 (Duckett).
[501] Transcript of the Commission, 19 November 2024 T6334.34-6335.5 (Collins).
[502] Transcript of the Commission, 18 September 2024 T5342.11-28 (Maisey).
[503] Transcript of the Commission, 20 November 2024 T6440.8-31 (Braithwaite).
[504] Transcript of the Commission, 16 August 2024 T5040.29-32 (Clout).

public health system should bear the significant costs spent on certain highly specialised and low volume procedures in all current locations, and/or the delivery of low-value care.[505] Whilst it is not for the Special Commission to decide or comment on decisions of this nature, whilst potentially politically unpopular, they must be made to guide the prioritisation of services and long-term planning decisions.

433. Perhaps more importantly, in circumstances where it is likely to continue receiving the same proportion of the State budget, NSW Health must determine the scope of the public health system, including whether it needs to meet every health need locally,[506] and if not, how services can best be distributed in a safe and economic way.

434. At present, there is a community expectation that the people of New South Wales "can receive every health service they need within 20 minutes of their home address".[507] There is also an expectation that services which have been provided within a Local Health District historically will not be withdrawn or ceased, regardless of whether they are providing efficient and safe outcomes. This has stemmed from the organic growth of services in response to changing community needs and, in a reality where health needs are infinite, a failure to "draw the line on what [the public health system's] role is and what other people's roles are".[508]

435. The challenges presented by community expectations of public healthcare which are unlimited and unrestricted were articulated by Mr Mark Spittal, Chief Executive of Western NSW Local Health District, who gave evidence that his Local Health District was operating seven emergency departments which were fully staffed 24/7 and saw fewer than 1,000 patients per year. In his view, the utility of these services for the community was "really low" and meant that other, higher volume, emergency departments within the district struggled with staffing. However, without "substantial political push", he considered that it would not be possible to close the low utility emergency departments and

[505] Transcript of the Commission, 14 November 2024 T6042.41-6043.34 (Begbie); Transcript of the Commission, 29 November 2023 T237.46-238.47 (Lyons).
[506] Transcript of the Commission, 19 November 2024 T6339.18-19 (Constable).
[507] Transcript of the Commission, 19 November 2024 T6338.29-39 (Constable).
[508] Transcript of the Commission, 21 November 2024 T6542.5-16 (Portelli).

reinvest the money in community-based interventions focused on emergency department avoidance.[509]

436. It is not sustainable for the public health system to fund and provide high cost and low utility services by virtue of community expectation alone. Rather, robust service planning should reflect population need by prioritising and allocating funding to the services of greatest importance to the community, and defunding or de-implementing those services which do not "offer … bang for buck".[510] This process is essential in recognising the current trend that NSW Health "won't be able to fund all of the care that's going to be needed" into the future,[511] and any attempt do so will result in the strained and under-resourced delivery of care within a thinly spread budget envelope.[512]

437. In this respect, under the approach to service planning outlined above, systematic planning would not support the evolution of a service within a district just "because [they] happen[ed] to have a clinician that had the expertise" to perform a specialty service, because this would not reflect quality, safety and value for money in service delivery.[513] To the contrary, this approach to service delivery would be seen to reflect a failure to prioritise services subject to the most community need within a limited budget envelope, resulting in an increasingly over-spread budget across the district and the risk of compromised service delivery.[514]

438. As noted above, in reaching a decision as to the scope of the public health system, including what it should offer and where, the Local Health District and the Ministry must have "open and transparent dialogue" with the people of the relevant locality, as well as clinicians, in relation to their shared vision for the public health system and how this might be reflected in place-based service and workforce planning.[515] Whilst these are undoubtedly difficult conversations, the implementation of a coordinated, system-wide plan for staffing and funding the public health system requires "understanding between governments, organisations like [Local Health Districts], others involved in the

[509] Transcript of the Commission, 16 April 2024 T2975.1-24 (Spittal).
[510] Transcript of the Commission, 20 November 2024 T6431.12-17 (Braithwaite).
[511] Transcript of the Commission, 20 November 2024 T6429.28-39 (Braithwaite).
[512] Transcript of the Commission, 20 November 2024 T6440.8-31 (Braithwaite).
[513] Transcript of the Commission, 19 November 2024 T6340.17-35 (Constable), T6342.39-45 (Mains).
[514] Transcript of the Commission, 19 November 2024 T6343.44-6344.5 (Mains).
[515] Transcript of the Commission, 16 April 2024 T2981.31-32 (Spittal).

delivery of health services and the community at large about what [to] expect in terms of the kind of services that might be available".[516] These discussions cannot take place *after* a decision about the shape or scale of health services in any particular locality has already been made by a Local Health District and/or the Ministry.

439. The conversation with the community must include an explanation of the financial constraints of the public health system, the identified health needs of the community, and the "trade-offs" which have to be made to deliver services that harmonise both patient safety, workforce sustainability and economic efficiency.[517] This may include conversations about the value of existing services, for example "the value of an emergency department that sees triage five patients largely, a thousand a year, compared to all of that money going into something else".[518] It will also inevitably cover any planning assessment which has been made as to:[519]

> *what services are needed for a community to have access to; which of those can appropriately be provided as close as possible to where people live, ie, in their community; which of those services [an LHD] can staff to, to ensure that the staff that are there are appropriate to provide safe and high quality services; and which ones it is going to be far better, just from the point of view of patient safety and quality, for someone to have a process of travelling to, or being provided in a different locality, so that specialist care can be provided when it is needed.*

440. This will, in turn, support Local Health Districts and the communities they serve in a transparent and consistent processes in prioritising particular services and workforce strategies in line with both population need and the broader service planning framework,[520] whilst also disinvesting in services which are not required.

441. Noting the often inherently political nature of decisions or the challenges associated with withdrawing a service over time from one area because it is being provided in another area, a transparent and centralised planning process

[516] Transcript of the Commission, 16 April 2024 T2907.15-30 (Spittal).
[517] Transcript of the Commission, 28 August 2024 T5144.17-19 (May); Transcript of the Commission, 20 November 2024 T6484.1-12 (Duckett); Transcript of the Commission, 16 April 2024 T2979.21-36 (Spittal).
[518] Transcript of the Commission, 16 April 2024 T2981.45-2982.2 (Spittal).
[519] Transcript of the Commission, 16 August 2024 T5040.36-5041.26 (Clout).
[520] Transcript of the Commission, 19 November 2024 T6354.5-7 (Cox).

around that decision-making at the State level would assist in signposting to the community that certain decisions relate to the strategic plan of the State, rather than the individual decision of a Local Health District Chief Executive.[521]

7.2.4 Identification of services being delivered by others

442. Complementary to place-based planning is an understanding that "health services don't exist in isolation" and planning for any one health service must also consider the broader network of health services which is available and interconnected.[522] Accordingly, linked to the consideration of what the public health system should offer within a particular community or district is the consideration of which other entities, including other Local Health Districts, are already (or are capable of) delivering the required services to the public health system.

443. NSW Health receives a finite budget and it is generally not economically efficient or beneficial for patient safety to duplicate all services across multiple Local Health Districts.[523] Whilst the duplication of services between Local Health Districts may be necessary with respect to some services, for example services which must be delivered to a patient on a regular basis (e.g. renal dialysis)[524] or where is a there is a high population demand, there are also a number of costly services operated by Local Health Districts with strained resourcing.

444. Thinking around this issue should not be confined to a range of high complexity, low volume services which are more efficient to deliver in narrowed locations.[525] These are the types of services which are presently intended to be concentrated within the supra-LHD service portfolio of the Ministry of Health.[526]

445. The Special Commission has heard evidence that in the Central Coast Local Health District, certain specialised services such as neurosurgery and cardiac surgery are not delivered anywhere in the district. The absence of these services reflects the fact that, despite the likely desire of some clinicians to bring

[521] Transcript of the Commission, 19 November 2024 T6348.39-6349.20 (Wilson).
[522] Transcript of the Commission, 15 May 2024 T2894.12-17 (Hawthorn); Transcript of the Commission, 16 April 2024, T2980.34-2981.8 (Spittal).
[523] Transcript of the Commission, 18 September 2024 T5290.47-5291.8 (Wong).
[524] Transcript of the Commission, 23 May 2024 T3334.5-17 (Astill).
[525] Transcript of the Commission, 19 November 2024 T6338.29-39 (Constable).
[526] Transcript of the Commission, 28 November 2023 T81.15-42 (Lyons).

those services within the Local Health District, for a population of 350,000, those services are already available on either side of the Local Health District at John Hunter Hospital and Royal North Shore Hospital, and to bring those services within the district and make them operational, effective, safe and efficient, would create significant workforce and training challenges.[527] Therefore, since the population need can be comfortably met outside the district, there is no need nor intention to bring these services into the Local Health District. However, decisions of this type cannot be made in an ad hoc manner, they must be informed by a system wide approach to service planning.

446. Appreciating that this is reflective of the existing approach to supra-LHD or statewide services,[528] Local Health Districts with responsibility for operating such services have the benefit of receiving appropriate funding for the scale of the services and projected activity.[529] Similarly, Local Health Districts relieved of operating such services have the capacity to divert the conserved budgetary resources into other programs based on local community need, whilst simply retaining the capacity to stabilise a patient and "get them to the right service as safely and efficiently and as quickly as possible".[530]

447. In addition to high complexity and specialised services, this supra-LHD approach could be applied to other types of services which would be more efficiently consolidated, rather than duplicated between Local Health Districts.[531]

448. In addition to the abovementioned economic and efficiency gains that would accompany a more deliberate distribution of services statewide, from a patient safety perspective, this type of overarching planning guidance is reflective of a recognition that, within the public health system:[532]

> *all places can't do all things, and so [for] these high acuity, low occurrence procedures ... whether it be cardiology, whether it be trauma, whether it be mental health, whether it be obstetrics, … patients do better in centres that are consolidated with people that are doing high volumes …*

[527] Transcript of the Commission, 19 November 2024 T6339.12-23 (Constable).
[528] Transcript of the Commission, 28 November 2023 T81.15-82.3 (Lyons).
[529] Transcript of the Commission, 20 November 2024 T6440.42-6441.19 (Braithwaite).
[530] Transcript of the Commission, 20 November 2024 T6483.2-14 (Duckett).
[531] Transcript of the Commission, 15 May 2024, T2896.14-32 (Hawthorn).
[532] Transcript of the Commission, 19 November 2024, T6348.17-23 (Morgan).

449. Accordingly, it is preferable for patients in terms of both efficiency and quality to limit certain types of services and procedures to a location where they are regularly performed.[533] This requires patients to understand that "it's better to travel and get very, very good care than get care next door that's substandard … because they're just not doing enough of those procedures".[534] It also requires a community to be sufficiently involved in the planning process to have a proper understanding of the benefits delivered - say, through the development of needed services not currently being delivered - through what might, in isolation, be viewed as adverse decisions. In these circumstances, Local Health Districts would continue to have a responsibility to ensure, through consultation with the Ministry, that people living within the catchment of that Local Health District have the basic services which communities 'should' have available to them, somewhere which is sufficiently proximate to be acceptable.

450. In order for this type of consolidation of services to be feasible, the Ministry needs to share central information about the "statewide blueprint" for service delivery with Local Health Districts to give context to the service delivery planning.[535] Without such information, Local Health Districts can only plan with an understanding of their direct context, which can lead to competition between Local Health Districts for resources (including workforce) to implement services which may be better shared or networked between them.[536] Further, decisions as to the appropriate locations and types of services to be consolidated, on the basis of the needs assessments undertaken at the Local Health District level, would be best made at the Ministry level.

451. However, as outlined above, decisions to withdraw a service from one area or facility because it is being provided in another area or facility are inherently political and challenging from both a community and clinician perspective, including where these decisions relate to services other than highly specialised services.[537] Greater transparency around the evidence base underpinning decisions to withdraw or relocate a service outside of a district, accompanied

[533] Transcript of the Commission, 28 November 2023 T82.8-26 (Lyons); Transcript of the Commission, 20 November 2024 T6440.8-40 (Braithwaite); Transcript of the Commission, 18 September 2024, T5343.9-27 (Maisey).
[534] Transcript of the Commission, 20 November 2024, T6441.41-46 (Braithwaite).
[535] Transcript of the Commission, 15 October 2024, T5707.31-40 (Minns).
[536] Transcript of the Commission, 15 October 2024, T5706.41-5707.2 (Minns).
[537] Transcript of the Commission, 20 November 2024 T6441.11-23 (Braithwaite).

by an explanation of the resulting benefit for local services which could better service community need, would be of significant benefit in navigating those political challenges.[538] It is not possible to offer this kind of rationale without an evidence-informed statewide planning approach through the Ministry which centralises particular services in a cost effective way,[539] or, in the case of non-specialised services, which communicates the prioritization process conducted by Local Health Districts and the advantages of the chosen approach.[540]

452. Although many high complexity, low acuity services are presently primarily concentrated in tertiary hospitals in metropolitan Local Health Districts, it is not suggested that the statewide planning with respect to these, or other, types of consolidated services should be brought exclusively into existing metropolitan hubs. To the contrary, services should be distributed across New South Wales consistently with service planning which has identified the relevant population need and the optimal location for such services in consideration of factors such as population density and quality of outcomes.[541] There will be opportunities for a hub and spoke model of service delivery into rural and remote localities from centralised service hubs to ensure equal access to the public health system.

7.2.5 Identify gaps or areas of need which are not being met

453. The final step underpinning the development of an effective service delivery and workforce plan is the analysis of the local population need, as compared to the services the public health system is willing and able to deliver, and the subsequent identification of the areas of need which are not presently met, or capable of being met.

454. In identifying service gaps requiring rectification, NSW Health should consider the impact of both infrastructure and workforce on service delivery, in addition to the services themselves. The extent to which population need is, or can be, met by services external to Local Health Districts (including private market-based solutions) will also relevant. [542]

[538] Transcript of the Commission, 20 November 2024 T6441.25-46 (Braithwaite).
[539] Transcript of the Commission, 20 November 2024 T6442.13029 (Braithwaite).
[540] Transcript of the Commission, 20 November 2024 T6485.9-28 (Duckett).
[541] Transcript of the Commission, 20 November 2024 T6443.19-38 (Braithwaite).
[542] Transcript of the Commission, 15 May 2024 T2891.2-37 (Hawthorn).

455. At the conclusion of the above process, NSW Health would be equipped to embark on a process of service planning which is cognisant of local community need, the services offered by the public health system which are capable of meeting that need, the private enterprise already satisfactorily meeting that need, the potential for community need to be appropriately met outside the locality of the Local Health District, and any remaining service gaps which need to be filled.

456. Sometimes it may be appropriate for service development for NSW Health to step in to fill gaps, however it may also be appropriate to pass relevant information about the identified area of need to another organisation under a "joined-up" planning approach overseen by the Ministry.[543]

7.3 The importance of "data" to system planning and service delivery

457. There are vast amounts of data within the health system. Some is collected and harnessed well. For example, the Ministry's access to comprehensive data relating to workforce issues, and financial performance of the system enables it to engage in detailed analysis of those matters. As much has been demonstrated in the assistance provided to the Special Commission through the preparation of reports and summaries.

458. However, there are barriers to collection and sharing of data – both across NSW Health agencies, and across the wider healthcare system – in other areas that mean that its power is not fully realised.

459. For example, clinical data is currently captured in a range of disparate systems across NSW Health and the healthcare system more broadly.[544] The siloed nature of the various data systems, including those used across NSW Health agencies, create gaps in understanding health outcomes, thereby hindering the ability of clinicians to be more proactive in administering optimal care and resulting in increased clinical risk.[545] That clinicians are unable to access a patient's comprehensive history due to information not being able to be passed

[543] Transcript of the Commission, 15 May 2024, T2891.2-37 (Hawthorn).
[544] Exhibit D.9, Statement of Sharon Smith (9 April 2024) [15] [MOH.9999.0980.0001 at 0004-0005]; Transcript of the Commission, 16 April 2024, T1895.14-1896.44 (Smith).
[545] See for example, Transcript of the Commission, 15 April 2024, T1812.9-1814.37 (Wood).

between the systems of different Local Health Districts is far from ideal in a modern health system.[546]

460. In this respect, in December 2022 the Strengthening Medicare Taskforce recommended implementing better connections in "health data across all parts of the health system, underpinned by robust national governance and legislative frameworks, regulation of clinical software and improved technology".[547] Consistently with that recommendation, NSW Health has acknowledged that a "secure, end-to-end view of patient information and interactions would greatly contribute to safe, high quality and efficient care giving".[548] To this end, NSW Health has implemented various digital projects and reforms targeted at improving data collection and integration, including the significant "Single Digital Patient Record" project.[549]

461. The strategic objective of the single digital patient record is to deliver a statewide, integrated clinical platform that will provide a holistic view of a patient's medical record at the point of care.[550] It is intended to replace several existing systems that are widely used across NSW Health agencies, namely nine electronic medical record systems, 10 patient administration systems and five pathology laboratory information management systems.[551] It is presently expected to be fully operational across the system in 2029.[552]

462. There is no doubt that the introduction of the single digital patient record will result in several benefits and enhancements across the system, including efficiencies,[553] reduction of unnecessary interventions and clinical errors,[554] better care experiences for patients,[555] and better access for patients to their medical records and information.[556]

[546] Transcript of the Commission, 28 November 2023, T185.26-188.12 (Willcox).
[547] Exhibit A.61, Strengthening Medicare Taskforce Report (December 2022) pp 8-9 [SCI.0001.0053.0001 at 0008-0009].
[548] Exhibit B.23.23, Future Health: Guiding the next decade of health care in NSW 2022-2032 (15 February 2024) p 44 [MOH.0001.0320.0001 at 0044].
[549] For a detailed list of completed and ongoing projects by eHealth NSW since 2018, see Exhibit B.6, Statement of Dr Zoran Bolevich (31 January 2024) [26]-[31] [MOH.0001.0433.0001 at 0005-0020].
[550] Exhibit D.10, Statement of Deborah Willcox AM (9 April 2024) [93] [MOH.9999.0981.0001 at 0032-0033].
[551] Exhibit B.6, Statement of Dr Zoran Bolevich (31 January 2024) [31] [MOH.0001.0433.0001 at 0014].
[552] Exhibit B.2, Statement of Adjunct Professor Michael Nicholl (29 January 2024) [31] [MOH.0001.0262.0001 at 0007].
[553] Transcript of the Commission, 19 April 2024, T2239.22-31 (Smith).
[554] Exhibit B.10, Statement of Vanessa Janissen (8 February 2024) [94] [MOH.9999.0008.0001 at 0033-0035]; Transcript of the Commission, 29 November 2023, T237.11-27 (Lyons).
[555] Transcript of the Commission, 28 November 2023 T185.42-186.3 (Willcox).
[556] Transcript of the Commission, 29 November 2023, T236.43-237.9 (Willcox).

463. However, there are some limitations in the Single Digital Patient Record that have been identified even at this stage of its development. For example:

a. Not all parts of the public health system are presently included. In this respect, it is not immediately clear whether the St Vincent's Health Network will be included in the project.[557] As a significant part of the New South Wales public health system as its only networked Affiliated Health Organisation, there does not appear to be any good reason why it ought not be included, and funded appropriately to facilitate that inclusion.

b. It will not interface with primary care providers, at least initially. The importance of accessibility of records between the primary and acute care settings was a consistent theme that emerged in the evidence, and there can be no doubt of the benefits that could be realised by clinicians having access to a patient's complete record irrespective of where that care is delivered.[558] Whilst the evidence suggests that the issue is under active consideration,[559] it appears that any action to achieve that integration will not occur until the completion of the roll-out in 2029.[560]

c. It will not integrate with interstate or private health systems.[561]

464. There are no doubt barriers to implementing complete integration of records across various systems. However, if the full benefit of the single digital patient record is to be realised, it must interface with other healthcare providers and their systems. Otherwise, many of the existing issues that arise from clinicians not having access to a patient's full record will remain.

465. In addition to patient records, data across the system is critical to effective service planning and delivery. It is evident that some enhancements to that capability can, and should, be pursued. For example, while elective surgery waitlists and emergency department waiting times are recorded, collated and analysed, data concerning other waiting lists – such as for outpatient clinic appointments[562] - do not appear to be approached in a similar way at a system

[557] Transcript of the Commission, 13 June 2024, T3629.21-3634.7 (McFadgen).
[558] Seem for example, Transcript of the Commission, 29 November 2023, T263.2-265.31 (Lyons).
[559] Transcript of the Commission, 23 February 2024, T983.2-984.7 (Belovich); Transcript of the Commission, 19 March 2024, T1397.37-1400.32 (Neal/Mills).
[560] Transcript of the Commission, 28 November 2023, T.185-188.12 (Willcox)
[561] Exhibit F.7, Outline of Evidence of Sally Pearce (Undated) [29] [MOH.9999.1245.0001]; Transcript of the Commission, 18 March 2024, T1279.36-1280.21 (Lindner); Transcript of the Commission, 21 March 2024, T1590.35-1593.23 (Yoosuff).
[562] See, for example, Transcript of the Commission, 21 November 2024, T6548.13-6551.3 (Smith/Portelli).

level. Without robust data of that kind, there is a very real risk that concepts of "demand" will continue to be assessed through the lens of historical "activity" rather than a reflection of present and emerging community need.

466. In addition to enhancing the planning function, capturing a wider range of data sets will enable a refreshed suite of key performance indicators, that are better aligned to measuring whether the relevant agency is meeting the needs the community, its population or, in the case of a Local Health District achieving its primary purpose to protect, promotion and maintain the health of the population for which it is responsible.

7.4 Developing a health service planning strategy

467. The identification and prioritisation of health needs, as per the above process, will support the development of a robust health service planning strategy which identifies exactly how those needs are to be met by the patchwork of services available, and is the product of a collaboration between the community, Local Health Districts, other providers of health services, and the Ministry of Health. Relevantly, the identification of service need, and prioritisation of services to meet that need, at the Local Health District level, will inform the overarching statewide strategy for service delivery at the Ministry level.

468. In this process, the first step is for Local Health Districts to feed the identified gaps in population health need to the Ministry for collaboration as to how those gaps are to be filled and how much funding is available to enable that to occur. This should involve the Ministry taking a system oversight role, in which Local Health Districts present:[563]

    a. The actual health needs of that particular community, including any identified gaps in service delivery;

    b. The services which the Local Health District believes, having prioritised spending within a limited budget envelope, will best meet the needs of that community, including any existing services which do not fall within that category; and

    c. A projection of what it will cost to deliver the priority services.

[563] Transcript of the Commission, 21 November 2024 T6537.5-6538.9 (Smith/Portelli).

469. On the basis of that information, the Local Health District can make a proposal to the Ministry as to the way in which the highest priority services will fit within its budgetary envelope. Alternatively, if the Ministry wants the Local Health District to provide something additional, the Local Health District can place the burden back on the Ministry to either provide additional funding or advise the Local Health District which services can be withdrawn, either because they are outside the scope of the public health system or because they are already adequately offered by other entities providing public health services.[564] In this way, both local and statewide planning processes can feed into funding decisions.[565]

470. In order for this approach to be successful, there is a clear need to rebuild planning capability at both a Local Health District and Ministry level and generate structures which foster genuine collaboration between the Local Health Districts and the Ministry in relation to service planning. Further, whilst the Ministry should take on an oversight role, this should not extend to dictating how Local Health Districts are to go about delivering their services. This is a matter for local decision making.[566] However, where the Ministry is required to drive the development and maintenance of services which are necessary to service the population needs of more than one Local Health District, the Ministry could drive that service delivery through purchasing and activity targets or specific initiatives.[567]

471. Once the Local Health Districts and Ministry have determined the most optimal and equitable way in which the Local Health Districts can provide essential public healthcare services to both local and statewide populations within a finite budget allocation, this decision making should form the basis of a Ministry-level health service planning strategy which is forward looking in nature and has a reasonable planning horizon.

472. It is necessary for a longer-term strategic process to underpin the decisions made about service provision as between the Local Health District and Ministry because it is not possible to change the shape of existing services within the

[564] Transcript of the Commission, 19 November 2024, T6340.37-6341.16 (Constable).
[565] Transcript of the Commission, 19 November 2024, T6342.19-26 (Mains).
[566] Transcript of the Commission, 21 November 2024, T6542.39-6544.38 (Smith/Portelli).
[567] Transcript of the Commission, 21 November 2024, T6589.31-6590.28 (D'Amato/Portelli).

State within a short period of time. However, over a longer planning horizon of approximately 10 years, it is possible to develop services which are consistent with both existing and anticipated need, as well as enable sufficient time for the necessary consultation and feedback from clinicians and the community.[568]

473. Key to the delivery of any services through a centralised or hub and spoke model will be a properly functioning patient transport service. In particular, there is benefit in a built-in hub and spoke model for both services and patient transport, whereby patients can access services centrally before being decanted back to either regional facilities for ongoing treatment, or their homes, as appropriate. The Chief Executive of NSW Ambulance, Dr Dominic Morgan, gave evidence that some jurisdictions had successfully implemented this kind of model by housing patient transport vehicles in large regional centres for the purpose of picking up and dropping off patients from small rural communities.[569] Such a model would support greater consolidation of certain services without compromising equity of access to those services for communities in rural and remote locations. It would however require a well-planned and funded patient transport service which could accommodate both the retrieval and decanting of non-emergency patients requiring public health care services.

474. This approach to service planning will also need to involve an integration of workforce planning with service planning to ensure the availability of the appropriate range and levels of clinical staff necessary to provide services.[570] This requires a collaborative approach between universities, specialist medical colleges and the Workforce Planning Branch of NSW Health to identify and implement the relevant training pathways. There was consensus in the evidence that this planning should not be siloed in the Workforce Planning Branch and that the Health Education and Training Institute should take on a greater role in planning training placements to ensure the composition and location of the NSW Health workforce is consistent with the service planning pipeline.[571]

[568] Transcript of the Commission, 19 November 2024, T6352.5-32 (Wilson).
[569] Transcript of the Commission, 19 November 2024, T6369.1-11 (Morgan).
[570] Transcript of the Commission, 15 August 2024, T4964.20-47 (Stapleton); Transcript of the Commission, 16 August 2024, T5048.33-35 (Clout).
[571] Transcript of the Commission, 14 October 2024 T5618.28-5620.14, T5650.25-5651.5, T5653.11-45 (Griffiths/Dominish).

475. Once developed, the strategy should incorporate regular and genuinely collaborative processes of monitoring and evaluating progress to ensure that the plan is delivering on its intended objectives and enables adjustment to be made where required. This is important for continuous improvement in service planning.[572]

476. NSW Health should also consider whether it would be appropriate for there to be money quarantined for the purpose of funding service planning processes. This may involve the quarantining of funding within Local Health District budgets for activity or initiatives which go towards the achievement of the Ministry's strategic priorities, with some account made for efficiency dividends.[573] Without any quarantining in place, necessary budget may be soaked up in addressing unforeseen and immediate needs.

7.5 Transparency and accountability

477. For the above planning process to be effective and insulate itself – to the greatest extent practicable – from political forces, it must be transparent. Those leading the planning process must also be accountable for delivering on its objectives.

478. There are no commercial sensitivities that realistically attach to the planning and delivery of what is ultimately the public health system. Members of the public are entitled to understand decisions that are made in relation to the prioritisation of the resources made available for the delivery of that system; they have a right to be informed of the extent to which the objectives pursued through those decisions have been achieved. Without transparency and accountability of this kind, NSW Health will not enjoy the trust of the public and political forces will continue to sway decision making in a manner which has the capacity to compromise its ability to best meet the health needs of the community with the finite resources available.

479. Local Health Districts should share with the communities they serve the outcome of the needs analysis which underpins service planning; this should be done in a clear and open way. Communities must understand what the Local

[572] Exhibit H.2.51. NSW Health Corporate Governance and Accountability Compendium (May 2024) [6.3.1] [MOH.0010.0256.0001 at 0069].
[573] Transcript of the Commission, 19 November 2024, T6357.41-6358.1 (Collins).

Health District believes to be their specific health needs and the services required to meet those needs; for example, the proportion of the community suffering from diabetes and the clinic and other services – including primary and specialist care and allied health support – required to address that need.

480. By sharing this information in an open and digestible format, an opportunity is created for the community, or other care providers, to identify hidden need or reflect on the particular way in which care should be delivered to address that hidden need. This information is critically important from a planning perspective as it informs decision making around what services should be provided to that community and how. This process will inevitably involve difficult decisions about how to prioritise the distribution of a limited budgetary envelope; those decisions, and the rationale behind them, must also be delivered to the community in a frank and transparent manner.

481. To that end, this process will frequently identify a far greater level of need than is able to be met by the health services available within the immediate community and its surrounds. As awkward as open discussions around this reality can be, it is critically important that they take place. NSW Health and Local Health Districts must ensure that community, clinicians and other providers of care understand, and are meaningfully engaged in the decision making processes about whether, and if so how, these health needs are going to be provided for within the public health system or elsewhere.

482. Importantly, the Local Health District should identify the intended outcomes of the planning process in terms which enable it – and the community it serves – to objectively monitor the extent to which those outcomes are being achieved.

483. Publicly available planning documents should spell out – in language that is clear – the identified health needs of the community, the services that it is anticipated will be required to meet those health needs, how (and by who) it is intended that those services will be provided. These documents should also be explicit about what members of the community requiring those services should expect in terms of accessibility (including transportation arrangements, were necessary) and waiting times (the metrics around which will inevitably be informed by appropriate clinical evidence). For the avoidance of doubt, this form

of information must extend well beyond what the community is to expect in terms of wait times for ambulance services, care delivered in emergency departments or for elective surgery; it should include (but by no means be limited to) wait times for the delivery of specialist outpatient care delivered through the public health system.

484. Finally, the extent to which these identified outcomes are being achieved must be measured and reported upon.

485. Views will likely differ as to whether these outcomes should inform the key performance indicators incorporated into the service agreements of the Local Health Districts/Specialty Health Networks.[574] To the extent that they reflect important health objectives to be delivered through the funds provided under those agreements, they probably should.

486. The Special Commission heard evidence that measuring outcomes in real time (other than adverse events) is challenging, but there is strong evidence that many process indicators correlate with program outcomes and benefits.[575] There is also a shift towards developing indicators that measure patient outcomes in areas such as mental health and renal supportive care.[576] It was noted that some terminology for the key performance indicators has to be matched to the national indicators against which the State's performance will be measured.[577]

487. The Special Commission was told by Local Health District board members that the list of indicators is long and mostly volume based, and whilst they find them useful for monitoring progress, they would like to see an evolution towards other indicators that reflect value based health care.[578] One Chief Executive noted that there are more than 100 indicators in the service agreements, mostly measuring inputs and outputs, and in her view there should be a better combination of input, output, outcome, lead and lag indicators.[579] There can also be tension between the efficiency improvement program and meeting the

[574] An approach which has been embraced by the Justice Health and Forensic Mental Health Network: see, for examples, Transcript of the Commission, 19 November 2024, T6321.23-6323.4 (Hoey).
[575] Transcript of the Commission, 28 November 2023, T92.9-42, T97.10-40 (Chant).
[576] Transcript of the Commission, 30 November 2023 T301.45-302.5 (Willcox).
[577] Transcript of the Commission, 16 April 2024 T1895.3-12,T1916.1-8 (Smith).
[578] Transcript of the Commission, 21 March 2024, T1544.38-1545.33 (Dixon/Kolbe).
[579] Transcript of the Commission, 18 September 2024, T5333.33-5335.9 (Maisey).

key performance indicator targets.[580] Particular challenges were noted with some quality indicators in facilities that have very small patient volumes, as one incident will automatically exceed the performance threshold.[581]

488. Approached in this way, they are likely to be more productive of allocative efficiency than many of the generic key performance indicators which are currently a feature of these documents. Whether or not they are reflected in key performance indicators, they must be measured and shared – perhaps with the independence injected by the Bureau of Health Information – with the community served by the Local Health District/Specialty Health Network.

489. Whatever approach is ultimately taken, the current suite of key performance indicators in service agreements and statements of service should be reviewed with a view to reducing the total number and improving the balance between the five types of indicators - input, output, outcome, lead and lag indicators. They should also be adapted to more meaningfully assess the extent to which a Local Health District Network is fulfilling its core function – including to protect, promote and maintain the health of the population.

490. Transparency of this type will inevitably result in the identification of areas where NSW Health is failing to deliver on the outcomes sought to be achieved through the above planning process; but it is essential to maintaining the trust of both clinicians and the community and promoting further collaboration between all relevant stakeholders in an attempt to address the highlighted challenges. Ultimately, a mature public health system should not be afraid to confront its failings.

7.6 Conclusion and key recommendations

491. At a practical level, NSW Health must implement a transparent, committed, and collaborative approach to system wide planning, of the type outlined below. Whilst the local identification of health needs and general perspective of Local Health Districts should remain an important part of this process, there is a need for greater system-wide planning, coordinated through the Ministry, and a far

[580] Transcript of the Commission, 18 September 2024, T5365.31-5363.34 (Maisey).
[581] Transcript of the Commission, 23 May 2024 T3366.38-3367.4 (Astill).

greater level of engagement of community and other providers of health services at every stage in the planning process.

492. That planning process must – in a tangible way – involve at least the following:

a. Identification of the health needs of the relevant community. This must be done in genuine collaboration with the community, including other providers of health care within the relevant place;

b. Identification of other entities, including other Local Health Districts, which are already (or are capable of) delivering services to meet the identified needs;

c. Identification of gaps or areas of need which are not being met;

d. Identification of which of those gaps the public health system 'should' fill and how, both generally and within the relevant community. Once again, this is something that must be done in an open collaboration with the community, clinicians and all other providers of health care within the relevant place;

e. A system wide approach, coordinated within the Ministry, to determining what services are to be provided through the public health system to ensure that the identified health needs of the relevant population are met in an accessible but sustainable way, recognising that not all services can or should be provided everywhere;

f. Ongoing and genuine collaboration with the community and other providers of health services to:

i. Determine how emerging gaps are to be filled and what funding is available to enable that to occur;

ii. Generate an evolving strategy which is forward looking and covers short, medium and long term planning horizons; and

iii. Incorporate genuinely collaborative and transparent processes of monitoring, to ensure the plan is delivering on its intended objectives and enables adjustment to be made where required.

493. System-wide, coordinated planning, of that kind needs to be accompanied by a transparent articulation of the planning process, the health needs of the community identified through that process, the way in which those health needs are to be met and, to the extent that they are not, this also needs to be clearly articulated and an explanation of the rationale for this decision provided. It is essential that the extent to which those objectives are being achieved is reported upon in a frank and transparent way, potentially supported by expanded reporting by the Bureau of Health Information.

8 STATEWIDE SERVICES

494. The Ministry has responsibility for a range of services that are "above" Local Health Districts. These services are referred to as "supra-LHD" services and consist of services which are highly specialised and need to be concentrated in a lesser number of sites.[582] The Ministry's Strategic Reform and Planning Branch oversees and manages supra-LHD services.

495. Examples of supra-LHD services, which are only provided at a small number of sites across the State, include:[583]

a. Adult Intensive Care Units;

b. Neonatal Intensive Care Services;

c. Mental Health Intensive Care;

d. Adult Liver Transplant;

e. Blood and Marrow Transplantation;

f. Heart and Lung Transplantation;

g. Severe Burn Services;

h. Spinal Cord Injury Services;

i. High Risk Transcatheter Aortic Valve Implantation;

j. Organ Retrieval Services; and

k. Neurointerventional Services endovascular clot retrieval for Acute Ischaemic Stroke.

496. There are a range of factors influencing the decision to concentrate highly specialised services into a more limited number of sites, however the primary driver is that "there are small numbers of those procedures done proportionally and there is a need to concentrate … [those] skills, in a site that enables that service to be available 24/7, 365 days a year".[584] Relevantly, there are better clinical outcomes where there is a concentration of highly specialised procedures within a team who regularly complete such procedures, and

[582] Transcript of the Commission, 28 November 2023 T81.15-27 (Lyons).
[583] Transcript of the Commission, 29 November 2023 T81.29-42 (Lyons); see, for example, Exhibit B.23.27, NSW Health Sample Service Agreement 2023-24 [MOH.0001.0288.0001 at 0009-0013].
[584] Transcript of the Commission, 28 November 2023 T82.5-17 (Lyons).

therefore can provide the highest quality care.[585] It would not be possible, nor appropriate, to replicate these types of services across multiple sites.[586]

497. The Service Agreements between the Secretary and Local Health Districts which host a supra-LHD service include a recognition that the Local Health District is providing a service which is for residents outside of their Local Health District.[587] In particular, the resources deployed into such Local Health Districts reflect that they have a responsibility to provide services on a statewide basis.[588] In procuring statewide services, the Ministry also identifies the populations that are accessing the services in order to inform decisions about access and equity to the supra-LHD services.[589]

8.1 Current arrangements for statewide services

498. As a matter of practice, the Ministry's oversight role does not extend to the planning or governance of statewide services, nor does it involve the funding of these services. Responsibility for planning, governance and funding is held at the local level, whether that be the relevant Local Health District, or the individual services themselves.

499. The Special Commission heard evidence from the Clinical Directors of two statewide services, the NSW Spinal Cord Injury Service and the NSW Brain Injury Rehabilitation Program, with respect to the arrangements for those services. In particular, James Middleton gave evidence in his capacity as Clinical Director of the NSW Spinal Cord Service and Stuart Browne gave evidence in his capacity as Clinical Director of the NSW Brain Injury Rehabilitation Program.

500. Both the NSW Brain Injury Rehabilitation Program and the NSW Spinal Cord Injury Service are made up of inpatient and community-based services which are highly specialised, high cost, and low volume.[590] The evidence relating to the arrangements for the NSW Spinal Cord Injury Service and the NSW Brain Injury Rehabilitation Program suggests that the present decentralised approach

[585] Transcript of the Commission, 28 November 2023 T82.19-26 (Lyons).
[586] Transcript of the Commission, 28 November 2023 T149.24-29 (Lyons).
[587] Transcript of the Commission, 28 November 2023 T81.15-27 (Lyons).
[588] Transcript of the Commission, 28 November 2023 T81.44-82.3 (Lyons).
[589] Transcript of the Commission, 28 November 2023 T82.31-37 (Chant).
[590] Transcript of the Commission, 24 April 2024 T2417.43-45 (Middleton).

to the governance and coordination of statewide services presents challenges with respect to service provision, equity of access and funding.

8.1.1 NSW Spinal Cord Injury Service

501. Spinal cord injuries are relatively rare but are a highly complex condition.[591]

502. The inpatient services falling within the NSW Spinal Cord Injury Service are delivered through three main hospitals, being Royal North Shore Hospital, Royal Rehabilitation Centre and Royal Prince of Wales Hospital; they are notionally available to the whole of New South Wales population. The community-based services, namely the statewide spinal outreach and rural services, are operated both in metropolitan Sydney, as well as in each rural Local Health District under the supervision of a rural coordinator.[592]

503. The statewide spinal outreach service, which forms part of the NSW Spinal Cord Injury Service, is a multidisciplinary service through which patients can receive a wide range of community-based advice and support for 12 months post-injury. This aspect of the Service supports the re-integration of patients into their communities through linkages with government and non-government services and is provided through the funding arrangement between Northern Sydney Local Health District and Royal Rehab.[593] Potential participants and candidates for services through the statewide outreach service are generally identified by word of mouth if they have not already been treated by specialist inpatient services, and may not be identified until “some time down the line”.[594]

504. Relevantly, there are a large number of people with a spinal cord injury that are not receiving care in a timely way, or at all, and who are not visible to the NSW Spinal Cord Injury Service. This is because the NSW Spinal Cord Injury Service only has visibility of patients who have been triaged through an acute service, specialised rehabilitation service, or through the outreach service.[595] Aside from the services within the NSW Spinal Cord Injury Service, there are no other

[591] Transcript of the Commission, 24 April 2024 T2417.45-47 (Middleton).
[592] Transcript of the Commission, 24 April 2024 T2417.43-2418.21 (Middleton).
[593] Transcript of the Commission, 24 April 2024 T2419.4-30 (Middleton).
[594] Transcript of the Commission, 24 April 2024 T2421.36-2422.2 (Middleton).
[595] Transcript of the Commission, 24 April 2024 T2424.26-33 (Middleton).

specialist spinal cord services in New South Wales. This presents challenges for the current structure, funding and governance of services.[596]

505. Compounding these barriers to access is the reality that there are insufficient specialist rehabilitation beds at Royal Rehabilitation Centre and Prince of Wales Hospital to enable patient flow and therefore those resources are very difficult to access.[597] There are also associated bottlenecks in intensive care and the acute services at Royal North Shore Hospital and Prince of Wales Hospital because there are insufficient rehabilitation beds but also challenges with discharging people into the community.[598]

506. Dr Middleton considered that the existing difficulties stemmed from the lack of centralised governance with respect to statewide services.[599] Local Health Districts are responsible for delivering statewide services, however the service agreements to deliver statewide services do not provide any guidance as to how those services are to be delivered. As a result of this lack of central coordination, services are coordinated within the major service hospitals, without input or negotiation at the Local Health District or Ministry level.[600]

507. In this regard, Dr Middleton noted that whilst patient flow data is managed well and tightly *within* Local Health Districts, it is not coordinated across district boundaries.[601] The lack of overarching governance or coordination with respect to the flow of patients between Local Health Districts for statewide services prevented any systematic prioritisation of which patients should attend which service to maximise "right care, right place, right time".[602]

508. Dr Middleton also raised the issue of funding and the limited avenues available to statewide services to have their funding reviewed or increased in accordance with growth. In particular, the funding allocated to statewide services is absorbed into already-stretched Local Health District budgets and it is difficult for statewide services to raise funding issues when they are dealing with statewide population health issues that are not necessarily on the radar of the

[596] Transcript of the Commission, 24 April 2024 T2418.33-36 (Middleton).
[597] Transcript of the Commission, 24 April 2024 T2425.3-11 (Middleton).
[598] Transcript of the Commission, 24 April 2024 T2425.3-11 (Middleton).
[599] Transcript of the Commission, 24 April 2024 T2424.1-18 (Middleton).
[600] Transcript of the Commission, 24 April 2024 T2419.35-2420.10, T2424.17-24, T2438.40-2439.12 (Middleton).
[601] Transcript of the Commission, 24 April 2024 T2422.3-7 (Middleton).
[602] Transcript of the Commission, 24 April 2024 T2423.25-34 (Middleton).

individual Local Health Districts that fund them.[603] Further, there is varying understanding, and awareness, of statewide services in some Local Health Districts, and Dr Middleton was concerned that rural Local Health Districts had rejected three business cases for enhancement of the rural spinal cord outreach services in the prior 12 months, despite modelling showing that the demand for the service had grown significantly.[604] The activity based funding provided through the NSW Spinal Cord Injury Service was also inappropriate and unsuitable for the types of highly specialised, highly complex spinal cord injuries treated by the service.[605]

509. Dr Middleton gave evidence that NSW Spinal Cord Injury Service's accessibility issues, particularly with respect to bed availability and length of wait, could only be resolved by a "multi-system" approach.[606] Accordingly, the NSW Spinal Cord Injury Service had been working on developing a networked model of care. This network model would involve an early notification system to coordinate and triage care for people with a spinal cord injury in a timely fashion. To this end, the Service is presently exploring with the Ministry whether the patient flow portal may be used as a mechanism for identifying patients with spinal cord injuries across services.[607] The Agency for Clinical Innovation, which the NSW Spinal Cord Injury Service falls under, has also been producing data models to assist in a business case for improving patient flows, timely access to care, improved outcomes, and the opportunity cost of maintaining existing systems.[608]

510. Dr Middleton gave evidence that the NSW Spinal Cord Injury Service's designation by NSW Health as a supra-LHD service did not make any practical difference to the operation of the service and did not involve any central oversight or mechanism. Relevantly, beyond a line in Service Agreements, the designation "doesn't really mean anything".[609] Dr Middleton also agreed that the role of the NSW Spinal Cord Injury Service at the Agency for Clinical Innovation level was related to the development of models of care. It does not have any

[603] Transcript of the Commission, 24 April 2024 T2428.12-23 (Middleton).
[604] Transcript of the Commission, 24 April 2024 T2427.24-2428.23 (Middleton).
[605] Transcript of the Commission, 24 April 2024 T2437.21-42 (Middleton).
[606] Transcript of the Commission, 24 April 2024 T2425.30-47 (Middleton).
[607] Transcript of the Commission, 24 April 2024 T2422.8-2423.1 (Middleton).
[608] Transcript of the Commission, 24 April 2024 T2425.18-28 (Middleton).
[609] Transcript of the Commission, 24 April 2024 T2437.7-19 (Middleton).

operational responsibility or involvement in the day-to-day workings of the Local Health Districts and spinal units.[610]

8.1.2 NSW Brain Injury Rehabilitation Program

511. The NSW Brain Injury Rehabilitation Program is a group of approximately 15 services spread across New South Wales, which are networked for the purpose of operations and communication.[611] The services provide complex and multidisciplinary rehabilitation for patients with severe or very severe traumatic brain injuries, with inpatient units for both adults and children, transitional living units, as well as community-based rehabilitation programs.[612] There are approximately 800 people admitted to the Program each year.[613]

512. The NSW Brain Injury Rehabilitation Program was developed in recognition of the fact that the type of impairments and disabilities suffered by patients with traumatic brain injury do not necessarily fit neatly within general rehabilitation wards, because injury to the brain from trauma is widespread and can range from complex physical impairments, to principally cognitive impairments, to difficulties with memory and communication impairments.[614]

513. The inpatient services are concentrated in Sydney, with adult inpatient rehabilitation units at the Royal Rehabilitation Centre, Liverpool Hospital and Westmead Hospital operating approximately 50 beds in total. These units target "working-age" people from approximately 16 to 70 years of age and are operated by multidisciplinary teams. For patients outside Sydney, regional community rehabilitation services are also available.[615] To ensure ongoing awareness of brain injury conditions outside of metropolitan areas, there is networking and information-sharing between the community teams and the inpatient teams.[616]

514. The inpatient units operated through the NSW Brain Injury Rehabilitation Program are concentrated in Sydney to maintain the expertise of clinicians in brain injury rehabilitation, which is a low volume condition.[617] The three units

[610] Transcript of the Commission, 24 April 2024 T2429.16-24 (Middleton).
[611] Transcript of the Commission, 23 April 2024 T2397.38-40, T2409.31-33 (Browne).
[612] Transcript of the Commission, 23 April 2024 T2397.38-2398.6 (Browne).
[613] Transcript of the Commission, 23 April 2024 T2405.24-35 (Browne).
[614] Transcript of the Commission, 23 April 2024 T2399.17-29 (Browne).
[615] Transcript of the Commission, 23 April 2024 T2400.4-2401.12 (Browne).
[616] Transcript of the Commission, 23 April 2024 T2409.31-2410.4 (Browne).
[617] Transcript of the Commission, 23 April 2024 T2405.12-20 (Browne).

see approximately 130 to 150 patients per year,[618] and it is intended that each of the units services one third of New South Wales for the purpose of inpatient services, with Royal Rehabilitation Centre servicing the Northern third, Westmead Hospital servicing the middle third, and Liverpool Hospital servicing the Southern third.[619] Whilst it would be desirable to have a greater spread of inpatient expertise in units outside of Sydney or Newcastle, the numbers of patients those units would receive would likely be insufficient to maintain such services.[620]

515. That said, according to Dr Browne, the three adult brain injury units for traumatic brain injury in Sydney cannot provide traumatic brain injury rehabilitation for all people in New South Wales who require that service, because there are not enough beds.[621] Dr Browne estimated that the three inpatient units in Sydney saw approximately half of the patients with serious traumatic brain injuries in a year.[622] It follows that the remaining patients are either treated within general rehabilitation units or receive outpatient care by way of community rehabilitation services. In addition to there being insufficient beds, Dr Browne attributed the unseen patient load to the fact that all three inpatient units are located in metropolitan Sydney, which is a long way for family members in, for example, far regional New South Wales to have to travel for months at a time,[623] as well as the admission criteria which favours patients of working age.[624] There had been no increase in the number of inpatient beds available in over 20 years despite a significant increase in population, which has placed a significant burden on the inpatient teams.[625]

516. The inability of the statewide service to keep up with population demand in part reflects the lack of central decision making through NSW Health in relation to the nature and/or volume of services to be provided through the NSW Brain Injury Rehabilitation Program. Similarly, there is no centralised decision making process for decisions relating to funding, the location of services, and staffing

[618] Transcript of the Commission, 23 April 2024 T2405.24-25 (Browne).
[619] Transcript of the Commission, 23 April 2024 T2409.31-41 (Browne).
[620] Transcript of the Commission, 23 April 2024 T2405.12-20 (Browne).
[621] Transcript of the Commission, 23 April 2024 T2404.36-44 (Browne).
[622] Transcript of the Commission, 23 April 2024 T2405.41-46 (Browne).
[623] Transcript of the Commission, 23 April 2024 T405.3-10 (Browne).
[624] Transcript of the Commission, 23 April 2024 T2406.1-11 (Browne).
[625] Transcript of the Commission, 23 April 2024 T2411.13-27 (Browne).

of services.[626] The various brain injury rehabilitation services are managed and funded by the Local Health Districts where they are located, and the locations of those services are historic.[627] The NSW Brain Injury Rehabilitation Program does not receive any funding directly for its services or patients.[628]

517. As a result, different Local Health Districts allocate different amounts of funding to services within the NSW Brain Injury Rehabilitation Program. These allocations may be relative to population need, for example, the inpatient services in Sydney treat a greater number of patients and therefore receive a greater amount of funding. Allocations may also be based on other factors, such as activity based funding, which does not work particularly well for community-based brain injury rehabilitation which involves significant planning and coordination that is not captured by the face-to-face patient therapy favoured by the activity based funding model. In regional New South Wales, community-based brain injury rehabilitation services are more prevalent than in metropolitan areas, and differences in funding allocations between regional Local Health Districts have seen some services transition from multidisciplinary rehabilitation teams to case management services which link patients with external rehabilitation supports, creating some inequities between regions with different make-ups of their therapy teams.[629]

518. Further, there is no central monitoring, oversight or control over service provision. The Local Health District which houses the relevant service has complete responsibility for service provision.[630] In circumstances where services within the NSW Brain Injury Rehabilitation Program are unavailable to patients with serious traumatic brain injuries, those patients may undergo their rehabilitation in a different hospital that is not a specialty traumatic brain injury service. Noting that patients who undergo rehabilitation in general units have worse outcomes than those who undergo rehabilitation in specialist inpatient units,[631] Dr Browne agreed that this was an area for improvement within the Program.[632]

[626] Transcript of the Commission, 23 April 2024 T2406.44-2407.11, T2411.13-27 (Browne).
[627] Transcript of the Commission, 23 April 2024 T2406.45-2407.7 (Browne).
[628] Transcript of the Commission, 23 April 2024 T2408.30-45 (Browne).
[629] Transcript of the Commission, 23 April 2024 T2407.22-2408.15, T2409.20-23 (Browne).
[630] Transcript of the Commission, 23 April 2024 T2407.13-20 (Browne).
[631] Transcript of the Commission, 23 April 2024 T2411.29-37 (Browne).
[632] Transcript of the Commission, 23 April 2024 T2412.3-19 (Browne).

519. With respect to the role of NSW Brain Injury Rehabilitation Program itself, Dr Browne considered that the Program's role was to bring together various services to consider data and identify service gaps, including by monitoring data relating to the number of clients who come through the Program's services, client demographics, length of stay, and other functional outcomes.[633] In this regard, the NSW Brain Injury Rehabilitation Program sits within the Agency for Clinical Innovation, which employs Dr Browne, as well as a full-time manager, data manager, and education officer, to act in a coordination role with respect to the Program.[634]

520. However, Dr Browne agreed that the coordination role undertaken by the NSW Brain Injury Rehabilitation Program was largely limited to the level of information sharing, rather than coordinating service provision or funding.[635] The Program's ability to identify service gaps was also reliant on measurement done, and data collected, at the level of the individual service providers and Local Health Districts.[636]

521. Despite operating services on a statewide scale, the NSW Brain Injury Rehabilitation Program is not designated as a supra-LHD service.[637] Dr Browne was unaware of the reason for this (lack of) designation but considered that the program did, in fact, provide a supra-LHD service.[638]

8.1.3 A more formalised approach to supra-LHD and statewide services?

522. There is no centralised governance, or executive sponsorship, of supra-LHD and statewide services of the kinds referred to above. Accordingly, there is also no mechanism for escalating issues for the purpose of "central and coordinated governance and management; coordination and resources; [and] clear funding that is adequate".[639] All governance instead exists at the local, rather than statewide level.

523. Relevantly, the Ministry previously had a Statewide Services Development Branch which was involved in statewide planning and developed specialised

[633] Transcript of the Commission, 23 April 2024 T2410.15-23 (Browne).
[634] Transcript of the Commission, 23 April 2024 T2410.41-2411.4 (Browne).
[635] Transcript of the Commission, 23 April 2024 T2411.6-11 (Browne).
[636] Transcript of the Commission, 23 April 2024 T2410.29-33 (Browne)
[637] Transcript of the Commission, 23 April 2024 T2412.21-27 (Browne).
[638] Transcript of the Commission, 23 April 2024 T2412.29-34 (Browne).
[639] Transcript of the Commission, 24 April 2024 T2426.2-12 (Middleton).

statewide plans every five years. Whilst this branch was not a mechanism to support the implementation of the statewide plans, it did provide opportunities to identify gaps in service provision, raise issues, and advocate for growth funding. The NSW Spinal Cord Injury Service's rural spinal cord outreach service was initially funded by the Statewide Services Development Branch following an extensive research project to develop and evaluate the model.[640] Whilst that funding has been maintained since the closure of the Branch, there has never been a review of the funding for growth purposes.[641]

524. For Dr Middleton, governance was the "very important missing piece" in the current arrangements for statewide services.[642] However, in his view, governance of statewide services needed to go further than the mere re-establishment of the Statewide Services and Development Branch within the Ministry of Health. Relevantly, whilst that branch was successful in producing a centralised approach to planning, it was not linked to funding.[643]

525. Dr Middleton gave evidence that the ideal centralised body or mechanism for governance of statewide services would involve the Agency for Clinical Innovation, the Local Health Districts and various parts of the Ministry responsible for financing, performance and planning. This body or mechanism would then hold responsibility for the overarching governance of statewide services, including planning, implementation, funding, data management, performance agreements, monitoring outcomes and review of the ways in which services are delivered.[644]

526. With respect to funding, Dr Middleton said funding for statewide services needed to be identified, managed and monitored centrally, before flowing down into the Local Health Districts with detailed service agreements specifying the services to be provided, the staffing required, and the measurable outcomes.[645] This approach would avoid the funding for statewide services having to compete against the other variable demands of a Local Health District and

[640] Transcript of the Commission, 24 April 2024 T2426.14-33 (Middleton).
[641] Transcript of the Commission, 24 April 2024 T2426.35-46 (Middleton).
[642] Transcript of the Commission, 24 April 2024 T2426.8 (Middleton).
[643] Transcript of the Commission, 24 April 2024 T2427.24-32 (Middleton).
[644] Transcript of the Commission, 24 April 2024 T2427.34-2428.10, T2436.10-16, T2442.37-2443.17 (Middleton).
[645] Transcript of the Commission, 24 April 2024 T2445.24-32 (Middleton).

would also allow the funding for statewide services to be reviewed in its own right and increased over time.[646]

527. Dr Browne agreed that the NSW Brain Injury Rehabilitation Program would benefit from central oversight. However, in his view, the benefits of this approach related primarily to ensuring equity of access in the location and scope of services, noting that centralisation would assist to ensure consistency in clinician to client ratios and enable people in different parts of New South Wales, both metropolitan and regional, to access a similar service.[647] In this regard, centralisation was "an important way of ensuring some degree of equity" for highly specialised, low volume services such as traumatic brain injury rehabilitation,[648] and could be assisted by greater access to telehealth services as "the most obvious starting point" as well as the possibility of having health professionals work across LHDs.[649]

528. The evidence of Dr Middleton and Dr Browne supports a finding that statewide services, which presently lack any coordinated framework for planning, service provision or funding, would benefit from a more formalised and centralised structure. The current structure, whereby statewide services are coordinated almost entirely at the local level, is neither an appropriate nor a transparent mechanism for providing such services in an optimal and equitable manner.

8.2 Paediatric Services

529. Paediatric services are delivered through three specialist children's tertiary referral hospitals (Sydney Children's Hospital at Westmead, Sydney Children's Hospital at Randwick, and John Hunter Children's Hospital, Newcastle), and within facilities in Local Health Districts.

530. However, there are presently some limitations as to how those highly specialised services integrate and support those delivered in the Local Health Districts. Associate Professor Preddy identified, from the perspective of a clinician practicing outside of the Sydney metropolitan area, as including:[650]

[646] Transcript of the Commission, 24 April 2024 T2443.19-43 (Middleton).
[647] Transcript of the Commission, 23 April 2024 T2408.47-2409.18, 2413.29-38 (Browne).
[648] Transcript of the Commission, 23 April 2024 T2413.42-46 (Browne).
[649] Transcript of the Commission, 23 April 2024 T414.14-37 (Browne).
[650] Exhibit G.33, Statement of Associate Professor John Preddy (30 May 2024) [12]-[15] [SCI.0011.0067.0001 at 0003-0004].

a. there were frequently insufficient beds available in specialist children's hospitals to get the quaternary care they need in a timely way, sometimes because the beds in the specialist hospitals were taken up by the provision of secondary and tertiary care that could be provided elsewhere;

b. children's hospitals often do not transfer back to the local paediatric department once the need for quaternary care has ended (which if done would free up capacity at the children's hospitals);

c. a lack of consistent referral pathways for General Practitioners to refer children for specialist treatment, with General Practitioners often referring directly to subspecialist paediatrician rather than general paediatricians; and

d. transfers often rely on relationships between clinical, noting that with the exception of NETS there is no centralised or coordinated system for managing transfers of children requiring quaternary or other specialised care.

531. Whilst, from his perspective, Associate Professor Preddy considered that escalation of care for paediatric patients in emergency situations works very well, referrals for specialised care in non-emergency situations did not work as well due to a lack of a coordinated approach to those processes, which could often result in patients not be referred back into his care for ongoing treatment and management once the need for specialised care had passed.[651]

532. Recognising some of those challenges, the Sydney Children's Hospitals Network has taken some steps to formalise its relationships with several Local Health Districts by entering into heads of agreement with each of them.[652]

533. However, a general consensus emerged in the evidence that paediatric services in New South Wales would benefit from a Statewide plan and strategy that (among other things) clearly identified the roles of the specialist children's hospitals and the services that exist in Local Health Districts, and how those

[651] Transcript of the Commission, 14 June 2024 T3646.23-35 (Preddy).
[652] Transcript of the Commission, 11 June 2024 T3431.20-3434.33 (Cox); See also Transcript of the Commission, 11 June 2024 T T3407.45-3408.42, T3409.41-3410.16 (Ging); See, for example, Exhibit G.114, Heads of Agreement between SCHN and Hunter New England LHD (December 2020) [MOH.9999.1676.0001]; Exhibit G.115, Heads of Agreement between SCHN and South Western Sydney LHD (30 October 2020) [MOH.9999.1678.0001]; Exhibit G.116, Service Agreements between SCHN and Prince of Wales Hospital – Shared Clinical Services within the Randwick Health Precinct (June 2023) [MOH.9999.1680.0001].

services interact with, and support each other.[653] As part of a Statewide paediatric services plan, several witnesses saw benefit in a clear identification of the referral pathways into the specialist children's hospitals and – importantly - back to services within Local Health Districts for ongoing care and management. That may include enhancing or expanding the opportunities to support services within Local Health Districts through virtual care or a hybrid of virtual and face-to-face care.[654]

534. Accordingly, as part of the overall statewide approach to planning, there is a need to develop a statewide plan for paediatric services that clearly identifies the roles of the specialist children's hospitals and local paediatric services, and how they interact with each other. Such a plan should establish clear pathways for transition of patients between those care settings such that paediatric care can be delivered in an integrated way.

8.3 Conclusion and key recommendations

535. As part of the system-wide approach to planning discussed above, the governance and accountability structures, planning function, and funding responsibility for all supra-LHD and their functional equivalents should sit within the Ministry, rather than Local Health Districts.

536. The system wide planning process described above should also include the development of a statewide plan for paediatric services that articulates the roles of the Sydney Children's Hospitals Network, John Hunter Children's Hospital and paediatric services within Local Health Districts. That plan should clearly identify the role of those highly specialised centres, both in providing care and supporting paediatric care that can and should be delivered in Local Health Districts or within the primary care setting.

[653]Exhibit G.33, Statement of Associate Professor John Preddy (30 May 2024) [5] [SCI.0011.0067.0001 at 0001]; Transcript of the Commission, 11 June 2024 T3400.13-3401.9 (Alexander), T3434.35-3437.3, T3442.45-3443.32 (Cox); Transcript of the Commission, 14 June 2024 T3641.28-42, T3651.27-36 (Preddy), T3700.38-3701.4, T3701.40-45 (Lyons); Exhibit G.17, NSW Health, Review of Governance for the Sydney Children's Hospitals Network (Alexander Report, June 2019) p 4 [SCI.0010.0004.0001 at 0004]; Exhibit G.96, Statement of Dr Joanne Ging (6 June 2024) [31(a)] [MOH.9999.1292.0001 at 0007]; 19 November 2024 T6355.28-41 (Cox)

[654] Exhibit G.106, Paediatric Service Capability (Paediatric Medicine and Surgery for Children) Guideline (1 December 2023) [MOH.0002.0146.0001]; Transcript of the Commission, 11 June 2024 T3411.40-3414.30 (Ging); Exhibit G.96, Statement of Dr Joanne Ging (6 June 2024) [31b] [MOH.9999.1292.0001 at 0007]; Transcript of the Commission, 14 June 2024 T3677.26-3678.35 (Craven), T3691.20-41, T3701.47-3702.24 (Lyons).

9 PRIMARY CARE AND AGED CARE

537. The importance of primary care in the wider health system is uncontroversial. It is a key component of all high-performing health systems.

538. With effective primary care, patient outcomes are improved, their need for specialist intervention or inpatient services is minimised, and unnecessary hospital admissions are avoided.[655]

539. There is ample evidence that strong primary care is associated with improved population health outcomes for all-cause mortality, all-cause premature mortality, and cause-specific premature mortality from major respiratory and cardiovascular diseases. Increased availability of primary care is also associated with higher patient satisfaction and reduced aggregate healthcare spending.[656]

540. Effective primary care is also a more cost-effective form of intervention than acute care delivered in the hospital setting.[657]

541. Ensuring the availability and accessibility of effective primary care to the wider population is a fundamentally important part of any health service's response to its population's evolving healthcare needs and a critical component of the care required by those with chronic disease.[658]

9.1 What is primary care?

542. The term "primary care" is most commonly associated with general practice but includes care delivered in community health centres, Aboriginal Community Controlled Health Organisations, mental health services, screening services, maternal and child health services, and a range of allied health practices.

543. While general practitioners and rural generalists have traditionally played a central role in the delivery of effective primary care, to paraphrase evidence given by Dr Michael Bonning, a general practitioner and former President of the Australian Medical Association (NSW), those individuals are "not very much

[655] Exhibit N.37, Rosemary Huxtable AO PSM, *Mid-Term Review of the National Health Reform Agreement Addendum 2020-2025* (Final Report, 24 October 2023) 10 [SCI.0011.0585.0001 at 0025].
[656] Exhibit E.47, Statement of Mark Spittal (30 April 2024) [17]-[19] [MOH.9999.1202.0001 at 0005]; Exhibit A.1, Joint Report of Dr Nigel Lyons, Dr Kerry Chant AO PSM and Ms Deb Willcox AM (17 November 2023) [142] [MOH.9999.0001.0001 at 0022].
[657] Exhibit N.37, Rosemary Huxtable AO PSM, *Mid-Term Review of the National Health Reform Agreement Addendum 2020-2025* (Final Report, 24 October 2023) 48 [SCI.0011.0585.0001 at 0053].
[658] Exhibit C.33.1, Statement of Jill Ludford (12 March 2024) [107]-[111] [MLH.0001.0016.0001 at 0023]; Transcript of the Commission, 17 May 2024, T3081.32-3082.15 (Williams).

without the allied health team and nursing team" that make up what they do in primary care.[659] Dr Bonning's observation underscores the inherently multidisciplinary nature of effective primary care and its heavy dependence upon a wide range of accessible referral pathways.[660] Those referral pathways are not confined to allied health professionals but include a range of specialist and sub-specialist medical professionals who may, from time to time, be called upon to contribute to a patient's care. For those referral pathways to be accessible they must be both available and affordable. Inevitably this means that, for some members of the community, those referral pathways must exist within the public health system and be reasonably available to those patients who genuinely require them. Where we refer below to primary care, we are using the term in its widest sense; encompassing general practice and the allied health services and specialist referral pathways required to support it.

544. Primary care is typically (although not exclusively) the first health service visited by patients with a health concern that does not require an urgent or immediate response at a hospital.[661]

545. The importance of primary care is clear; it is key in the prevention, timely detection, and/or effective treatment and management of health conditions, and essential to the promotion of health and well-being in a cost-effective way. By focusing on proactive measures and addressing health concerns at their initial stages, primary care can prevent the escalation of illnesses and the need for more costly interventions that are typically performed in hospitals.[662]

9.2 The current state of the primary care sector

546. There is ample evidence that the primary care system across New South Wales (and Australia more generally) is under severe strain, particularly in regional, rural and remote areas. That strain manifests itself in various ways, from the complete absence of any primary care services in some locations, to practices

[659] Transcript of the Commission, 16 October 2024, T5811.24-5812.6 (Bonning), T5812.15-36 (Christmas).
[660] Transcript of the Commission, 16 October 2024, T5806.37-44, T5812.38-5813.16 (Sloane).
[661] Exhibit A.1, Joint Report of Dr Nigel Lyons, Dr Kerry Chant AO PSM and Ms Deb Willcox AM (17 November 2023) [95] [MOH.9999.0001.0001 at 0012]; 'About primary care' *Department of Health and Aged Care* (Web Page, 3 April 2023) <https://www.health.gov.au/topics/primary-care/about> (accessed 1 December 2024).; Transcript of the Commission, 23 May 2024 T3343.7-41 (Astill).
[662] Exhibit N3.17, Rosemary Huxtable AO PSM, *Mid-Term Review of the National Health Reform Agreement Addendum 2020-2025* (Final Report, 24 October 2023) 48 [SCI.0011.0585.0001 at 0053].

with their books closed to new patients in others, a lack of accessible bulk billing practices and long appointment waiting times.[663]

547. Although each city, town and region has unique features that must be considered,[664] there are increasingly large areas of the State that do not now have, or are at serious risk of losing, reasonable access to primary care services.

548. For example, in 2019, the Western New South Wales Primary Health Network (which encompasses the Western New South Wales Local Health District and the Far West Local Health District - approximately 53% of the land area of New South Wales[665]) identified more than 40 towns that were at "significant risk" of not having a general practitioner by 2029, demonstrating the challenges of attracting and retaining a primary care workforce in regional and remote areas of the State.[666] At the halfway point of the period covered by that projection, it remains accurate.[667]

549. That assessment is consistent with recent projections contained in the Department of Health and Aged Care's *Supply and Demand Study: General Practitioners in Australia*, which indicate that, at the national level, there is a current shortfall of over 800 General Practitioners, which is expected to rise to a shortfall of more than 2,600 in 2028 and 8,600 in 2048.[668] In New South Wales, that study identified a current shortfall of 230 full-time equivalent general practitioners from the number required to meet the health needs of the community.[669] That number is predicted to increase to 800 by 2028 and 2,300

[663] Exhibit E.37, Report of the inquiry into Health Outcomes and Access to Health and Hospital services in Rural, Regional and Remote New South Wales, Legislative Council Portfolio Committee No 2 (May 2022), [2.10]-[2.16] [SCI.0009.0077.0001 at 0047-0048]; Transcript of the Commission, 16 April 2024 T3011.33-3012.3012.17 (Spencer); Transcript of the Commission, 14 May 2024 T2671.22-2673.15 (Chua); Transcript of the Commission 18 September 2024 T5306.39-5307.43 (Wong); Transcript of the Commission, 19 September 2024, T5390.38-5381.23 (Grotwoski), T5431.3-24 (McCosker), T5475.33-5476.13 (Nankervis/Koschel); Transcript of the Commission, 16 October 2024 T5810.29-5811.6 (Bonning/Sloane).
[664] Transcript of the Commission, 16 October 2024, T5809.4-5810.27 (Sloane/Christmas/Hoffman/Bonning)
[665] Transcript of the Commission, 17 May 2024, T3076.11-16 (Williams).
[666] Exhibit E.47, Statement of Mark Spittal (30 April 2024) [129] [MOH.9999.1202.0001 at 0025]; Transcript of the Commission, 15 May 2024 T2872.44-2873.28 (Arnold); Transcript of the Commission, 22 May 2024, T3119.36-3121.17 (Nott).
[667] Transcript of the Commission, 17 May 2024 T3095.39-3096.7 (Williams).
[668] Exhibit J.2, Department of Health and Aged Care, *Supply and Demand Study: General Practitioners in Australia (*August 2024) pp 8-9 [SCI.0011.0392.0001 at 0009-0010]. It may be that those projections are based on conservative assumptions, and the shortfalls are indeed greater: see Transcript of the Commission, 28 August 2024 T5125.2-5126.24, 5128.24-29 (May).
[669] See description of "baseline demand": Exhibit J.2, Department of Health and Aged Care, *Supply and Demand Study: General Practitioners in Australia (*August 2024) p 8 [SCI.0011.0392.0001 at 0008].

in 2048,[670] which equates to a shortfall of approximately 4,000 general practitioners by 2048.[671]

550. Similarly, in a 2021 report titled *Rural health care: Paper 1 – Changes in rural medical workforce and health service delivery since 1990*,[672] the Sax Institute concluded that "the ratio of GPs to the population is lower in rural than urban areas, despite the complexities of providing care in remote and small rural communities" and that "rural communities report significant difficulties with the accessibility of high-quality primary care".[673] Although Dr Hoffman, Chair of the New South Wales and Australian Capital Territory Faculty Council of the Royal Australian College of General Practitioners, has suggested that the problem is by no means confined to rural and regional areas and that there are pockets of Sydney where it is very difficult to access general practice, particularly at short notice.[674]

551. The reasons for that strain are multifactorial. They include the inherent challenges associated with the operation of general practice; including increasing patient complexity[675], the perceived inadequacy current MBS rates[676], and the pressures associated with operating a small business (and their impact on the well-being of clinicians).[677] Those challenges exist in all areas of the State, but can be more acute in regional areas.[678]

552. Whilst somewhat anecdotal, it has also been suggested by many who have given evidence that there have been changes to the way in which younger general practitioners are choosing to work, with many electing to work fewer hours than they, and their predecessors, have in the past. As a result, it can no longer be assumed that a single full-time equivalent workload will be filled by

[670] Exhibit J.2, Department of Health and Aged Care, *Supply and Demand Study: General Practitioners in Australia (*August 2024) p 12 [SCI.0011.0392.0001 at 0013].
[671] Exhibit J.2, Department of Health and Aged Care, *Supply and Demand Study: General Practitioners in Australia (*August 2024) Figure 3, p 12 [SCI.0011.0392.0001 at 0009-0013].
[672] Exhibit H.2.25, Sax Institute, Rural Healthcare Paper 1: Changes in rural medical workforce and health service delivery since 1990 (2021) [MOH.0010.0299.0001].
[673] H2.25, Sax Institute, Rural Healthcare Paper 1: Changes in rural medical workforce and health service delivery since 1990 (2021) p 24, [MOH.0010.0299.0001 at 0024].
[674] Transcript of the Commission, 16 October 2024 T5818.18-34 (Hoffman)
[675] Transcript of the Commission, 18 March 2024 T1214.35-1215.21 (Shanouda); Transcript of the Commission, 16 October 2024 T5828.29-46 (Christmas).
[676] Transcript of the Commission, 15 August 2024, T4882.26-35 (Buist); Transcript of the Commission, 16 October 2024, T5835.34-40 (Sloane).
[677] Exhibit A.33, Royal Australian College of General Practitioners, *General Practice Health of the Nation 2023,* pp vii-viii, 1-7 34-35, 43-56 [SCI.0001.0029.0001 at 0010-0011, 0014-0020, 0056-49].
[678] See, for example, Exhibit J.1, Statement of Professor Jennifer May (27 August 2024) [11] [SCI.0011.0384.0001 at 0002]; Transcript of the Commission, 28 August 2024 T5123.10-40 (May).

one clinician or that any single clinician retained in a full time primary care role will deliver in excess of one Full Time Equivalent ("FTE") worth of care in the way that many of their predecessors did; with the consequence that is likely that a greater number of clinicians will be required to maintain current capacity into the future.[679]

553. Of even greater concern is the fact that the number of medical graduates pursuing general practice as a vocation has decreased, whilst the numbers pursuing other specialities has risen[680] (although there has been a recent increase in the number of graduates electing to pursue specialist training as a general practitioner).[681] As a result, the general practitioner workforce is ageing,[682] and like many aspects of the healthcare workforce, there is significant maldistribution of the primary care workforce, concentrated towards metropolitan areas.[683]

9.3 The impact of a lack of access to primary care

554. Declining access to primary care has obvious detrimental effects on the wider community. Given the role of primary care in promoting and maintaining the health of the wider population, it is of no surprise that there is a correlation between a decline in access to primary care and a subsequent increase in patients presenting to hospitals with higher levels of acuity.[684]

555. For example, in the region served by the Murrumbidgee Local Health District, a high proportion of the population's healthcare needs would benefit from consistent management in the primary care setting, particularly in circumstances where:

a. 16.6% of adults have diabetes;

b. 36% of adults have high cholesterol;

[679] Transcript of the Commission, 28 August 2024, T5128.38-5129.15 (May).
[680] Exhibit J.1, Statement of Professor Jennifer May (27 August 2024) [6]-[7] [SCI.0011.0384.0001 at 0001-0002]; Exhibit A.33, Royal Australian College of General Practitioners, *General Practice Health of the Nation 2023*, pp 57-58 [SCI.0001.0029.0001 at 0070-0071]; Transcript of the Commission, 28 August 2024 T5122.37-5123.40 (May).
[681] Transcript of the Commission, 14 April 2024 T2684.14-2685.2 (Hoffman); Transcript of the Commission, 16 October 2024 T5818.18-5819.14 (Hoffman).
[682] Exhibit A.33, Royal Australian College of General Practitioners, *General Practice Health of the Nation 2023*, p 33 [SCI.0001.0029.0001 at 0046].
[683] Exhibit A.33, Royal Australian College of General Practitioners, *General Practice Health of the Nation 2023*, p 34-35 [SCI.0001.0029.0001 at 0047-0048].
[684] Transcript of the Commission, 29 November 2023 T210.38-211.36 (Lyons); Transcript of the Commission, 30 July 2024 T4223.13-44 (Fielding); Transcript of the Commission, 19 November 2024 T6374.25-6375.11 (Constable).

c. 31% of adults have high blood pressure;

d. 24% of children are developmentally vulnerable in one or more domains in their first year of school; and

e. there is a higher prevalence of many lifestyle-associated risk factors when compared with the average across New South Wales.[685]

556. The Australian Government Intergenerational Report 2021: Australia over the next 40 years, concluded that:[686]

> *The cost and prevalence of chronic conditions are relevant to future health spending. Chronic conditions are long lasting with persistent effects, and include conditions such as arthritis, back pain, cardiovascular disease, diabetes, and mental health conditions. These conditions tend to develop gradually and become more common with age. In 2017-18, 1 in 2 Australians had 1 or more of 10 selected chronic conditions. As the population ages, chronic conditions will increase overall health spending. Most care for chronic conditions is provided in the primary health care setting by general and allied health practitioners. Effective primary health care is important to help prevent unnecessary hospitalisations from chronic conditions and improve health outcomes.*

557. With limited access to primary care (contributed to by a decline in bulk-billing rates within local general practices and limited access to specialist referral pathways) demand on emergency departments has been increasing.[687] That lack of access also amplifies the various health risk factors that exist within the population, particularly in rural areas.[688]

558. Brad Astill, Chief Executive of the Far West Local Health District, described the impact of limited access to primary care services within that District as follows:[689]

> *The market failure of local General Practitioners (GPs) has significantly increased the dependence on FWLHD EDs for fundamental medical care for the community. Since the COVID 19 pandemic there has been significant contraction in the number of GPs providing primary care services*

[685] Exhibit C.33.1, Statement of Jill Ludford (12 March 2024) [28] [MLH.0001.0016.0001 at 0004].
[686] Exhibit A.9, Australian Government Intergenerational Report 2021: Australia over the next 40 years [SCI.0001.0018.0117].
[687] Exhibit C.33.1, Statement of Jill Ludford (12 March 2024) [107] [MLH.0001.0016.0001 at 0023]; Transcript of the Commission, 21 March 2024 T1632.13-45 (Yoosuff); Transcript of the Commission, 16 October 2024 T5846.3-10 (Sloane); Transcript of the Commission, 18 November 2024, T6284.13-19 (Kastoun).
[688] E.47, Statement of Mark Spittal (30 April 2024) [18] [MOH.9999.1202.0001 at 0005].
[689] Exhibit F.1, Statement of Brad Astill (8 May 2024) [76]-[80] [MOH.9999.1258.0001 at 0011-0012].

> *to the community in Broken Hill. This has resulted in considerable limitations to access GP services for the community. Patients often wait 6-8 weeks for an appointment with a GP for a routine consultation like a repeat script or a medical certificate. The impact for FWLHD resulted in a marked increase in low acuity presentations to the ED. The result is that the community of Broken Hill is not receiving an equitable share of Medicare funding for primary care and there is likely a subsequent reduction in health in the community.*

559. A lack of access to primary care also means that continuity of care – an important feature of effective primary healthcare, particularly for those with multiple chronic conditions – is difficult to maintain.[690] For example, in 2018-19, 84,281 hospitalisations in New South Wales could potentially have been avoided through timely preventative care and early management of those with chronic conditions.[691]

560. That experience is consistent with the views of those within the Ministry. In their joint report Dr Lyons, Dr Chant and Ms Willcox described the importance of primary care in addressing chronic disease as follows:[692]

> *In responding to the changing burden of disease, coordinated investment in preventative health and early intervention is part of a whole of health and social system response, including the need to address the wider determinants of health.*
>
> *Preventive services and early interventions should be strong pillars of Australia's healthcare system to support people to be healthy and well. People living in Australia are experiencing increasingly complex health care needs.*
>
> *Low proportional investment in preventive health, the wider determinants of health and increasing burden of chronic disease has led to increased spending on treatments to manage conditions that could be prevented, detected earlier or managed more effectively in a comprehensive primary care setting reducing the need for hospitalisation.*

561. In addition to increased demand for acute care services, declining numbers of general practitioners in the regions also impacts on the delivery of hospital

[690] Exhibit A.9, NSW Intergenerational Report 2021-2022 [SCI.0001.0016.0001 at 100]; Exhibit E.37, *Report of the inquiry into Health Outcomes and access to health and hospital services in rural, regional and remote New South Wales*, Legislative Council Portfolio Committee No 2 (May 2022), [2.16] [SCI.0009.0077.0001 at 0048].
[691] Exhibit A.9, NSW Intergenerational Report 2021-2022 [SCI.0001.0016.0001 at 0075].
[692] A.1, Joint Report of Dr Nigel Lyons Dr Kerry Chant AO PSM and Deb Willcox AM (17 November 2023) [173]-[175] [MOH.9999.0001.0001 at 0025].

services in those areas. Traditionally, the medical workforce in rural and regional areas has included general practitioners who are visiting medical officers, many of whom have specialist qualifications in a range of areas, such as obstetrics, anaesthetics and surgery. That long standing model has been described as being "absolutely critical for rural health".[693] As is obvious – if there are no general practitioners in a particular region, the visiting medial officer model will become unsustainable. Even where there are primary care services available, the proportion of general practitioners in rural and regional areas who are willing to accept appointments as visiting medical officers to provide care in the acute setting and take on the significant personal and professional burden associated with it is in decline.[694] There is already significant pressure on those models in some areas of the State[695] and any assumption that this model will continue to sustain services delivered through smaller rural and regional hospitals would be wholly flawed.

9.4 Mid-term review of the National Health Reform Agreement Addendum

562. The Mid-Term Review of the Addendum to the National Health Reform Agreement 2020-2025[696] (conducted by Rosemary Huxtable AO PSM) considered a range of matters, including the extent to which the objectives of the Addendum are being met, whether the Addendum's health funding, planning and governance architecture remains fit-for-purpose, and reform in the primary care, aged care, disability and mental health systems as they relate to the operation of the Addendum.[697]

563. The review made several findings in relation to primary care, that are consistent with the evidence received by the Special Commission and the matters outlined above. Those findings included that:

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[693] Transcript of the Commission, 16 August 2024 T5095.16-5096.35 (Bennett).
[694] Transcript of the Commission, 21 March 2024 T1600.8-36 (Yoosuff); Transcript of the Commission, 22 March 2024 T1697.8-41 (Ludford); Transcript of the Commission, 17 May 2024 T3096.10-25 (Williams); Transcript of the Commission, 15 August 2024 T4932.30-4933.10 (Stapleton); Exhibit E.37, *Report of the inquiry into Health Outcomes and access to health and hospital services in rural, regional and remote New South Wales*, Legislative Council Portfolio Committee No 2 (May 2022), [3.24] [SCI.0009.0077.0001 at 0073.
[695] Transcript of the Commission, 18 March 2024, T1171.15-21 (Christmas); Transcript of the Commission, 20 March 2024, T1514.2-9 (Marchioni); Exhibit E.37, *Report of the inquiry into Health Outcomes and access to health and hospital services in rural, regional and remote New South Wales*, Legislative Council Portfolio Committee No 2 (May 2022), [3.23] [SCI.0009.0077.0001 at 0072].
[696] Exhibit N3.17, Rosemary Huxtable AO PSM, *Mid-Term Review of the National Health Reform Agreement Addendum 2020-2025* (Final Report, 24 October 2023) [SCI.0011.0585.0001].
[697] Exhibit N3.17, Rosemary Huxtable AO PSM, *Mid-Term Review of the National Health Reform Agreement Addendum 2020-2025* (Final Report, 24 October 2023) 14 [SCI.0011.0585.0001 at 0019].

a. Ageing populations and increased rates of chronic disease have seen an increasing demand for primary care. At the same time, there is a fall in the proportion of doctors training as general practitioners and an ageing general practitioner workforce.[698]

b. Lack of access to primary care in rural areas has a significant impact on health outcomes and increases reliance on local public hospitals and emergency department utilisation.[699]

c. When primary care struggles to meet demand, avoidable hospital presentations result, that this is neither cost nor clinically effective and that States and Territories need to step in as providers of last resort.[700]

564. The focus on setting and meeting national weighted average unit or activity based funding targets to attract Commonwealth funding was seen by stakeholders as driving care to the inpatient setting, rather than preventing hospitalisations through individualised health interventions and early disease management, usually delivered in primary and community-based care settings.[701]

565. Current funding mechanisms and the delineation of roles and responsibilities, particularly between hospital care, and aged, disability and primary care discourage a continuum of healthcare service delivery across multiple settings, which hinders the capacity to deliver the right care in the right place at the right time, detracting from allocative efficiency and patient experience. There are deficiencies in referral networks, patient transfer and transition support.

9.5 The role of NSW Health in relation to primary care

566. Despite the clear recognition by NSW Health of the central role of primary care in the promotion, protection and maintenance of health within communities, evidence given by witnesses called from both the Ministry and Local Health Districts is replete with references to the proposition that primary care is the

[698] Exhibit N3.17 Rosemary Huxtable AO PSM, *Mid-Term Review of the National Health Reform Agreement Addendum 2020-2025* (Final Report, 24 October 2023) 40 [SCI.0011.0585.0001 at 0045].
[699] Exhibit N3.17, Rosemary Huxtable AO PSM, *Mid-Term Review of the National Health Reform Agreement Addendum 2020-2025* (Final Report, 24 October 2023) 37 [SCI.0011.0585.0001 at 0042].
[700] Exhibit N3.17, Rosemary Huxtable AO PSM, *Mid-Term Review of the National Health Reform Agreement Addendum 2020-2025* (Final Report, 24 October 2023) 27 [SCI.0011.0585.0001 at 0032].
[701] Exhibit N3.17, Rosemary Huxtable AO PSM, *Mid-Term Review of the National Health Reform Agreement Addendum 2020-2025* (Final Report, 24 October 2023) 32 [SCI.0011.0585.0001 at 0037].

responsibility of the Commonwealth government and not NSW Health.[702] In limited theoretical respects that may be true. But as a description of the role and responsibility of NSW Health in relation to the delivery of primary care, it is too narrow.

567. The notion that primary care is the responsibility of the Commonwealth government presumably flows from the Addendum to the National Health Reform Agreement 2020-2025, which relevantly provides (emphasis added):

> *13. Under this Addendum the Commonwealth will be responsible for:*
>
> *…*
>
> ***system management and support, policy and funding for GP and primary health care services*** *including lead responsibility for Aboriginal and Torres Strait Islander Community Controlled Health Services (noting contributions of the States)*

568. As is clear from that passage, the responsibility of the Commonwealth government is in "system management, support, policy and funding" of primary care.[703] However, the Commonwealth government is not engaged in service delivery. In this context, Mr Spittal's observation that although the Commonwealth provides funding for primary care through the Medicare Benefits Schedule, it bears no responsibility for delivering these services and thus lacks a clear obligation to rectify market failures is apt. Consequently, where there is no market available to provide care funded by the Medicare Benefits Schedule scheme, the cost ultimately shifts to the State in any event as patients who cannot access primary care, present to emergency departments or require acute services at a later stage of their disease progression.[704]

569. To the extent that the public health system in New South Wales is said to have a role in delivering primary care, it has been described as a provider of "last

[702] See for example, Exhibit E.47, Statement of Mark Spittal (30 April 2024) [18] [MOH.9999.1202.0001 at 0001-0005]; Transcript of the Commission, 29 April 2023, T2494.24-2495.41 (Daly); Transcript of the Commission, T1506.11-1507.33 (Lawrence; Transcript of the Commission, 29 April 2024, T2532.33-40, T2540.14-30 (Willcox); Exhibit E.37, *Report of the inquiry into Health Outcomes and access to health and hospital services in rural, regional and remote New South Wales*, Legislative Council Portfolio Committee No 2 (May 2022), [3.6] [SCI.0009.0077.0001 at 0066].
[703] Transcript of the Commission, 29 April 2024, T2540.14-30 (Willcox).
[704] See for example, Transcript of the Commission, 16 April 2024, T2941.17-2942.26 (Spittal).

resort", primarily through emergency departments.[705] For example, Mr Daly, Deputy Secretary, System Sustainability and Performance, NSW Health, described the role of the New South Wales public system in primary care as follows:[706]

> *Q. To what extent, if any, is the negotiation around service level agreements picking up a consideration of the LHD's need to meet unmet service delivery for, say, primary health care within the geographic boundary of the LHD?*
>
> *A. I don't believe chief executives have in the past, nor probably should they be, investing in primary care. That is the responsibility of the Commonwealth. I guess where we've seen leadership in New South Wales is by government policy around urgent care services that is very much jumping in to the primary care market, where it's failed, and I think there is increasing evidence around the ED avoidance that that program has been able to deliver that otherwise would have seen patients in EDs.*
>
> *Q. You say the delivery of primary care is the responsibility of the Commonwealth. Why do you say that?*
>
> *A. Because it is - has traditionally been; its funding is from the Commonwealth; we don't attract any funding from the Commonwealth under the National Health Reform Agreement for anything that resembles primary care. The national administrator and the independent hospital pricing and aged care authority polices that and we have had models of care rejected for Commonwealth funding because it was too like primary care services that the Commonwealth is responsible for.*
>
> *…*
>
> *Q. The Commonwealth clearly provides a source of funding for primary care through the MBS.*
>
> *A. (Witness nods).*
>
> *Q. But as to who is responsible for the delivery of primary care to the extent that the market-based system funded by the MBS might not*

[705] Exhibit A.1, Joint Report of Dr Nigel Lyons, Dr Kerry Chant AO PSM and Ms Deb Willcox AM (17 November 2023) [200] [MOH.9999.0001.0001 at 0028]; Transcript of the Commission, 21 March 2024, T1630.34-40, T1633.19-1634.10 (Yoosuff); Transcript of the Commission, 22 April 2024, T2257.4-9 (Schembri).
[706] Transcript of the Commission, 29 April 2023, T2494.24-2495.41 (Daly).

be working, does it not get picked up by the broad function of the LHD provided for in section 9 of the Health Services Act?

A. Well, I guess ultimately, depending upon the level of that primary care market failure, the LHD does pick it up, because it lands in the ED. It's like most social determinants and problems, it's the last port of call, and that is the volume that we have been working to divert to better care settings than the emergency departments.

570. Mr Danos, Chair of the Board of the Northern Sydney Local Health District, gave evidence that whilst there are aspects of the services provided by the Local Health District that "*come close*" to primary care, "*we are not providers of primary care*" although "*we do have people who turn up to the emergency department with conditions that might otherwise be suited to visiting a GP*".[707]

571. That approach, however, does not necessarily engage with the critical issues faced by those without access to primary care. It also gives rise to a tension within the system which finds itself delivering care (as a provider of last result and in a sub-optimal setting) that it considers it does not have a responsibility to fund and deliver. For example, Mr Spittal gave evidence that:[708]

> *The Commonwealth doesn't necessarily fund the New South Wales health system to be a provider of last resort. And there are many examples, whether it is in aged care… or primary care or general practice, where, in the interests of the community, in the interests of improving health outcomes, chief executives of local health districts and, indeed, officials in the Ministry of Health, will stray far beyond the traditional bounds that one might have expected of a chief executive, let's say, 10, 15 years ago within the New South Wales health system with problems to solve … simply because there is nobody else who is going to.*

572. Mr Portelli, Executive Director, System Purchasing, NSW Health, gave evidence that the system "will always prioritise the most urgent patients" in budgeting decisions because NSW Health is the only, or the primary, provider of acute health care and that "if [funding primary care] comes at a cost of a service that only [NSW Health] provide[s], that's not a tenable solution".[709]There are three fundamental problems with this proposition.

[707] Transcript of the Commission, 24 April 2024, T2448.21-2451.47 (Danos).
[708] Transcript of the Commission, 16 April 2024, T2940.3-18 (Spittal); see also Exhibit A.9., NSW Intergenerational Report 2021-2022 [SCI.0001.0016.0100].
[709] Transcript of the Commission, 21 November 202, T6540.26-6541.36 (Portelli).

573. First, the reference to 'most urgent patients' indicates that it rests on assumption that the areas in which NSW Health has traditionally – and for largely historical reasons - operated, should always be prioritised over the delivery of effective primary care where the latter is not capable of being adequately delivered by an external market based solution. In the case of some services provided through the public health system, this assumption may be sound; in others, it will not.

574. Secondly, it assumes that the State would not have access to a Commonwealth funding stream to at least partially offset the cost of delivering the service were it to step in and provide that primary care; numerous examples around the state reveal the fragility of this assumption.

575. Finally, it is somewhat circular insofar as it fails to grapple with the reality that the absence of adequate primary care will likely only increase the demand for "a service that only [NSW Health] provide[s]"; namely, that delivered through emergency departments or in the acute care setting; at vastly higher cost and with inferior long term clinical outcomes for patients.

576. The necessary decisions around funding priorities are complicated by the fact that, although it is uncontroversial that significantly greater investment in preventative and primary care is necessary to address the shifting burden of disease there is a perception that the return on that investment would be both difficult to trace and would only materialise many years after the investment is made.

577. For example, Phil Minns, Deputy Secretary, People, Culture and Governance, NSW Health, gave evidence that while he thought Treasury would "conceptually" support large scale investment in "preventative or primary care measures that might shorten the morbidity of the population in terms of chronic disease", the difficulty with that proposition is that the effective return on the investment would not present for 20 years.[710] That is, it would take an extended period of time before the benefits of shortened or lessened morbidity from chronic disease, brought about by increased investment in preventative and primary care, would translate to saved costs in acute care. In the meantime,

[710] Transcript of the Commission, 7 August 2024, T4822.34-4823.19 (Minns).

the system will still need to deliver levels of acute care similar to those presently being delivered through the relevant emergency department.

578. Ultimately, searching for the long term savings potentially generated by filling voids in the availability of primary care across the State rather obscures the real point. As was observed by Professor Andrew Wilson in relation to the prioritisation of prevention within the public health system, "[i]t's about improving and extending the quality and length of human life ... [a] side benefit of that, from my perspective, is that we may reduce the load in certain areas within the health system...".[711] These observations can be applied equally to the delivery or supplementation of effective and accessible primary care where existing market-based providers are unable to do so.

579. Perhaps most significantly, the notion that it is not the function of the Local Health Districts to invest in the provision of primary care is incompatible with their statutory purpose and functions as set out in ss 9 and 10 of the *Health Services Act*. Relevantly, s 9 provides:

> *9 Primary purposes of local health districts*
>
> *The primary purposes of a local health district in its area are as follows—*
>
> *(a) to provide relief to sick and injured persons through the provision of care and treatment,*
>
> *(b) to promote, protect and maintain the health of the community.*

580. Consistently with those primary purposes, their statutory functions include to "promote, protect and maintain the health of the residents of its area" and "establish and maintain an appropriate balance in the provision and use of resources for health protection, health promotion, health education and treatment services".[712] Activities directed to health protection, promotion and education are not limited to acute care settings and, in many respects, are core functions of primary care.[713]

581. Properly understood, the statutory regime contemplates that Local Health Districts will deliver the care needed to fulfil their stated primary purposes. In

[711] Transcript of the Commission, 11 December 2024, T6899.29-31 and 35-37 (Wilson).
[712] *Health Services Act 1997* (NSW) s 10(a) and (i).
[713] Transcript of the Commission, 30 November 2023, T276.45-277.45 (Willcox); Transcript of the Commission, 21 March 2024, T1546.15-1548.5 (Dixon/Kolbe); Transcript of the Commission, 22 March 2024, T1724.43-1725.25 (Ludford); Transcript of the Commission, 22 April 2024, T2256.43-2257.2 (Schembri); Transcript of the Commission, 22 April 2024, T2315.34-45 (McLachlan).

doing so, it does not draw a distinction between primary care and acute care, or hospital and community-based services.[714]

582. While it may be accepted that the Commonwealth has – through the National Health Reform Agreement – accepted responsibility for *funding* primary care (as well as system management, support and policy), that does not absolve the state of any role or responsibility for the delivery (or supporting the delivery) of primary care services where doing so is necessary to "*provide relief to sick and injured persons*" or to "*promote, protect and maintain the health*" of the population;[715] for example, where the local market will not – for any reason – sustain viable primary care within a community.

583. Indeed, several Chief Executives embraced the proposition that Local Health Districts had a role in providing access to primary care services where they are not otherwise available in the market. For example, Associate Professor Schembri, Chief Executive, Northern Sydney Local Health District, gave evidence as follows:[716]

> *Q. …we shouldn't understand you to suggest that there is no role for the local health district in the provision of primary care where it is needed?*
>
> *A. No, there is absolutely a role. So there is a role in health promotion, for example, in public health; there is a role with very vulnerable people; there is also a role for the other jurisdictions as well.*
>
> *Q. What about where there may not be available primary care in a particular part of an LHD, does the LHD have a role to play in the provision of that care in such a circumstance?*
>
> *A. Definitely we become the service of the last resort in those environments.*
>
> *Q. Is there a role for the LHD to proactively provide primary care in such a circumstance?*
>
> *A. Yes, in the absence of other jurisdiction, yes.*

584. Accordingly, the notion that responsibility for primary care rests solely with the Commonwealth should be rejected. The State clearly has a role and

[714] Transcript of the Commission, 23 April 2024, T2334.39-2335.21 (MacLellan).
[715] *Health Services Act 1997* (NSW) s 9.
[716] Transcript of the Commission, 22 April 2024, T2256.43-2257.13 (Schembri).

responsibility, through the Local Health Districts, to provide access to primary care services where that is necessary to "provide relief to sick and injured persons" and to "promote, protect and maintain the health of the community", and not merely as a provider of "last resort" when those patients present to emergency departments.

585. The extent to which that is to be done will depend on the circumstances of the region or town being considered, including – critically – the availability of other services. As Dr Hoffman rightly observed, "*one town is one town is one town*".[717] The needs and circumstances will change from region to region, and so too will the response required from the Local Health District. Accordingly, the extent to which a Local Health District ought to provide access to primary care services, or offer tangible support to a struggling primary care market, must be approached in a "place-based" way and as part of the strategic planning process discussed elsewhere in this outline.

586. Where a community is adequately serviced by a primary care market, there may be no need for the Local Health District to provide those services itself. However, where there is a thin primary care market, such that it does not meet the needs of the community, or no market at all, the Local Health District may need to provide primary care services – or support the delivery of primary care in a struggling market – consistent with its primary purpose and statutory function.

587. Indeed, there are several examples of where Local Health Districts are currently doing exactly that in areas of need, including (among others) in the Murrumbidgee Local Health District,[718] the Mid-North Coast Local Health District,[719] the Hunter New England Local Health District, Western NSW Local Health District and the Central Coast Local Health District.[720]

588. As is clear from those examples, Local Health Districts are best placed – together with Primary Health Networks and any existing service providers - to identify and address gaps in primary care services. That enables "place-based"

[717] Transcript of the Commission, 14 May 2024, T2698.27-2699.32 (Chua/Hoffman); Transcript of the Commission, 16 October 2024, T5859.10-35 (Hoffman).
[718] Transcript of the Commission, 21 March 2024, T1547.16-37 (Dixon).
[719] Exhibit K.49, Statement of Stewart Dowrick (12 September 2024) [67]-[68] [MOH.0011.0069.0001 at 0016-0017]; Exhibit K.52, Statement of Jill Wong (6 September 2024) [27] [MOH.0011.0061.0001 at 0007].
[720] Transcript of the Commission, 22 April 2024, T2315.34-2316.3 (McLachlan).

solutions to be designed having regard to the needs of the community, which may include the Local Health District itself providing, or providing support for, primary care.

589. Those "place-based" solutions necessarily include attracting a workforce to deliver the care needed in those regions. The overwhelming weight of the evidence supports a conclusion that clinicians who have historical links to regional areas, or who undertake their training in regional areas, are more likely to return to practice in them.[721] The evidence also indicates that providing individuals with the opportunity to deliver primary care through a salaried position would likely enhance the prospect of professionals opting to commit to the delivery of primary care in rural and remote areas; perhaps with the added benefit of utilising that workforce synergistically to address workforce challenges in other areas of the public health system within the regions.

590. A range of models have been deployed to leverage those connections. For example, the New South Wales Rural Generalist Single Employer Pathway, has been shown to support training and engagement of rural generalists.[722] The concepts underpinning that model could also be effectively used for nursing and allied health professionals.[723]

591. As part of a "place-based response", consideration should be given to engaging a salaried primary care workforce, whereby general practitioners and other workers are employed by NSW Health to provide accessible primary care in underserviced areas.[724]

592. To the extent that NSW Health provides traditional primary care services, the Ministry should pursue funding from the Commonwealth – whether through s 19(2) exemptions or otherwise. Given that, had those services been provided by a private market, Commonwealth funding of that kind would ordinarily flow there is no clear reason why the Commonwealth would resist funding the service to at least the same extent as it would a market based general

[721] Exhibit J.1, Statement of Professor Jennifer May (27 August 2024) [14] [SCI.0011.0384.0001 at 0003-0004].
[722] Transcript of the Commission, 19 September 2024, T5383.5-28 (Grotowski).
[723] Transcript of the Commission, 19 September 2024, T5479.5-37 (Koschel).
[724] See for example, Transcript of the Commission, 16 October 2023, T5835.1-42 (Sloane).

practitioner delivering the same care; it has done so in each of the above instances in which the State has stepped in and provided primary care.

9.6 Aged Care

593. Thin or failing aged care markets are also having a significant and detrimental impact on care delivered through public hospitals in New South Wales.

594. On any given day there are significant numbers of patients occupying beds in hospitals that could, if an aged care bed were available, be discharged. Patients in that category are described as "maintenance patients".[725]

595. The high number of maintenance patients occupying hospital beds at any given time has financial implications for the public health system and creates risks for patients and staff.

596. Maintenance patients are a high cost to the system. For example, the average cost of a bed for a maintenance patient in the Illawarra Shoalhaven Local Health District is $1,014 per day,[726] while the maintenance fee (i.e. the patient fee) is around $20 per week.[727] In some instances, this fee will be waived due to hardship.[728] Those costs are borne by the Local Health Districts.[729]

597. The large numbers of maintenance patients also creates bed block, impacting the ability of a facility to move patients through the hospital.[730]

598. For example, as at November 2024, there were 25 patients in acute beds awaiting a residential aged care placement at Wollongong Hospital, inhibiting the ability to provide acute care, resulting in the patients being unable to be admitted from the emergency department.[731] This in turn can result in ambulance ramping or the treatment of patients in the waiting room, "which may not be optimal for all patients and may be unsafe in certain circumstances."[732]

599. Similarly, in the Broken Hill Health Service, there are 40 "ED accessible beds" through which the facility manages its unplanned acute load.[733] As of May 2024,

[725] Transcript of the Commission, 15 November 2024, T6162.5-11 (Potter).
[726] Transcript of the Commission, 15 November 2024, T6163.43-47 (Wakeling).
[727] Transcript of the Commission, 15 November 2024, T6162.17-19 (Potter).
[728] Transcript of the Commission, 15 November 2024 T6163.16-37 (Okulicz).
[729] Transcript of the Commission, 18 September 2024 T5293.19-37 (Wong).
[730] Transcript of the Commission, 15 November 2024 T6188.23-6190.26 (Wakeling); Transcript of the Commission, 15 November 2024 T6192.2-4 (Okulicz).
[731] Transcript of the Commission, 15 November 2024 T6188.36-42 (Wakeling).
[732] Transcript of the Commission, 15 November 2024 T6189.13-31 (Wakeling).
[733] Transcript of the Commission, 23 May 2024 T3350.10-19 (Astill).

26 of those beds were occupied by aged care patients who were suitable for discharge if a place had been available.[734] On at least one occasion, the high numbers of aged care patients occupying hospital beds meant that some elective surgery, including for patients who had been waiting up to 365 days for their procedure, had to be cancelled because of a lack of available post operative beds.[735]

600. Furthermore, when elderly patients are in maintenance beds, they are not in the optimal environment they should be.[736] Being in a hospital beyond the time when a patient is clinically suitable for discharge term brings with it certain risks, including hospital-acquired complications and a higher risk of falls in elderly patients, and the effects of long periods of isolation away from their home environment and families.[737]

9.7 National Disability Insurance Scheme patients

601. A similar issue arises in relation to patients who are suitable for discharge but waiting on National Disability Insurance Scheme acceptance and support. In November 2024, in the Illawarra Shoalhaven Local Health District, there were 38 National Disability Insurance Scheme patients in this category occupying hospital beds.[738] Of these, 40% were in the district's mental health bed base and 60% in its sub-acute bed base.[739] This has a similar impact on the bed flow of facilities to aged care patients.[740]

602. This patient cohort can be resource intensive to maintain in a hospital setting. Ms Amy Okulicz, Nurse Unit Manager in the Rehabilitation and Geriatric Rehabilitation Unit at Wyong Hospital, gave the example in evidence of two National Disability Insurance Scheme patients in her ward who had come to hospital because of severe aggression and violent episodes which had resulted in significant injuries to their carers.[741] These patients were not actually unwell but had been sent to hospital because they could not be safely managed in their

[734] Transcript of the Commission, 23 May 2024 T3350.21-22 (Astill).
[735] Transcript of the Commission, 23 May 2024 T3350.21-37 (Astill).
[736] Transcript of the Commission, 15 November 2024 T6187.3-11 (Wakeling).
[737] Transcript of the Commission, 15 November 2024 T6187.13-17 (Wakeling); Transcript of the Commission, 15 November 2024 T6199.14-35 (Hawkins); Transcript of the Commission, 15 November 2024 T6202.14-41 (Okulicz); Transcript of the Commission, 15 November 2024 T6203.20-31 (Shortis); Transcript of the Commission, 29 November 2023 T216.24-31 (Willcox).
[738] Transcript of the Commission, 15 November 2024 T6153.30-38 (Wakeling).
[739] Transcript of the Commission, 15 November 2024 T6153.30-38 (Wakeling).
[740] Transcript of the Commission, 15 November 2024 T6188.26-34 (Wakeling).
[741] Transcript of the Commission, 15 November 2024 T6174.7-16 (Okulicz); see also Exhibit K.52, Statement of Jill Wong (6 September 2024) [16] [MOH.0011.0061.0001 at 0004].

own home and remained there for four months.[742] While admitted, those patients required isolation areas, security guards and one-on-one nursing for the patients to avoid harm to hospital staff. The security bill for one of the patients alone was $100,000, which was not covered by the National Disability Insurance Scheme.[743]

603. Allied health clinicians often absorb the brunt of such circumstances, having become (by default) "expected to undertake onerous and time intensive assessments and report writing" in addition to their core responsibilities.[744] These scenarios also lead to burnout with staff undertaking significant amounts of overtime, as well as psychological distress from having to deal with behaviourally challenged patients who can also be physically violent. [745]

9.8 Conclusion and key recommendations

604. NSW Health should significantly increase its involvement in the delivery of primary care and aged care.

605. Where there is market failure of primary care, NSW Health should, via the relevant Local Health District (and as an integral part of the service planning exercise), conduct an assessment of the unmet primary care needs and collaborate with other stakeholders to ensure that adequate primary care is delivered. In many cases, this will inevitably involve NSW Health stepping in to deliver that care; where necessary it should do so in a manner which capitalises on synergies with its wider operations. Access to Commonwealth funding streams for the delivery of this care should clearly be pursued by the Ministry but the delivery of primary care in communities where it is lacking should not await the outcome of those intergovernmental discussions.

606. As part of its system-wide planning process, NSW Health should facilitate more regional training opportunities for primary care workers, and provide the training and support required for those contributing to the delivery of primary care to exercise their full scope of practice.

[742] Transcript of the Commission, 15 November 2024 T6174.43-6176.43 (Okulicz).
[743] Transcript of the Commission, 15 November 2024 T6175.7-6176.14 (Okulicz).
[744] Exhibit K.52, Statement of Jill Wong (6 September 2024) [18] [MOH.0011.0061.0001 at 0005].
[745] Transcript of the Commission, 15 November 2024 T6209.32-47 (Okulicz).

607. Similarly, where market failure in the aged care sector is having a direct and adverse impact on the delivery of acute care through public hospitals, NSW Health should, via the relevant Local Health District, and in consultation with the community and other stakeholders, conduct an assessment of the unmet aged care needs in the relevant community and coordinate with other stakeholders to support or deliver the required aged care services. Once again, there will inevitably be locations in which NSW Health will need to step in and deliver that care; as it is already doing through numerous Multi-Purpose Services located in rural and remote areas of the State and capitalising on available synergies with its wider operations. Commonwealth funding streams for the delivery of this care should obviously be pursued by the Ministry but the provision of aged care to the extent required to relieve the existing, and unsustainable, burden on public hospitals should not await the outcome of those intergovernmental discussions.

10 THE HEALTH WORKFORCE

608. As is obvious, the public health system cannot function without a high-quality, engaged and well-supported workforce, that is present in the places where it is needed to meet the demands of the NSW population.[746] It is not surprising, then, that some of the most prominent themes to emerge in the evidence relate to the varied workforce issues and challenges confronting the system in New South Wales, and more widely.

10.1 A snapshot of the NSW Health workforce

609. As of June 2024, the NSW Health workforce comprised over 165,000 employees by headcount (almost 140,000 FTE).[747] This constitutes over one third of the entire NSW public sector workforce by FTE. Employee and visiting medical officer related costs comprise approximately 60% of NSW Health's overall annual expenditure.[748]

610. The NSW Health workforce comprises clinical and non-clinical staff. The non-clinical staff comprise corporate or "back office" staff, employed both in the Ministry and in public health organisations, and front-line support staff.[749] They constitute approximately 26 per cent of the total NSW Health workforce by FTE.

611. The Ministry divides clinical staff into four categories:[750]

    a. medical – constituting approximately 11 per cent of the total NSW Health workforce by FTE;

    b. nursing and midwifery – constituting approximately 40 per cent of the total NSW Health workforce by FTE;

    c. allied health – constituting approximately 10 per cent of the total NSW Health workforce by FTE; and

    d. other clinical, including professional and para-professional support staff, scientific and technical clinical support staff, oral health practitioners,

[746] Exhibit B.23.23, Future Health: Guiding the next decade of health care in NSW 2022-2032, NSW Health (Report Summary, May 2022) [MOH.0001.0320.0001 at 0012]; Exhibit L.13, NSW Health Workforce Plan 2022-2032, NSW Health (Report, 23 June 2022) [MOH.9999.3112.0001].
[747] Exhibit H.5.21, Statement of Richard Griffiths (16 July 2024) [6] [MOH.0011.0022.0001 at 0003].
[748] Exhibit H.5.23, Statement of Melissa Collins (17 July 2024) [61] [MOH.0011.0025.0001 at 0010]; Exhibit B.36, NSW Health Annual Report 2022-23, NSW Health (November 2023) p 138 [SCI.0001.0059.0001 at 0147].
[749] Exhibit H.5.24, Rian Thompson, *Workforce Data Report* (Report, 17 July 2024) p 6 [MOH.0010.0377.0001 at 0006].
[750] Exhibit H.5.24, Rian Thompson, *Workforce Data Report* (Report, 17 July 2024) p 6 [MOH.0010.0377.0001 at 0006].

support workers and ambulance staff – constituting approximately 13 per cent of the total NSW Health workforce by FTE.

612. The medical workforce may be divided into:

a. junior medical officers, comprising:

i. prevocational trainees, being medical officers (doctors) who have not obtained a position in an accredited vocational training program for a medical specialty, generally in their first year (referred to as "intern" or "PGY1") and second year (referred to as "resident" or "PGY2"); and

ii. registrars, being medical officers who are training in an accredited vocational training program or have had at least three years' public hospital experience (the latter, if they are not training in an accredited program, are sometimes referred to as "unaccredited registrars");

b. career medical officers, comprising non-specialist doctors who are not appointed in or occupying junior medical officer positions; and

c. specialists, comprising doctors who have completed an accredited vocational training program and obtained fellowship of the relevant specialist medical college. Specialists may be employed, in which case they are referred to as staff specialists, or engaged as visiting medical officers.

613. NSW Health recognises 23 allied health professional groups,[751] which cover diverse fields including art therapy and music therapy, audiology, counselling, exercise physiology, genetic counselling, nutrition and dietetics, occupational therapy, pharmacy, physiotherapy, psychology, radiation therapy, speech pathology and social work.[752]

614. The composition of the NSW Health workforce has remained broadly consistent over the last five years, although the total workforce has grown by 13.8 per cent (16,597 FTE) in that time.[753] That growth rate has been slightly higher in rural

[751] Exhibit H.5.21, Statement of Richard Griffiths (16 July 2024) [112c] [MOH.0011.0022.0001 at 0035].
[752] A full list of the 23 recognised allied health professional groups is in Exhibit H.2.28, NSW Health, *Allied Health Workforce Macro Trends Report* (Report, May 2022) p 8 [MOH.0003.0234.0001 at 0010].
[753] Exhibit H.5.24, Rian Thompson, *Workforce Data Report* (Report, 17 July 2024) p 7 [MOH.0010.0377.0001 at 0007].

and regional Local Health Districts compared with metropolitan Local Health Districts,[754] but the overall distribution of the workforce between them has remained broadly the same.[755]

615. NSW Health workers are engaged on three main legal bases:

a. as employees;

b. as visiting practitioners (notably by the engagement of specialist doctors as visiting medical officers); or

c. through agencies (notably as locum doctors or agency nurses).

616. As of June 2024, approximately 78.5 per cent of the NSW Health workforce was employed on a permanent basis.[756]

617. A relatively low proportion of the workforce (in overall terms) is engaged as a visiting medical officer or through an agency. However, the proportion of the medical workforce engaged on those bases, and the associated costs, are nevertheless substantial. In this respect,

a. Approximately 50% of the current specialist medical workforce are engaged by means of visiting medical officer appointments.[757] The total visiting medical officer expenditure in the 2022/23 financial year was approximately $1.042 billion, which is less than the total payroll expenditure for staff specialists in that same period.[758]

b. Medical locums represent approximately 4.3% of the overall medical workforce (668.7 FTE in 2023/24), at a total cost of $270 million.[759] However, there is a substantial disparity between locum usage in metropolitan areas (1.35% of the medical workforce in 2023/24) and in rural and regional areas (9.26% in 2023/24).[760] The usage of locums has increased significantly since 2018/19, disproportionately so in rural and regional areas compared with metropolitan areas.[761]

[754] Exhibit H.5.24, Rian Thompson, *Workforce Data Report* (Report, 17 July 2024) p 7 [MOH.0010.0377.0001 at 0007].
[755] Exhibit H.5.24, Rian Thompson, *Workforce Data Report* (Report, 17 July 2024) Figure 3 at p 9 [MOH.0010.0377.0001 at 0009].
[756] Exhibit H.5.24, Rian Thompson, *Workforce Data Report* (Report, 17 July 2024) Table 11 at p 26 [MOH.0010.0377.0001 at 0026].
[757] Exhibit H.5.23, Statement of Melissa Collins (17 July 2024) [110] [MOH.0011.0025.0001 at 0018].
[758] Exhibit H.5.23, Statement of Melissa Collins (17 July 2024) [110]-[111] [MOH.0011.0025.0001 at 0018-0019].
[759] Exhibit H.5.24, Rian Thompson, *Workforce Data Report* (Report, 17 July 2024) p 25 [MOH.0010.0377.0001 at 0025].
[760] Exhibit H.5.24, Rian Thompson, *Workforce Data Report* (Report, 17 July 2024) p 24 [MOH.0010.0377.0001 at 0024].
[761] Exhibit H.5.24, Rian Thompson, *Workforce Data Report* (Report, 17 July 2024) p 24 [MOH.0010.0377.0001 at 0024]; Transcript of the Commission, 6 August 2024 T4769.4-20 (Griffiths).

618. There were 481.6 FTE of agency nurses engaged across NSW Health in June 2023, at a total cost year to date of approximately $55.9 million. The use of agency nurses has decreased since it peaked in June 2021. Like medical locums, agency nurses are predominantly used in rural and regional Local Health Districts with the exception of Sydney Local Health District, which has consistently had the high rates of agency nurse since June 2021.[762]

619. NSW Health has generally seen relatively high and stable retention rates across all of its workforce groups, together with low attrition and turnover rates, including in comparison with the public sector generally.[763]

10.2 General framework of employment and engagement of NSW Health workers

10.2.1 Employees

620. Most staff who are employed in NSW Health agencies are employed in the "NSW Health Service".[764] Staff employed in the NSW Health Service are employed by the Government of NSW in the service of the Crown.[765] As a consequence, their employer is the State of New South Wales.[766] The *Health Services Act* provides expressly that Local Health Districts and Statutory Health Corporations cannot employ staff.[767]

621. As noted above, the Secretary exercises the employer functions in relation to staff employed in the NSW Health Service, apart from chief executives and senior executives of Local Health Districts and specialty networks (for whom the employer functions are exercised by the Board and the chief executive respectively).[768] The Secretary also has the power to fix the salary, wages and conditions of employment of staff employed in the NSW Health Service in so far as they are not fixed by or under any other law.[769] Those functions can be, and to a large extent have been, delegated by the Secretary.[770] As a

[762] Exhibit H.5.24, Rian Thompson, *Workforce Data Report* (Report, 17 July 2024) Table 8 at p 20 [MOH.0010.0377.0001 at 0020].
[763] Exhibit H.5.24, Rian Thompson, *Workforce Data Report* (Report, 17 July 2024) pp 30-31 [MOH.0010.0377.0001 at 0030-0031]; Exhibit H.5.21, Statement of Richard Griffiths (16 July 2024) [28] [MOH.0011.0022.0001 at 0010]; Transcript of the Commission, 6 August 2024, T4772.8-4773.26 (Griffiths).
[764] *Health Services Act 1997* (NSW) ss 115(1), 116(1).
[765] Health Services Act 1997 (NSW) s 115(1).
[766] For the purposes of the *Crown Proceedings Act 1988* (NSW) s 5(1).
[767] *Health Services Act 1997* (NSW) ss 22(2), 45(2).
[768] *Health Services Act 1997* (NSW) ss 116(3), (3D).
[769] Health Services Act 1997 (NSW) s 116A(1).
[770] *Health Administration Act 1982* (NSW) s 21(1); Exhibit H.1, NSW Health, *Combined Delegations Manual* [MOH.9999.0817.0001].

consequence, most of the day-to-day functions associated with employment are exercised by Local Health Districts and other public health organisations.[771] Outside of specific initiatives, the Ministry's workforce role is largely confined to matters of policy and strategy, setting terms and conditions of employment, and conducting industrial negotiations and matters.[772]

622. While all employees in the NSW Health Service are employed under contracts of employment, their terms and conditions of employment are principally those set out in awards. Some employees receive additional or different terms and conditions of employment set out in determinations approved by the Ministry. A small number have been employed under what have been described as unauthorised "non-standard arrangements".

623. Some employees within the NSW health system, principally in "back office" roles in the Ministry, are employed in the New South Wales Public Service rather than the NSW Health Service. This means they are subject to different employment arrangements.[773]

10.2.2 Visiting practitioners

624. Visiting practitioners are medical practitioners or dentists appointed by a public health organisation to practise as a medical practitioner or dentist in a particular public hospital or other health service in accordance with specified terms.[774] They are recognised within the *Health Services Act* and are appointed under a "service contract".[775]

625. The *Health Services Act* recognises two main types of remunerated service contracts for visiting medical officers: a "fee-for-service" contract, which provides for the partitioner to be paid per service they provide, and a "sessional" contract, which provides for the practitioner to be paid per "session" of service at an hourly rate.[776]

[771] There are exceptions – including, for example, in relation to the recruitment of medical interns and graduate nurses: see, for example, Exhibit H.5.15, Statement of Dr Josephine Burnand (11 July 2024) [10] [MOH.0011.0017.0001 at 0002]; Exhibit H.5.10, Statement of Jacqui Cross (8 July 2024) [40] [MOH.0011.0007.0001 at 0008].
[772] Exhibit H.5.22, Statement of Philip Minns (17 July 2024) [7]-[8] [MOH.0011.0024.0001 at 0002]; Exhibit H.5.23, Statement of Melissa Collins (17 July 2024) [25] [MOH.0011.0025.0001 at 0004].
[773] Under the *Government Sector Employment Act 2013* (NSW) rather than the *Health Services Act 1997* (NSW): Exhibit H.5.23, Statement of Melissa Collins (17 July 2024) [19] [MOH.0011.0025.0001 at 0003].
[774] Health Services Act 1997 (NSW) s 76.
[775] Health Services Act 1997 (NSW) s 78.
[776] Health Services Act 1997 (NSW) ss 82, 83.

626. The arrangements for engagement of visiting practitioners compared with employees in the NSW Health Service differ in two material ways. The first is that they are not employees, and therefore are not subject to the terms and conditions of employment set out in awards or the provisions of the *Industrial Relations Act 1996* (NSW). The second is that their legal relationship is with the particular public health organisation (the Local Health District etc), and not with the Government or the Crown.

627. However, the terms of service contracts are nevertheless subject to regulation under the *Health Services Act*. The Act does this in two main ways:

    a. First, it provides for the Minister to approve a set of conditions recommended by the Australian Medical Association for inclusion in service contracts of a particular class (fee-for-service contracts and sessional contracts being discrete classes).[777] If the Minister does this, all remunerated service contracts of that particular class must contain those approved terms, and must not contain any inconsistent terms, or else the contract is void.[778]

    b. Second, it provides a process for arbitration on application by the Minister or the Australian Medical Association, to be conducted by an arbitrator appointed by the Minister administering the *Industrial Relations Act*, to determine the terms and conditions of work, the amounts or rates of remuneration and the bases on which those amounts or rates are applicable in respect of medical services provided by visiting medical officers under fee-for-service contracts or sessional contracts (or both).[779] A determination made by the arbitrator is, in substance, contractually binding, and any inconsistent contractual terms are of no effect.[780] At present, the arbitrator must be a former judicial officer of a superior court of record of the Commonwealth, a State or a Territory or an Australian legal practitioner of at least seven years' standing,[781] although a private

[777] Health Services Act 1997 (NSW) s 87(1).
[778] *Health Services Act 1997* (NSW) ss 87(2), 88(1)-(2).
[779] Health Services Act 1997 (NSW) s 91(1).
[780] Health Services Act 1997 (NSW) s 98.
[781] *Health Services* Act 1997 (NSW) s 90(2); *Health Services Regulation 2018* (NSW) cll 34(1)(a) and (3).

member's bill has recently been introduced into Parliament to amend this to a judicial member of the Industrial Relations Commission.[782]

628. There are two determinations presently in force in relation to visiting medical officers: one relating to sessional contracts[783] and the other relating to fee-for-service contracts.[784] These are now ten years old, although there have been periodic increases to the rates of remuneration set out in them.[785] Those determinations are addressed further below.

10.2.3 Locums and agency nurses and midwives

629. Although locum medical officers are commonly sourced through an agency, they are engaged as casual or temporary employees.[786] The main difference between locums and other employees is that locums are paid at higher rates. While there is a Ministry Policy Directive setting out indicative rates to be paid to non-specialist locums,[787] it is outdated and not followed in practice.[788]

630. In contrast, agency nurses are engaged directly by Local Health Districts, Specialty Health Networks and statewide services when required, under contracts with the agencies.[789] NSW Health is in the process of establishing a Whole of Health Nursing Agency Panel with a statewide contract for agency nurses and midwives.[790]

10.2.4 Other key stakeholders

a. Health Education and Training Institute

631. As observed above, the role of the Health Education and Training Institute is to provide leadership to Local Health Districts, Specialty Health Networks and other public health organisations and training providers on the development and

[782] The *Health Services Amendment (Industrial Relations) Bill 2024* was introduced by Dr J G McGirr MP on 12 November 2024.
[783] Exhibit H.4.18, Public Hospitals (Visiting Medical Officers - Sessional Contracts) Determination 2014 [MOH.0010.0100.0001].
[784] Exhibit H.4.19, Public Hospitals (Visiting Medical Officers - Fee-for-Service Contracts) Determination 2014 [MOH.0010.0090.0001].
[785] Exhibit H.5.23.2, Supplementary Statement of Melissa Collins (3 August 2024) [4], [9] [MOH.0011.0038.0001 at 0001, 0003]; Exhibit H.3.44, NSW Health, *Remuneration Rates for Fee-for-Service Visiting Medical Officers* (IB2021_054) (4 November 2021) [MOH.9999.1034.0001]; Exhibit H.4.23, NSW Health, *Remuneration Rates for Sessional Visiting Medical Officers* (IB2024_001) (10 January 2024) [MOH.9999.1038.0001].
[786] Exhibit H.3.31, NSW Health, Employment and Management of Locum Medical Officers by NSW Public Health Organisations (PD2019_006) (1 February 2019) [MOH.9999.0074.0001].
[787] Exhibit H.4.29, NSW Health, *Remuneration Rates for Non-Specialist Medical Staff - Short Term/Casual (Locum)* (PD2012_046) (10 August 2012) [MOH.0010.0321.0001].
[788] Exhibit H.5.20, Statement of Dr Rebecca Nogajski (16 July 2024) [16(b)] [MOH.0011.0021.0001 at 0004].
[789] Exhibit H.5.21, Statement of Richard Griffiths (16 July 2024) [72] [MOH.0011.0022.0001 at 0021].
[790] Exhibit H.5.21, Statement of Richard Griffiths (16 July 2024) [75]-[78] [MOH.0011.0022.0001 at 0022].

delivery of education and training across the NSW public health system.[791] It is predominantly funded by the Ministry.[792].

632. The Health Education and Training Institute has several critical roles in relation to the wider health workforce, including:

a. The recruitment of medical interns, allocating those interns to positions throughout the New South Wales health system, and accrediting the prevocational training programs delivered to interns and other prevocational trainees at the local level.[793] While the Health Education and Training Institute generally determines the allocation of candidates to intern positions, it does not determine the number or distribution of the available intern positions or how interns rotate through networks once in a position. Responsibility for those matters rests with the relevant Local Health District, Specialty Health Network or Affiliated Health Organisation.[794]

b. Support for vocational training networks relating to Basic Physician Training (part of the physician specialty training), Psychiatry, Paediatric Physician, Emergency Medicine, Radiology, Advanced General Medicine, and Medical Administration.[795] Those networks were established centrally by NSW Health, and each typically includes at least one rural or regional hospital as well as metropolitan hospitals,[796] and a central governance structure[797]. Whilst the Health Education and Training Institute provides support for these governance structures and positions, it is not directly involved or responsible for decisions concerning the day-to-day operation

[791] Exhibit H.1.17.1, NSW Health, *Determination of Functions of Statutory Health Corporation (HETI)* (13 September 2017) cl 1 [SCI.0001.0060.0001 at 0001].
[792] Exhibit H.5.11, Statement of Annette Solman (9 July 2024) [5] [MOH.0011.0012.0001 at 0001]. Its expense budget has decreased by about $5.5 million in the period 2020 to 2024: Exhibit H.5.11, Statement of Annette Solman (9 July 2024) [6] [MOH.0011.0012.0001 at 0002].
[793] Exhibit H.5.11, Statement of Annette Solman (9 July 2024) [56]-[60] [MOH.0011.0012.0001 at 0012-0013]; Exhibit H.5.15, Statement of Dr Josephine Burnand (11 July 2024) [10] [MOH.0011.0017.0001 at 0002].
[794] Transcript of the Commission, 22 July 2024 T3795.44-45 (Burnand). Although all facilities that offer intern positions must be accredited by the Health Education Training Institute's Prevocational Accreditation Committee: Exhibit H.5.15, Statement of Dr Josephine Burnand (11 July 2024) [33]-[36] [MOH.0011.0017.0001 at 0006-0007]; Transcript of the Commission, 22 July 2024 T3802.19-26 (Burnand).
[795] Exhibit H.5.15, Statement of Dr Josephine Burnand (11 July 2024) [47] [MOH.0011.0017.0001 at 0008].
[796] Exhibit H.5.15, Statement of Dr Josephine Burnand (11 July 2024) [38]-[44] [MOH.0011.0017.0001 at 0007-0008].
[797] Including a State Training Council and, in most cases, network governance committees that manage the local delivery of training: Exhibit H.5.15, Statement of Dr Josephine Burnand (11 July 2024) [48] [MOH.0011.0017.0001 at 0008]. Each network also has Network Directors and Education Support Officers (and, in some cases, other network-related positions), which are generally funded by the Ministry: Exhibit H.5.15, Statement of Dr Josephine Burnand (11 July 2024) [50]-[51] [MOH.0011.0017.0001 at 0008-0009].

of the vocational training networks,[798] the establishment and distribution of vocational training positions,[799] the extent to which trainees rotate through the networks (although this function is supported administratively),[800]the recruitment of vocational trainees,[801] accreditation of specialist training positions or locations (which is the responsibility of the specialist medical training colleges).[802]

c. Administration of the ClinConnect system used to manage clinical placements for students across NSW Health in the sense of making that system available and maintaining it from a technical perspective.[803] However, the negotiation, establishment, allocation and management of clinical placements are conducted at the local level between universities and the relevant local organisation.[804]

b. Nursing and Midwifery Office

633. The Nursing and Midwifery Office is part of the Ministry, led by the Chief Nursing and Midwifery Officer.[805] In addition to providing advice within the Ministry on professional and policy issues relating to nursing and midwifery, the Office coordinates the recruitment of graduate nurses and midwives within the NSW health system through a centralised recruitment program and an initial allocation of candidates to facilities based on preferences.[806] However, local organisations then undertake their own interviews, selection and onboarding of candidates, as well as determining the available positions.[807]

c. Universities

634. As the primary source of the future health workforce, Universities are an important feature of the workforce landscape.

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[798] Exhibit H.5.15, Statement of Dr Josephine Burnand (11 July 2024) [45]-[46] [MOH.0011.0017.0001 at 0008]; Transcript of the Commission, 22 July 2024 T3813.3-22 (Burnand).
[799] Transcript of the Commission, 22 July 2024 T3809.37-44 (Burnand).
[800] Transcript of the Commission, 22 July 2024 T3811.41-3812.12 (Burnand).
[801] Transcript of the Commission, 22 July 2024 T3809.37-44 (Burnand). With the apparent exception of the Psychiatry network: Transcript of the Commission, 24 July 2024 T4034.33-42 (Virgona).
[802] Transcript of the Commission, 22 July 2024 T3809.46-3810.1 (Burnand).
[803] Exhibit H.5.11, Statement of Annette Solman (9 July 2024) [51]-[52] [MOH.0011.0012.0001 at 0012]; Transcript of the Commission, 22 July 2024 T3791.7-3792.15 (Solman).
[804] Exhibit H.5.11, Statement of Annette Solman (9 July 2024) [54]-[55] [MOH.0011.0012.0001 at 0012]; Transcript of the Commission, 22 July 2024 T3791.37-42 (Solman).
[805] Exhibit H.5.10, Statement of Jacqui Cross (8 July 2024) [5] [MOH.0011.0007.0001 at 0001].
[806] Exhibit H.5.10, Statement of Jacqui Cross (8 July 2024) [5]-[6], [40] [MOH.0011.0007.0001 at 0001, 0008]; Transcript of the Commission, 23 July 2024 T3917.38-3918.23 (Cross).
[807] Exhibit H.5.10, Statement of Jacqui Cross (8 July 2024) [40] [MOH.0011.0007.0001 at 0008].

635. There are a range of interfaces between universities and the NSW health system, but most are established and operate at the local level. For example, there are several rural clinical schools and regional training hubs throughout New South Wales, which involve partnerships between particular universities and particular Local Health Districts to allow students to undertake part or all of their studies and clinical placements in rural or regional locations.[808] Those clinical placements are generally based on agreements between Local Health Districts and universities, with students being allocated to places manually at the local level.[809] In cases of limited supply, the ad hoc nature of these arrangements can lead to competition for students as between Local Health Districts and for placements as between universities.[810]

636. Similarly, the establishment of conjoint professorial appointments or research collaborations between universities and particular facilities or Local Health Districts can assist in attracting clinical staff,[811] but these are not presently organised in a systematic or co-ordinated way.

d. Registration authorities

637. Health practitioners in Australia are subject to a regulatory scheme established under nationally consistent laws. In New South Wales, that scheme is established by the *Health Practitioner Regulation National Law 2009 (NSW)*. The National Law restricts individuals holding themselves out as being registered or qualified to practise as a health practitioner, or using certain "protected titles" (including, for example, "medical practitioner", "nurse", "midwife", "paramedic", "pharmacist" and "psychologist") unless they are registered with a National Board.[812]

[808] Transcript of the Commission, 19 March 2024 T1360.23-28, 1361.18-37 (Stephenson); Transcript of the Commission, 20 March 2024 1441.20-T1442.40 (MacKenzie); Transcript of the Commission, 22 May 2024 T3161.44-3162.9 (Jones); Transcript of the Commission, 30 July 2024 T4231.39-4232.22 (Fielding).
[809] Exhibit H.5.12, Statement of Professor Peter Hockey (10 July 2024) [7]-[8] [MOH.0011.0013.0001 at 0002]; Transcript of the Commission, 23 July 2024 T3895.15-33 (Hockey).
[810] Exhibit H.5.10, Statement of Jacqui Cross (8 July 2024) [16] [MOH.0011.0007.0001 at 0003]; Transcript of the Commission, 23 July 2024 T3914.38-46 (Cross).
[811] Exhibit H.5.12, Statement of Professor Peter Hockey (10 July 2024) [14]-[15] [MOH.0011.0013.0001 at 0004]; Exhibit H.5.31, Statement of Professor Steevie Chan (29 July 2024) [34(a)] [MOH.0011.0031.0001 at 0010-0011].
[812] *Health Practitioner Regulation National Law 2009* (NSW) Pt 7, ss 31, 113-119; *Health Practitioner Regulation National Law Regulation 2018* (NSW) cl 4. The National Boards are supported administratively by the Australian Health Practitioner Regulation Agency: *Health Practitioner Regulation National Law 2009* (NSW) Pt 4.

638. The National Boards each develop registration standards, codes (for example, codes of conduct) and guidelines for their respective professions.[813] In New South Wales, non-compliance can result in disciplinary action.

e. Specialist medical colleges and the Australian Medical Council

639. A medical practitioner who wishes to hold themselves out as a specialist in Australia must obtain specialist registration with the Medical Board of Australia.[814] Leaving aside international medical graduates, the only pathway to obtaining specialist registration in Australia is to obtain (or be assessed as eligible to obtain) fellowship of a specialist medical college.[815] Those programs of study are accredited by the Australian Medical Council.[816] In practice, international medical graduates wishing to obtain specialist registration are also assessed by the relevant college, except for those whose qualifications are on the "Expedited Specialist" pathway (which include certain qualifications obtained in the United Kingdom, Ireland and Canada).[817]

640. There are 16 specialist medical colleges in Australia, several of which also cover New Zealand.[818]

641. Each of the colleges sets the curriculum for its training program and determines the requirements that must be completed by a trainee to attain fellowship.[819] In addition, each of the colleges conducts its own accreditation process to determine whether training at a particular facility or in a particular position will be recognised for the purposes of its training program. This is not a function recognised by statute or in any other formal way, and to date has been relatively unregulated, although the accreditation processes applied by the colleges may be considered by the Australian Medical Council as part of its consideration of

[813] *Health Practitioner Regulation National Law 2009* (NSW) ss 38-39.
[814] Health Practitioner Regulation National Law 2009 (NSW) s 115.
[815] *Health Practitioner Regulation National Law 2009* (NSW) ss 57(1)(a), 58; see, for example, Transcript of the Commission, 18 October 2024 T5960.25-29, T5964.38-46 (Page); Transcript of the Commission, 18 October 2024 T6002.8-20 (Lim).
[816] *Health Practitioner Regulation National Law 2009* (NSW) s 5 (definition of "approved program of study"), Part 6; Exhibit H.2.39, National Health Practitioner Ombudsman, Processes for progress – Part one: A roadmap for greater transparency and accountability in specialist medical training site accreditation (October 2023) pp 19-20 [MOH.0010.0053.0001 at 0019-0020].
[817] Exhibit H2.53, Medical Board of Australia, *Draft Revised Registration Standard: Specialist Registration* (3 June 2024) pp 2-3 [MOH.0010.0054.0001 at 0002-0003].
[818] Exhibit H.2.39, National Health Practitioner Ombudsman, Processes for progress – Part one: A roadmap for greater transparency and accountability in specialist medical training site accreditation (October 2023) p 20 [MOH.0010.0053.0001 at 0020].
[819] Transcript of the Commission, 18 October 2024 T5958.37-5960.29 (Burnand/Lim/Page).

whether to accredit or reaccredit a college's training program.[820] Consequently, each college has developed its own approach to the accreditation process.[821]

642. However, there are some similarities between college accreditation processes. A notable similarity is that each of the colleges – with greater or lesser rigidity – imposes requirements as to the maximum number of trainees who can be supported per supervisor at a facility (in effect, a ratio).[822]

643. Another is that, while agreeing that their accreditation standards should be "outcomes-based" and "evidence-informed"[823], several colleges viewed the function of their accreditation standards as including setting broader professional or workplace standards for those working in the relevant specialty.[824] This might be thought to be reflected in some of the colleges' accreditation standards that deal with matters such as adequate office space, administrative support, and the appointment processes for senior clinical staff.[825]

644. Colleges have, from time to time, withdrawn or downgraded the accreditation of certain facilities. The consequence of withdrawing accreditation is that the college will no longer recognise training conducted at that facility as contributing to satisfying its training requirements. This can have substantial practical consequences for facilities and trainees.[826] There have been occasions when colleges have withdrawn, downgraded or threatened to withdraw or downgrade a facility's accreditation because of what might be regarded (without diminishing their importance) as cultural issues in the relevant department, including allegations of workplace bullying and harassment.[827]

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[820] Exhibit H.2.39, National Health Practitioner Ombudsman, Processes for progress – Part one: A roadmap for greater transparency and accountability in specialist medical training site accreditation (October 2023) pp 20-21, 24 [MOH.0010.0053.0001 at 0020-00021, 00024].
[821] By way of a simple example, colleges differ in relation to whether they accredit training sites (facilities) or positions: Transcript of the Commission, 16 October 2024 T5792.24-27 (Yik); Transcript of the Commission,18 October 2024 T5976.12-14 (Haq); Transcript of the Commission, 18 October 2024 T6007.18-27, T6009.4-11 (Burnand/Page).
[822] Exhibit H.1.5.1, RANZCR, *Accreditation Standards for Education, Training and Supervision of Clinical Radiology Trainees* (December 2018) p 20 [COR.0002.0006.0001 at 0022]; Transcript of the Commission, 31 July 2024 T4314.23-41 (Angelico).
[823] Exhibit H.2.39, National Health Practitioner Ombudsman, Processes for progress – Part one: A roadmap for greater transparency and accountability in specialist medical training site accreditation (October 2023) p 38 [MOH.0010.0053.0001 at 0038]; Transcript of the Commission, 24 July 2024 T3990.10-19 (Page); Transcript of the Commission, 25 July 2024 T4152.1-34 (Findley); Transcript of the Commission, 31 July 2024 T4338.26-4339.8 (Angelico).
[824] Transcript of the Commission, 24 July 2024 T3954.32-41 (Page).
[825] See, for example, Exhibit H.1.53.2, ANZCA, *ANZCA Handbook for Accreditation* pp 13-19 [ACA.0001.0007.0001 at 0013-0019].
[826] See, for example, Exhibit H.5.19, Statement of Dr Linda MacPherson (12 July 2024) [104] [MOH.0011.0020.0001 at 0020]; Exhibit H.5.27, Statement of Mark Spittal (17 July 2024) [16]-[21] [MOH.0011.0023.0001 at 0004]; Transcript of the Commission, 30 July 2024 T4214.20-31 (Fielding); Transcript of the Commission, 30 July 2024 T4295.23-41 (Chan).
[827] See, for example, Exhibit H.5.31, Statement of Professor Steevie Chan (29 July 2024) [43] [MOH.0011.0031.0001 at 0014]; Exhibit H.5.31.8, Letter from Dr Estall and Dr Lisa Sullivan to Dr Louise Nardone regarding Accreditation of Central Coast Cancer Centre for Radiation Oncology (15 November 2023) pp 1-2 [MOH.0010.0218.0001 at 0001-0002].

645. In relation to the role of the colleges in the accreditation of specialist training, there have been concerns within NSW Health that colleges' accreditation decisions might occasionally have been influenced by industrial considerations (perhaps as an unconscious byproduct of the fact that colleges lack any compulsory investigative powers and so are commonly constrained to act upon information provided to them by their own fellows).[828] Whilst the evidence does not support that such an approach is widespread, some colleges accept that accreditation could be used as a "lever" to achieve outcomes desired by the college.[829]

646. Different arrangements apply as between the colleges as to whether they are involved in the recruitment and selection of trainees or whether these processes were left to local organisations.[830] Those colleges that are involved in recruitment and selection considered this to be valuable because it allowed them to bring their fellows' expertise to bear on those processes.[831]

647. However, apart from influencing the maximum number of trainees who may be engaged at a given site and their training conditions, colleges have a limited capacity to influence the number and distribution of trainees in NSW.[832] They do not determine the number or distribution of trainee positions: the establishment of a position is a discrete and additional step to the college's accreditation of sites or positions in which training is delivered.[833] While most colleges have, to varying degrees, implemented initiatives aimed at increasing rural training (including through Commonwealth Specialist Training Program and Flexible Approach to Training in Expanded Settings funding),[834] all of the college representatives who gave evidence expressed a view that their colleges had no or inadequate access to data about service demands and workforce

[828] Exhibit H.5.30, Statement of Graeme Loy (25 July 2024) [7] [MOH.0011.0030.0001 at 0002].
[829] Transcript of the Commission, 25 July 2024 T4112.37-4113.11 (Haq).
[830] Exhibit H.5.19, Statement of Dr Linda MacPherson (12 July 2024) [121] [MOH.0011.0020.0001 at 0023].
[831] Transcript of the Commission, 30 July 2024, T4208.21-36 (Fielding); Transcript of the Commission, 24 July 2024, T4035.10-27 (Virgona).
[832] Transcript of the Commission, 24 July 2024 T3968.13-16 (Page); Transcript of the Commission, 30 July 2024 T4213.28-35 (Clota).
[833] Transcript of the Commission, 23 July 2024 T3871.3-20 (Nogajski).
[834] Transcript of the Commission, 24 July 2024 T3967.12-3970.21 (Page); Transcript of the Commission, T4086.15-22 (Haq); Transcript of the Commission, 30 July 2024 T4236.33-45 (Fielding).

planning needs, which constrained their ability to contribute meaningfully to solving shortage and distribution problems.[835]

648. The roles and responsibilities of colleges, particularly in accreditation, have recently been the subject of a report by the National Health Practitioner Ombudsman.[836] That report included 23 recommendations, most of which are directed at improving the fairness and transparency of the colleges' accreditation processes including setting accreditation standards, assessing whether accreditation should be granted, monitoring, non-compliance, and dealing with grievances about accreditation decisions.[837] All jurisdictional health ministers have supported these recommendations[838] and the Australian Medical Council has been directed to work with jurisdictions and the colleges to implement them.[839] Most of the college representatives who gave evidence said their colleges also endorsed the National Health Practitioner Ombudsman's recommendations.[840]

f. Industrial organisations:

649. Turning away from education and training to industrial matters, the key stakeholders on the employee side are industrial organisations. The key industrial organisations relevant to the NSW health system are:

a. the Australian Medical Association (representing visiting medical officers);

b. the Australian Paramedics Association (NSW) (representing some paramedics);

c. the Australian Salaried Medical Officers Federation (NSW) (representing employed doctors);

[835] Transcript of the Commission, 24 July 2024 T4015.32-38 (Moyle); Transcript of the Commission, 24 July 2024 T4038.12-24, T4038.12-24, T4056.16-35 (Virgona); Transcript of the Commission, 25 July 2024 T4097.36-42 (Kanhutu/Haq); Transcript of the Commission, 30 July 2024 T4209.33-43 (Fielding); Transcript of the Commission, 31 July 2024 T4323.10-33 (Angelico). Each would prefer, and could make use of, access to more data about these matters: Transcript of the Commission, 25 July 2024 T4172.20-36 (Findley); Transcript of the Commission, 31 July 2024 T4323.35-41 (Angelico); Transcript of the Commission, 18 October 2024 T5986.42-5987.1 (Haq); Transcript of the Commission, 18 October 2024 T5991.1-4 (Fielding).
[836] Exhibit H.2.39, National Health Practitioner Ombudsman, Processes for progress – Part one: A roadmap for greater transparency and accountability in specialist medical training site accreditation (October 2023) [MOH.0010.0053.0001].
[837] Exhibit H.2.39, National Health Practitioner Ombudsman, Processes for progress – Part one: A roadmap for greater transparency and accountability in specialist medical training site accreditation (October 2023) pp 5-7 [MOH.0010.0053.0001 at pp 0005-0007].
[838] Exhibit H.2.42, Health Ministers Meeting, Communique (10 November 2023) p 1 [MOH.0010.0302.0001 at 0001].
[839] Exhibit H.3.49, Ministerial Policy Direction 2023-1: Medical college accreditation of training sites (1 September 2023) p 1 [MOH.0010.0063.0001 at 0001].
[840] Transcript of the Commission, 25 July 2024 T4095.37-4096.4 (Haq/Kanhutu); Transcript of the Commission, 25 July 2024 T4162.13-37 (Findley); Transcript of the Commission, 30 July 2024 T4201.28-39 (Fielding); Transcript of the Commission, 31 July 2024 T4324.33-40, T4338.20-24 (Angelico).

d. the Health Services Union (representing a wide range of health workers but notably allied health professionals and non-clinical staff working in hospitals, as well as some paramedics); and

e. the New South Wales Nurses and Midwives' Association (representing nurses and midwives).

650. Industrial organisations are typically parties to awards covering employees who are or are eligible to be their members.

g. External complaints agencies

651. As set out above, the *National Law* establishes a scheme for dealing with health, performance and conduct issues involving registered (and formerly registered) health practitioners.[841] Among other things, the scheme provides for complaints about health practitioners to be made to the relevant Council for the profession or the Health Care Complaints Commission,[842] and then dealt with by a variety of means including proceedings in the Civil and Administrative Tribunal which can result in the suspension or cancellation of a practitioner's registration.

10.3 The nature and extent of workforce shortages and maldistribution

10.3.1 The medical workforce

652. The weight of the evidence supports the general conclusions that:

a. there is currently a shortfall in prevocational medical trainees compared with available positions;

b. there is a shortfall in applicants for training positions and/or in training positions for a number of specialty training programs, including psychiatry, radiology and emergency medicine;

c. there is a shortfall in specialists compared with available positions in a number of medical specialties including psychiatry, emergency medicine, radiology, anaesthesia and general practice; and

[841] *Health Practitioner Regulation National Law 2009* (NSW) Pt 8.
[842] Which is governed by separate but overlapping legislation: *Health Care Complaints Act 1993* (NSW).

d. there is a general maldistribution of the medical workforce between metropolitan areas and rural and regional areas.

653. Demonstrative of those shortages is the fact that in 2024, approximately 8% intern positions (94.5 out of 1153.5) were unfilled after candidates were allocated across all recruitment pathways.[843] 66 of those unfilled positions (almost 70 per cent) were in rural or regional New South Wales.[844] As at June 2024, there were 168 PGY1 and PGY2 vacancies, which again were disproportionately reflected in rural and regional locations.[845] Concurrently with those shortfalls, Ministry modelling projects a need for an additional 165 to 212 medical graduates per annum.[846]

654. In relation to registrar or vocational training positions, the Ministry approaches this issue in two ways. The first is to look at the number of applicants for training positions compared with the number of available training positions for a given specialist training program. This analysis indicates there are overall shortages in applicants in some specialities – such as psychiatry and emergency medicine training.[847] The second approach is to model the number of additional trainees per year needed to meet projected demand for specialists in the relevant specialty.[848] That modelling was last undertaken in 2021,[849] although the data set appears to be from 2019.[850] The results of that modelling are made publicly available (albeit in a relatively high-level form)[851] and indicate "significant" career opportunities (corresponding with a relatively high number of additional trainees needed each year) in psychiatry, diagnostic radiology, ophthalmology, rehabilitation medicine, as well as neurosurgery.[852]

[843] Exhibit H.5.19, Statement of Dr Linda MacPherson (12 July 2024) [79], [83] [MOH.0011.0020.0001 at 0016].
[844] Exhibit H.5.19, Statement of Dr Linda MacPherson (12 July 2024) [83] [MOH.0011.0020.0001 at 0016].
[845] Exhibit L.2, Statement of Justine Harris (2 October 2024) [8] [MOH.0011.0077.0001 at 0002].
[846] Exhibit H.5.21, Statement of Richard Griffiths (16 July 2024) [47] [MOH.0011.0022.0001 at 0015].
[847] Exhibit H.5.21, Statement of Richard Griffiths (16 July 2024) [47] [MOH.0011.0022.0001 at 0015].
[848] Exhibit H.5.21, Statement of Richard Griffiths (16 July 2024) [47] [MOH.0011.0022.0001 at 0015].
[849] Exhibit H.5.21, Statement of Richard Griffiths (16 July 2024) [46] [MOH.0011.0022.0001 at 0015].
[850] Exhibit H.1.115, NSW Health, *Psychiatry Workforce modelling factsheet* [SCI.0011.0273.0001].
[851] NSW Health 'Medical Workforce Modelling', NSW Health (Web Page, 5 July 2023) <https://www.health.nsw.gov.au/workforce/modelling/Pages/medical-modelling.aspx> (accessed 10 December 2024).
[852] NSW Health 'Medical Workforce Modelling', NSW Health (Web Page, 5 July 2023) <https://www.health.nsw.gov.au/workforce/modelling/Pages/medical-modelling.aspx> (accessed 10 December 2024).

655. In relation to specialists, there are shortages in terms of the number of specialists to fill available positions in several specialities, including psychiatry, emergency medicine, radiology and anaesthesia, as well as general practice.[853]

656. The Special Commission heard evidence from a diverse range of clinicians about their own experiences and observations of shortages across the medical workforce in rural and regional New South Wales.[854] That evidence is consistent with the data about locum usage being disproportionately higher in those areas.

657. The underlying causes of those shortages and the resultant maldistribution were said to be multifactorial, but included:

a. a lack of connection with and at least a perception of a lack of professional and social support in rural and regional areas, especially for those clinicians that have trained in metropolitan areas;[855]

b. a lack of suitable accommodation, child-care and other facilities and services in rural and regional areas;[856]

c. a perception of the work in rural and regional areas as being less interesting and diverse, but also more onerous (including in relation to on-call obligations);[857] and

d. insufficient financial incentives to move to rural or regional areas.[858]

10.3.2 Nurses and midwives

658. In relation to the nursing and midwifery workforce, the evidence supports the conclusion that:

a. there is a significant shortage of midwives across NSW;

[853] Exhibit L.2, Statement of Justine Harris (2 October 2024) [10] [MOH.0011.0077.0001 at 0002]. A common theme in relation to psychiatry, radiology and anaesthesia is that the public sector experiences significant competition from the private sector, which pays substantially more: see, for example, Transcript of the Commission, 18 September 2024, T5320.8-13 (Wong); Transcript of the Commission, 7 August 2024, T4796.39-44 (Minns).
[854] See, for example, Exhibit H.7.6, Statement of Dr Nicholas Spooner (17 July 2024) [11] [SCI.0011.0249.0001 at 0002]; Exhibit H.5.31, Statement of Professor Steevie Chan (29 July 2024) [6], [27] [MOH.0011.0031.0001 at 0003, 0008]; Exhibit H.7.8, Statement of Dr Michelle McRae (17 July 2024) [9] [SCI.0011.0257.0001 at 0002]; see also Exhibit H.5.22, Statement of Philip Minns (17 July 2024) [18] [MOH.0011.0024.0001 at 0005] (referring to shortages in 14 of 64 medical specialties in regional areas).
[855] Exhibit H.5.22, Statement of Philip Minns (17 July 2024) [17] [MOH.0011.0024.0001 at 0004-0005]; Exhibit L.2, Statement of Justine Harris (2 October 2024) [11(d)] [MOH.0011.0077.0001 at 0003]; Exhibit L.3, Statement of Luke Sloane (3 October 2024) [7] [MOH.0011.0079.0001 at 0002].
[856] Exhibit H.5.22, Statement of Philip Minns (17 July 2024) [17] [MOH.0011.0024.0001 at 0004-0005]; Exhibit H.7.8, Statement of Dr Michelle McRae (17 July 2024) [25] [SCI.0011.0257.0001 at 0004]; Exhibit L.16, Statement of Andrew Holland (1 October 2024) [28] [SCI.0011.0469.0001 at 0005].
[857] See, for example, Exhibit H.5.18, Statement of Dr Karen Murphy (12 July 2024) [20] [MOH.0011.0019.0001 at 0005]; Exhibit L.2, Statement of Justine Harris (2 October 2024) [11(b)-(c)] [MOH.0011.0077.0001 at 0003]; Exhibit L.9, Statement of Dr Natalie Rainger (28 July 2024) [18] [SCI.0011.0286.0001 at 0003].
[858] See, for example, Exhibit H.5.18, Statement of Dr Karen Murphy (12 July 2024) [22] [MOH.0011.0019.0001 at 0006].

b. there is a significant shortage of enrolled nurses across NSW; and

c. there is a maldistribution of the nursing and midwifery workforce between metropolitan areas and rural and regional areas. [859]

659. The evidence suggests that shortages in rural and regional Local Health Districts commonly coincide with difficulty in attracting students for clinical placements and attracting applicants for graduate positions,[860] notwithstanding there being a range of incentives, scholarship and cadetship programs aimed at increasing the attractiveness of rural and regional work.[861] Those shortages are also reflected with a greater usage of agency nurses in those areas.[862]

660. There is some disagreement between the Ministry and the NSW Nurses and Midwives Association as to whether there are general shortages (as opposed to maldistribution) among registered nurses.[863] The Ministry suggests that there is a sufficient supply of graduate registered nurses to meet demand. However, the NSW Nurses and Midwives Association has received feedback from its members of a generalised experience of shortages even among registered nurses. That feedback is based in part on observations of vacancies in nursing positions.

661. That disagreement serves to highlight the limited use that is presently made of vacancy data. It is not presently a data set that is systematically monitored by the Ministry (that data sits only at the Local Health District level[864]), and the Ministry appears sceptical about its value as an indicator of workforce shortages.[865] Accepting that some caution may be needed in interpreting vacancy data – including that the fact that there is a vacancy does not mean

[859] Transcript of the Commission, 14 October 2024, T5569.25-5570.1.6, T5572.20-26 (Griffiths/Dominish); Exhibit H.5.10, Statement of Jacqui Cross (8 July 2024) [43]-[44] [MOH.0011.0007.0001 at 0008); Exhibit H.5.21, Statement of Richard Griffiths (16 July 2024) [48] [MOH.0011.0022.0001 at 0015]; Exhibit K.36, Statement of Jennifer Richter (5 September 2024) [5]-[11] [MOH.0011.0056.0001 at 0001-0002]; Exhibit H.5.28, Statement of Jonathan Morris [8] [MOH.0011.0028.0001 at 0002]; Exhibit K.40, Statement of Tracey McCosker PSM (13 September 2024) [81]-[86] [MOH.0011.0062.0001 at 0021-0022]; Exhibit K.34, Statement of Tracey Maisey (9 September 2024) [157] [MOH.0011.0064.0001 at 0032-0033]; Exhibit I.30, Statement of Margaret Bennett (6 August 2024) [102] [MOH.0011.0041.0001 at 0022]; Transcript of the Commission, 14 October 2024 T5596.20-35 (Griffiths); Exhibit H.5.26, Statement of Hayley Scuiriaga (18 July 2024) [22] [MOH.0011.0027.0001 at 0005].

[860] Exhibit K.36, Statement of Jennifer Richter (5 September 2024) [14] [MOH.0011.0056.0001 at 0003]; Exhibit H5.16, Statement of Jacqueline Blackshaw (11 July 2024) [9]-[17] [MOH.0011.0016.0001 at 0003-0005].

[861] Exhibit H5.21, Statement of Richard Griffiths (16 July 2024) [34] [MOH.0011.0022.0001 at 0012]; Exhibit H5.10, Statement of Jacqui Cross (8 July 2024) [46] [MOH.0011.0007.0001 at 0009].

[862] Although there are some limitations in the data in this respect, as it is presented as raw figures rather than, for example, agency nursing FTE or expenditure relative to FTE of or expenditure on employed nurses: Exhibit H.5.24, Rian Thompson, *Workforce Data Report* (Report, 17 July 2024) pp 20-21 [MOH.0010.0377.0001 at 0020-0021].

[863] Transcript of the Commission, 14 October 2024 T5570.42-5571.6 (Whaites).

[864] Exhibit H.5.21.2, Supplementary Statement of Richard Griffiths (2 August 2024) [4]-[11] [MOH.0011.0039.0001 at 0001-0003].

[865] Exhibit H.5.21.2, Supplementary Statement of Richard Griffiths (2 August 2024) [4]-[11] [MOH.0011.0039.0001 at 0001-0003]; Transcript of the Commission, 6 August 2024, T4786.46-4788.28 (Griffiths); Transcript of the Commission, 7 August 2024 T4818.21-4819.21 (Minns).

that the position is unfilled through agency staff, or overtime etc – there can be little doubt that data concerning "aged vacancies" (that is, vacancies in respect of permanent positions that have been advertised but unfilled for some time) might assist in quantifying the extent of a workforce shortage in a particular facility or in a particular region.

662. Accordingly, it would be an appropriate step for the Ministry to seek to enhance its data suite (as part of an enhanced system level planning process) to capture and consider data of that kind.

10.3.3 Allied health

663. The Ministry conducted workforce modelling for 22 allied health disciplines in 2021, the broad outputs of which are publicly available.[866] That modelling indicates that there are some allied health disciplines facing significant shortages compared with demand, including, for example, radiation therapy, sonography, pharmacy, psychology, podiatry and occupational therapy.[867] There is also a general maldistribution of allied health workers in most disciplines.[868]

664. The reasons for those shortfalls and workforce maldistribution in the allied health workforce are, again, multifactorial but include:

a. competition from the private sector and NDIS providers, which typically pay more and offer more flexibility;[869]

b. at least a perception of reduced career development or progression opportunities, particularly in rural and regional areas;[870] and

[866] Exhibit H.5.21, Statement of Richard Griffiths (16 July 2024) [46] [MOH.0011.0022.0001 at 0015]; NSW Health 'Medical Workforce Modelling', NSW Health (Web Page, 5 July 2023) <https://www.health.nsw.gov.au/workforce/modelling/Pages/allied-health.aspx> (accessed 10 December 2024).
[867] Exhibit H.5.21, Statement of Richard Griffiths (16 July 2024) [49] [MOH.0011.0022.0001 at 0016]; Transcript of the Commission, 14 October 2024, T5636.25-31 (Griffiths); Transcript of the Commission, 14 October 2024, T5642.15-18 (Dominish); Exhibit H.7.1, Statement of Jill Harris (12 July 2024) [7]-[8] [SCI.0011.0155.0001 at 0002]; Exhibit H.7.5, Statement of Professor Lil Vrklevski (16 July 2024) [21]-[22] [SCI.0011.0198.0001 at 0005]; Exhibit L.13, Statement of Jerry Yik and Dr Jonathan Penm (26 September 2024) [SCI.0011.0459.0001 at 0017]; Exhibit H.6.4, Statement of the Royal Australian and New Zealand College of Anaesthetists (15 July 2024) [21] [SCI.0011.0181.0001 at 0004].
[868] Exhibit H.5.22, Statement of Philip Minns (17 July 2024) [17] [MOH.0011.0024.0001 at 0004-0005]; Exhibit H.5.16, Statement of Jacqueline Blackshaw (11 July 2024) [21] [MOH.0011.0016.0001 at 0006]; Exhibit H.5.17, Statement of Emma-Kate Dewhurst (10 July 2024) [11] [MOH.0011.0018.0001 at 0003]; Transcript of the Commission, 23 July 2024, T3933.10-12 (Dewhurst).
[869] Exhibit H.5.16, Statement of Jacqueline Blackshaw (11 July 2024) [21] [MOH.0011.0016.0001 at 0006]; Exhibit H.5.17, Statement of Emma-Kate Dewhurst (10 July 2024) [36] [MOH.0011.0018.0001 at 0008-0009]; Transcript of the Commission, 23 July 2024 T3935.25-3936.17 (Dewhurst); Transcript of the Commission, 14 October 2024, T5636.18-31 (Griffiths).
[870] Exhibit H.5.16, Statement of Jacqueline Blackshaw (11 July 2024) [21] [MOH.0011.0016.0001 at 0006].

c. insufficient supervisors to allow students to complete clinical placements.[871]

665. There is limited agency staff use in allied health professions compared with nursing and midwifery and medicine.[872]

10.4 Workforce planning and establishment

10.4.1 The current framework

666. The current framework for service planning, workforce planning and the establishment of clinical positions has five core features that warrant consideration.

667. First, clinical service planning – that is, determining what health services will be supplied and with what resources – is conducted at the local level.[873] While the Ministry conducts supply and demand modelling and makes it available to local organisations to inform their service planning,[874] it is ultimately a matter for the local organisation as to whether and how it uses that modelling to inform its service planning.

668. Second, as observed above, workforce planning and establishment – that is, planning and establishing positions for clinical workers – is also conducted at the local level (with the exception of some specific Ministry-led programs). Again, the Ministry makes modelling available to local organisations to inform these processes but does not direct their use. In this respect, the function of workforce planning and establishment is almost entirely devolved to local organisations.

669. Third, while service and workforce planning generally occur at a local level, the Ministry that has visibility of a substantial amount of data relevant to the workforce across the system.[875] In contrast, as a general proposition, local organisations do not appear to perform, or always have the capacity to perform, detailed and sophisticated analysis of that data (at least to the same extent that

[871] Transcript of the Commission, 14 October 2024, T5636.46 – 5637.2 (Griffiths); Transcript of the Commission, 14 October 2024, T5649.39-46 (Newton-John).
[872] Transcript of the Commission, 14 October 2024 T5640.20-25 (Dominish).
[873] Exhibit L.6, Statement of Philip Minns (8 October 2024) [10] [MOH.0011.0082.0001 at 0003]; Exhibit L.7, Statement of Richard Griffiths (8 October 2024) [112] [MOH.0011.0083.0001 at 0025].
[874] Transcript of the Commission, 25 July 2024 T4119.44 – 4120.5 (Dominish); Transcript of the Commission, 7 August 2024 T4824.9-38 (Minns).
[875] Exhibit H.5.21, Statement of Richard Griffiths (16 July 2024) [146] [MOH.0011.0022.0001 at 0044-0045]; Transcript of the Commission, 6 August 2024 T4776.21-30 (Griffiths).

the Ministry does).[876] In any event, their focus is naturally local, rather than adopting a system wide perspective in their planning activities.[877]

670. Fourth, the Ministry provides limited practical or operational direction to local organisations about service planning or workforce planning and establishment.[878] The Ministry provides strategic guidance, for example in the *Workforce Plan*,[879] but this is a very high-level document that does not provide any significant operational direction. The Ministry also holds meetings with local organisations from time to time to discuss concerning trends in the data monitored by the Ministry,[880] but these appear to be ad hoc.

671. Relatedly, the service agreements between the Secretary and local organisations do not impose any obligations relating to the use of supply and demand modelling to inform their service or workforce planning. The agreements address service delivery obliquely and in limited fields which are mostly uninformative as to the effectiveness of the organisation's service planning for meeting population demands (for example, time to see emergency department presentations). To the extent that Key Performance Indicators address workforce matters, they do so generally in narrow and formulaic ways focused mostly on culture (for example, People Matter Experience Survey results) and workforce participation (for example, an Aboriginal workforce participation target).

672. However, the Ministry does engage in some direct interventions in relation to workforce issues. For example, in response to the 2019 NSW bushfires, the Ministry established a unit that actively deploys staff (mostly nursing and allied health) to areas of high demand. This unit has recently expanded to 400 FTE staff and the Ministry plans to expand it further.[881] As noted above, the Ministry has also established a whole-of-health agency nursing panel and is exploring establishing an "internal" agency for medical locums.[882] Those are welcome

[876] Exhibit H.7.6, Statement of Dr Nicholas Spooner (17 July 2024) [23]-[24] [SCI.0011.0249.0001 at 0005].
[877] Transcript of the Commission, 15 October 2024, T5706.41-5707.13 (Minns).
[878] Transcript of the Commission, 6 August 2024, T4761.32-38 (Griffiths).
[879] Exhibit L.13.2, NSW Health, *NSW Health Workforce Plan 2022-2032* [MOH.9999.3112.0001]; see also Exhibit H.2.36, NSW Health, *Workforce Plan 2022-2032: A supplementary guide* [MOH.0010.0275.0001].
[880] Transcript of the Commission, 6 August 2024, T4766.9-4767.30 (Griffiths).
[881] Transcript of the Commission, 6 August 2024, T4762.38-4763.18, T4763.43-4765.10 (Griffiths).
[882] Exhibit L.7, Statement of Richard Griffiths (8 October 2024) [62]-[73] [MOH.0011.0083.0001 at 0015-0017]. An "internal" locum agency would go some way to eliminating the untenable circumstance of NSW Health agencies bidding against each other to secure the services of a clinicians.

initiatives, which should be pursued and embedded at a system level. In this respect, an internal locum agency would likely go some way to eliminating the untenable circumstance of Local Health Districts, or individual facilities, "bidding" against each other to secure medical locums,[883] and to manage costs.

673. However, (and without intending to diminish their value) they are somewhat reactive in nature, rather than indicative of a pro-active approach to emerging workforce issues at a system level or long-term strategic planning.

674. Finally, in contrast to the data sharing that occurs between the Ministry and local organisations, there are inconsistencies in the level and consistency of data sharing that occurs with other stakeholders including universities, specialist medical colleges and industrial organisations. Stakeholders have access to publicly available data sources, including data made available by NSW Health through the Bureau of Health Information and some high-level workforce modelling outputs published on NSW Health's website. But aside from those modelling outputs, this data is not typically collated, correlated or otherwise analysed as the Ministry does;[884] this situation needs to change.

675. The often contentious nature of the relationship between the Ministry and several of these stakeholders – especially the industrial organisations – significantly undermines the extent to which they can collaborate to overcome what are often entrenched workforce challenges. The sharing of information with these organisations by the Ministry is critical if these relationships are to change in a way that maximises the benefit that each can bring to what is ultimately a public health system. The Ministry must overcome its fear that any information shared – particularly that relating to challenging aspects of the public health system or difficult decisions that must be made in the prioritisation of the limited resources available – will be weaponised against it by stakeholders, including industrial organisations. Stakeholders entrusted with this wider range of information must use it responsibly. This is not to suggest that the sharing of difficult information will not be challenging. However, a mature and high performing health system must embrace those areas in which

[883] Exhibit H.5.31, Statement of Professor Steevie Chan (29 July 2024) [32] [MOH.0011.0031.0001 at 0010].
[884] Transcript of the Commission, 22 July 2024 T3758.22-3759.12 (Halse).

it knows that it is failing and work collaboratively with all relevant stakeholders remedy that situation.

10.4.2 The need for a system-wide and systematic approach

676. The current framework of workforce planning in the wider public health system is characterised by the lack of a system-wide and systematic approach to those functions. There is no system-wide approach in the sense that the clinical workforce is not established or structured by reference to a detailed assessment of population needs or the supply of clinicians across the system.

677. These characteristics are not surprising given the highly devolved approach that has been adopted in relation to service and workforce planning functions, which does not include substantive involvement from the Ministry, notwithstanding that the Ministry is the only one with visibility across the system and the capability to model system-wide supply and demand.

678. The need for a system-wide approach to workforce planning and engagement has increased in circumstances where the finite nature of the financial and human resources available to the system have become more acutely felt.

679. As is addressed elsewhere in this outline, whatever may have been the position in the past, the post-pandemic environment is a very different one that has as its feature constrained resources, both financial and human. Difficult choices need to be made as to what services are made available, where, and in what form if the system is to be sustainable. The advantage of a system-wide perspective in responding to that new environment is that it provides an opportunity to maximise effective and efficient delivery of health services across State, by ensuring the most effective deployment of its workforce to achieve that aim.

680. There are several good reasons why the Ministry should have a key role in that process. Critically, it has oversight over large amounts of workforce data and has the ability to analyse and interpret that data at a system level. It also largely controls the funding allocated to local organisations to fund their workforce needs.

681. Greater co-ordination at a system level would also provide opportunities to eliminate inefficiencies. For example:

a. Some rural and regional Local Health Districts have taken the initiative of attempting to recruit doctors, nurses and midwives from overseas, with success. These initiatives have largely involved each developing its own processes, engaging its own recruitment agencies, offering its own incentives to attract candidates, and taking responsibility itself for the associated administrative work including sponsorship documentation.[885] However, some Local Health Districts have not been able to afford the costs of conducting international recruitment or not managed to achieve success on this front for other reasons.[886] A more coordinated approach to workforce planning and structuring may provide an opportunity to develop a centralised process for international recruitment.

b. While there are centralised recruitment processes for graduate nurses and midwives and medical interns, there are no such processes for allied health professions or medical trainees in many specialty training programs.[887] This means that candidates are required to put in multiple applications, and local organisations are required to conduct duplicative recruitment processes, despite the fact that it may be the same (or largely the same) cohort of applicants applying for the same set of available positions.[888]

c. There is no central coordinating function in relation to clinical placements, which leads to competition between universities for those placements.[889]

d. As observed above, the current structures have given rise to the untenable situation of parts of the system competing with one another for agency nurses and locums, driving up the cost. An example of the benefits of a system wide approach is the Ministry's whole-of-health locum and agency staff initiatives, which appear likely to result in significant benefits.

[885] Exhibit K.36, Statement of Jennifer Richter (5 September 2024) [8]-[12] [MOH.0011.0056.0001 at 0002-0003]; Exhibit H.5.26, Statement of Hayley Sciuriaga (18 July 2024) [12] [MOH.0011.0027.0001 at 0003]; Exhibit H.5.28, Statement of Jonathan Morris (19 July 2024) [15d] [MOH.0011.0028.0001 at 0004]; Exhibit H.5.31, Statement of Professor Steevie Chan (29 July 2024) [31] [MOH.0011.0031.0001 at 0010].
[886] Exhibit H.5.14, Statement of Barbara Crawford (11 July 2024) [26] [MOH.0011.0015.0001 at 0005]; Exhibit H.5.25, Statement of Melissa Pickering (18 July 2024) [22]-[23] [MOH.0011.0026.0001 at 0004].
[887] Cf Transcript of the Commission, 22 July 2024 T3827.10-3828.5 (Twigg); Transcript of the Commission, 14 October 2024 T5645.18-23 (Dominish).
[888] Transcript of the Commission, 16 October 2024 T5787.32-5789.23 (Yik/Penm); Transcript of the Commission, 24 July 2024 T3976.12-23, T3978.5-3982.47 (Page/Moyle).
[889] Exhibit H.5.10, Statement of Jacqui Cross (8 July 2024) [16] [MOH.0011.0007.0001 at 0003].

682. In highlighting the need for a system wide approach, it is not suggested that Ministry assume ultimate control over workforce issues. The benefits of devolution remain critical, and in particular the importance of local perspectives, and the importance of local organisations and local facilities having substantial input into workforce planning and structuring, when they are the ones with direct (and statutory)[890] responsibility for delivering health services to their local populations. But there does need to be a higher and more consistent level of operational oversight and co-ordination from the Ministry to ensure that workforce planning (including in relation to the future workforce pipeline) and engagement supports a long-term sustainable system. It must be a collaboration in which the Ministry provides support, advice and direction, rather than "taking over".[891]

683. Several witnesses recognised the desirability of bringing a system-wide perspective to bear upon workforce planning and structuring in a more regular and proactive way. For example, Philip Minns, Deputy Secretary, People Culture and Governance, described "a missing middle function related to service planning and configuration".[892] Referring by analogy to Defence capability planning, Mr Minns expressed the following views:[893]

> *Throughout the long period of capital investment since 2011, there has been a very limited application of a Defence style capability lens where whole of health system strategic objectives would operate to influence specific localised decisions while also drawing the linkages between strategy, service delivery planning and capability, redesigned models of care, sustainable financial resources and workforce availability –both immediately and after deployment of pipeline building strategies. The statement of Mr Richard Griffiths prepared to address workforce solutions, makes this point under the heading "identifying current in demand service areas".*
>
> *This missing middle function existed prior to the 2011 governance changes to the NSW public health system. Recreating this missing middle function cannot be done in a way that removes the involvement of clinicians, staff and communities in local planning for individual service plans. Rather, what*

[890] *Health Services Act 1997* (NSW) s 10.
[891] See also, Transcript of the Commission, 14 October 2024, T5614.18-33 (Griffiths).
[892] Exhibit L.6, Statement of Philip Minns (8 October 2024) [10] [MOH.0011.0082.0001 at 0003].
[893] Exhibit L.6, Statement of Philip Minns (8 October 2024) [13]-[15] [MOH.0011.0082.0001 at 0003-0004].

> *needs to happen is that this local engagement occurs in a coherent overarching context provided by a system level design of networked service delivery.*
>
> *The aim of this different approach to health system capability planning would be to ensure that we are indeed making investment and planning decisions based on the direction of the Future Health Strategy, and in workforce terms, we are assessing workforce challenges, constraints and reform opportunities at the earliest point in health system capability planning.*

684. The changes in 2011 referred to in that extract involved the then-Director General of NSW Health "adopt[ing] a fundamental principle of a commitment to devolution and localism" which moved the function of clinical service planning from the Ministry to the local organisation level, limiting "broader statewide oversight of service design and alignment".[894]

685. Richard Griffiths, Executive Director, Workforce Planning and Talent Development, the Ministry, reflected on the issue in this way:[895]

> *At present, NSW Health focusses too strongly on adapting models of care to the current workforce and the way it currently works, rather than building workforce for delivery of new models of care. Our service planning structure tends to replicate what has previously been done, and then workforce is retrofitted.*
>
> *In my view, NSW Health needs to move away from looking at networking opportunities after developing individual service plans and instead start with a system level networked approach to service. How we identify what workforce is needed and where and how to supply the identified workforce needs greater central oversight to facilitate system visibility and more contemporary service planning. We need to conduct workforce planning not by looking at workforce as a limiting factor but to design Clinical Services Plans in a more connected way between LHDs and consider the new models of care available and the workforce that might be created to deliver them. Although MOH has expectations that the LHDs will demonstrate networking in their Clinical Services Plans, greater centralisation of this function would ensure that we standardise models of care, capture innovation opportunities and look at supply of workforce to meet these*

[894] Exhibit L.6, Statement of Philip Minns (8 October 2024) [12] [MOH.0011.0082.0001 at 0003].
[895] Exhibit L.7, Statement of Richard Griffiths (8 October 2024) [111]-[112] [MOH.0011.0083.0001 at 0025].

opportunities, rather than determining that existing workforce prevents these opportunities from being considered.

686. It would be undesirable to be too prescriptive as to the structures and processes that should be implemented to achieve the greater degree of central coordination and system focus accepted as being desirable. The Ministry and local organisations are best placed to design these (with appropriate consultation). However, there are several matters that have emerged in the evidence that should be reviewed as part of that process. They include:

a. rationalising existing incentives, which are largely ad hoc;[896]

b. whether further centralising recruitment processes may be beneficial either for improving efficiency or improving the capacity of the system to match workforce supply with population needs or both;

c. whether in engaging a medical workforce, terms and conditions should include an obligation for practitioners to support service delivery in rural and regional locations, including by attending those locations to deliver clinics or conduct procedures from time to time, providing virtual care into those locations, and/or providing remote supervision to trainees in a rural or regional location, with appropriate compensation;[897] and

d. steps that may be taken to expose students and junior practitioners to fields in which there are workforce shortages, for example psychiatry and general practice, as well as supporting opportunities for more training to be undertaken in rural and regional locations, from early in their careers.[898]

10.5 The role of the Health Education and Training Institute

687. A particular manifestation of the issues described above is the planning, establishment and allocation of clinical placements for university students and vocational training positions for registrars.

10.5.1 Student placements

688. As set out above, placements in all disciplines are established by agreements between individual universities and individual local organisations. While the

[896] Exhibit L.7, Statement of Richard Griffiths (8 October 2024) [37] [MOH.0011.0083.0001 at 0008].
[897] Transcript of the Commission, 30 July 2024, T4233.17-28 (Fielding).
[898] Exhibit H.5.12, Statement of Professor Peter Hockey (10 July 2024) [13], [16] [MOH.0011.0013.0001 at 0003, 0004].

Health Education and Training Institute administers a central computer-based system (ClinConnect) that facilitates the "booking" of students into placements,[899] there is no central coordination of where placements are established or how students are allocated to them, no doubt because of the local nature of the relevant arrangements.

689. This approach creates some obvious problems, including that:

a. either universities or local organisations end up competing with each other depending on whether demand for placements exceeds supply in the relevant local area or the reverse;[900]

b. the matching of students with placements is largely manual rather than allocated in the nature of, for example, the medical intern program;

c. because the matching of supply and demand occurs locally based on local relationships, there may be a supply of students at one university and a demand for students at a local organisation which are never matched with one another because there is no central coordination or visibility;

d. there is a duplication of administrative work because of the need for both universities and local organisations to make and administer multiple arrangements with one another, with variable terms;[901]

e. there is no central monitoring or direction as to the number of clinical placements that should be established or where they should be established in order to match demand for placements, or future service requirements;[902] and

f. perhaps most importantly, the public health system is depriving itself of the significant benefits that might obtain – from a workforce mix and distribution perspective – were a more coordinated approach taken to the

[899] Transcript of the Commission, 22 July 2024, T3792.7-15 (Solman).
[900] Exhibit H.5.10, Statement of Jacqui Cross (8 July 2024) [16] [MOH.0011.0007.0001 at 0003].
[901] Transcript of the Commission, 14 October 2024, T5608.3-11 (Griffiths).
[902] An important point given that it is uncontroversial that the prospect of encouraging clinicians to move to or stay in rural or regional locations improves with more time spent in those locations earlier in their careers: Transcript of the Commission, 25 July 2024, T4085.43-T4086.10 (Haq); Transcript of the Commission, 15 May 2024, T2856.9-20, T2856.42-2857.5 (Arnold); Transcript of the Commission, 22 July 2024, T3824.23-28 (Twigg); Transcript of the Commission, 15 October 2024, T5675.37-5679.14 (Morrison); Exhibit L.14, Statement of Dr Matthew Ingram (27 September 2024) [18] [SCI.0011.0461.0001 at 0003]; Exhibit L.20, Statement of Dr Tom Morrison (4 October 2024) [9]-[10] [SCI.0011.0478.0001 at 0002].

allocation of university placements and recruitment of those being placed into identified areas of need at the time of their likely graduation.

690. Those matters suggest there would be benefit in a more strategic, whole-of-system approach to allocating clinical placements that aligns (so far as possible) with projected future demand for clinicians in the relevant field. In the absence of that type of approach, local organisations can feel that they are "passive recipients of universities having students wanting to come to us, and we do our best to accommodate the students, rather than trying to identify what our future workforce needs might be, and then to try and pull students in".[903]

691. Any intervention in the current frameworks relating to clinical placements, must acknowledge that:

a. there are long-standing and well-developed relationships between certain universities and certain local organisations that both have value and would be challenging to untangle;[904]

b. the capacity for a particular local organisation to take students on clinical placements depends to a large extent on the availability of their employees to supervise those students,[905] which makes it important for the Ministry to undertake any more centralised role in collaboration with local organisations rather than overriding them.[906] This collaboration would, of course, include ensuring that both placements and the supervision of them are adequately funded. Achieving this within a devolved system may require those members of the workforce distributed throughout the system who are responsible for coordinating and delivering education to the funded through the Health Education Training Institute so as to insulate them from the constant pressure imposed upon Local Health Districts to harness efficiency in the core business of delivering care. The apparent focus by the Systems Sustainability and Performance Branch on rudimentary measures such as a divergence between a growth in activity

[903] Transcript of the Commission, 23 July 2024, T3896.17-22 (Hockey); Transcript of the Commission, 23 July 2024, T3936.35-41 (Dewhurst).
[904] Transcript of the Commission, 14 October 2024 T5622.35-46 (Baird); transcript of the Commission, 14 October 2024 T5623.3-12 (Dominish); Transcript of the Commission, 14 October 2024, T5651.7-5652.4 (Anderson).
[905] Transcript of the Commission, 14 October 2024, T5600.5-39 (Griffiths/Cross).
[906] Transcript of the Commission, 14 October 2024, T5614.14-T5615.2 (Griffiths).

and FTE growth as measures of inefficiency highlight the potential need for such an approach; and

c. there are real financial barriers to students participating in placements away from home, described as "placement poverty".[907] This issue is particularly acute in the present environment of high living costs; its impact on students should not be underestimated.

692. While acknowledging these complexities, several witnesses accepted there was room for the Ministry to do more in terms of ensuring there was appropriate capacity in the system to accept clinical placements and to manage those placements.[908] Indeed, the fact that the capacity to accept student placements goes hand in hand with the availability of clinicians within the system to supervise those students highlights the desirability of a more coordinated approach to student placements for the same good reasons why it is desirable to implement a more coordinated approach to workforce planning generally.

693. Again, it is not desirable to be overly prescriptive as to the form that role should take. However, it is apparent that it is a function that is best located within the Health Education Training Institute, and is one that should involve (at a minimum):

a. regular and systematic collaboration with local organisations and universities with a view to directing the establishment of clinical placements in a way that best meets the future workforce pipeline requirements of the system and, to the extent it can be accommodated within that objective, student demand. This function should be informed by input from the universities as to their student placement needs, data gathered and modelling generated within the Ministry as to system needs, and the availability of appropriate supervision structures. It should also be informed by a recognition that embedding placements in rural and regional locations for as long as practicable is most likely to facilitate the development of a future rural and regional workforce, but also that such

[907] Transcript of the Commission, 14 October 2024, T5610.29-38 (Griffiths); Transcript of the Commission, 14 October 2024, T5625.25-32 (Whaites); Transcript of the Commission, 14 October 2024, T5659.29-32 (Griffiths); Transcript of the Commission, 16 October 2024, T5796.21-30 (Yik/Penm).
[908] Noting that some discussions to that effect are already happening in the allied health space: Transcript of the Commission, 14 October 2024, T5606.20-27, T5608.3-34 (Griffiths); Transcript of the Commission, 14 October 2024, T5608.36-5609.32 (Cross); Transcript of the Commission, 23 July 2024, T3898.20-40 (Hockey).

placements will require investment to support students whose financial situations would otherwise prevent their participation. Every effort should be made to ensure that this is a genuine collaboration;

b. a more active role in allocating students to available placements. This could take the form of a preference matching approach similar to the one taken with medical interns but should at least have regard to future workforce needs; and

c. whatever approach is adopted, it must avoid a situation where students are forced into "placement poverty". To this end, the Ministry and Local Health Districts should facilitate employment opportunities for those who are participating in placements wherever possible; both to offset the risk of placement poverty and, as importantly, to maximise the prospect that those participating in the placement program will become embedded within the particular section of the health workforce where they will be most needed upon graduation. This may also require a high degree of collaboration by training organisations, which should be encouraged to structure the delivery of their respective courses in a manner which facilitates paid employment opportunities which align with placements so as to maximise the benefit obtained by both students and the wider health system.

694. To reap the benefits of such a structure, consideration should also be given to providing quarantined funding for clinical educator roles (perhaps sitting within the Institute) that provide an interface between universities, students and local organisations to ensure that local organisations are appropriately supported to deliver high-quality and effective student placements.[909]

10.6 Training networks

695. There are several benefits to the existing vocational training networks, including that:

a. They assist trainees by providing a complete pathway to meet all the requirements of their training program, rather than requiring the trainee to

[909] Transcript of the Commission, 14 October 2024 T5642.22-34, T5653.6-45 (Dominish); Transcript of the Commission, 14 October 2024 T5653.47-5654.22 (Anderson); Transcript of the Commission, 22 July 2024 T3748.37-3749.11 (Halse).

self-manage their training pathway, which may include having to apply for discrete positions to collate the necessary experience. This is important in overcoming potential bottlenecks in the progression through training programs.[910]

b. They provide trainees with exposure to different types of facilities, supervisors and working conditions. [911]

c. They are governed under an overarching structure of experts with oversight of the whole training pathway. This provides an opportunity for the network governing bodies to shape the locations where trainees gather the requisite experience by grouping them into rotations which the trainees are required to complete.[912]

d. They reduce the administrative burden on individual sites and local organisations, and support consistency, including by allowing for more centralised recruitment and the sharing of educational resources.[913]

e. They can assist in attracting trainees to rural and regional sites.[914]

696. However, they have their limitations.

697. The existing networks relate to a limited number of specialties. The main (and perhaps only) reason for this appears to be a lack of funding to expand them.[915] In this respect, Dr Josephine Burnand, Acting Medical Director, Health Education Training Institute, gave evidence that:[916]

> *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*

[910] Such bottlenecks have been experienced in anaesthesia, whilst the networked structure as enabled such bottlenecks in radiology training to be resolved: Transcript of the Commission, 24 July 2024, T3957.46-3958.3 (Page); Transcript of the Commission, 30 July 2024, T4255.41-4256.42 (MacPherson); Transcript of the Commission, 18 October 2024, T5957.46-5958.9 (Burnand); Exhibit L.2, Statement of Dr Justine Harris (2 October 2024) [81]-[85] [MOH.0011.0077.0001 at 0016].
[911] Transcript of the Commission, 25 July 2024, T4085.13-4087.29 (Haq/Kanhutu).
[912] Transcript of the Commission, 30 July 2024 T4254.12-41 (MacPherson).
[913] Transcript of the Commission, 24 July 2024 T3981.7-47 (Moyle); Transcript of the Commission, 25 July 2024, T4087.31-4088.7 (Kanhutu); Transcript of the Commission, 25 July 2024 T4149.39-45 (Findley).
[914] Transcript of the Commission, 25 July 202, T4087.31-4088.7 (Kanhutu).
[915] Exhibit H.5.19, Statement of Dr Linda MacPherson (12 July 2024) [165] [MOH.0011.0020.0001 at 0032]; Transcript of the Commission, 30 July 2024, T4256.44-4257.5 (MacPherson); Exhibit L.2, Statement of Dr Justine Harris (2 October 2024) [26] [MOH.0011.0077.0001 at 0006]; Transcript of the Commission, 18 October 2024, T5979.11-26 (Harris).
[916] Transcript of the Commission, 18 October 2024, T5957.46-5958.9 (Burnand).

> *meeting particular training requirements … some of those bottlenecks that occur in order to meet the college requirements for the training.*

698. The existing training networks have a "metro-centric" focus.[917] This is partly symptomatic of a broader metro-centric approach to accreditation and training, which has seen the bulk of training concentrated in metropolitan areas.[918] But it is also a discrete network problem. For example, the Central Coast Local Health District considers that it has minimal influence over the allocation of specialist trainees within networks because this allocation is centralised and conducted in a metro-centric way.[919] This is consistent with the perception by at least some college representatives that the Health Education and Training Institute (along with other parts of the wider system) is metropolitan-focused.[920]

699. The existing networks are also presently focused on education and training, rather than planning. In this respect, the Health Education and Training Institute and the Ministry currently play no established coordinating role in determining where training positions are required. This leads to a lack of "longitudinal and system coordination".[921] The immediate benefits in that co-ordination were described by Dr Justine Harris, Chief Medical Workforce Advisor, as follows:[922]

> *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.*

700. There are, of course, challenges in any expansion of the vocational training networks and its related functions to address these deficiencies. These include:

    a. The need to accommodate colleges' accreditation requirements. This will require the Ministry, Health Education and Training Institute and the colleges to work together to develop mutually acceptable solutions. There may be innovative ways of doing this. For example, ANZCA has a system of "satellite" facilities which are not accredited themselves but operate

[917] Exhibit H.5.21, Statement of Richard Griffiths (16 July 2024) [59] [MOH.0011.0022.0001 at 0019]; Transcript of the Commission, 30 July 2024, T4248.31-43 (MacPherson); Transcript of the Commission, 18 October 2024, T5974.36-5975.6 (Newton).
[918] Transcript of the Commission, 25 July 2024 T4103.41-46 (Kanhutu); Transcript of the Commission, 30 July 2024, T4224.23-33 (Fielding); Exhibit L.10, Statement of Dr Sanjay Hettige (31 July 2024) [8] [SCI.0011.0287.0001 at 0002].
[919] Exhibit H.5.31, Statement of Professor Steevie Chan (29 July 2024) [26] [MOH.0011.0031.0001 at 0007].
[920] Transcript of the Commission, 18 October 2024 T5989.7-24 (Fielding).
[921] Transcript of the Commission, 18 October 2024 T5984.29-5985.27 (Harris); Transcript of the Commission, 18 October 2024 T5987.18-19 (Kanhutu).
[922] Transcript of the Commission, 18 October 2024 T5980.21-25 (Harris).

under another facility's accreditation to deliver particular training requirements.[923] Several colleges are also increasing flexibility in supervision requirements by allowing for some volume of remote, virtual supervision.[924] Standardisation of some accreditation requirements with the colleges should also be explored.

b. The need to provide sufficient "protected time" for supervisors to enable them to deliver training effectively.[925] This is a general problem but may be particularly acute in rural or remote facilities.

c. The need to have appropriate structural supports in place for trainees required to live and work away from home for some or all of their training programs, including accommodation and social supports.[926]

d. The need for adequate funding for the development of new training networks, including for network director and educator roles, and for the enhanced coordinating role in terms of workforce planning. This will probably require some centralised, quarantined funding[927] otherwise there is a real risk that through notional "efficiency" measures, positions such as those will not be retained.

e. The need to keep in mind colleges' national / binational jurisdictions and trying to minimise "change fatigue" for colleges, which have gone through other recent reviews impacting on their operations.[928]

701. However, none of these challenges is an insuperable obstacle to expanding the Health Education and Training Institute's role in relation to training networks. At least some will be mitigated by ensuring that any expansion is done in a collaborative way with colleges and local organisations, and use continues to be made of colleges' specialist expertise including in network governance and planning (which should include appropriate data sharing).

[923] Transcript of the Commission, 24 July 2024 T3964.9-18 (Moyle).
[924] Transcript of the Commission, 30 July 2024 T4236.33-45 (Fielding).
[925] Transcript of the Commission, 18 October 2024 T5977.9-15 (Haq).
[926] Transcript of the Commission, 18 October 2024 T5996.25-42 (Kanhutu); Transcript of the Commission, 18 October 2024 T6003.4-8 (Page).
[927] Transcript of the Commission, 18 October 2024 T5993.9-18 (Harris).
[928] Transcript of the Commission, 18 October 2024 T6005.5-19 (Haq); Transcript of the Commission, 18 October 2024, T6010.9-27 (Newton/Kanhutu).

702. On the other hand, there are likely to be real benefits in this expansion. The training system plays a central role in shaping the medical workforce. There are good reasons to think that intervention in training pathways – including by expanding rural and regional training opportunities, relieving bottlenecks and seeking to structure the delivery of training to reflect future service and workforce needs – will help to produce a more evenly distributed medical workforce in the future. A medical workforce that is more appropriately distributed in terms of specialties and locations will better meet the needs of the population and will support long-term system sustainability.

10.7 Engaging the workforce

703. The general framework in which the health workforce is engaged is set out above. In the paragraphs below, certain aspects of those arrangements as they relate to employees and visiting medical officers, and potential enhancements to them, are explored in more detail.

10.7.1 Employees

704. In practice, there are three main sources of terms and conditions of employment for NSW Health Service employees:

a. Awards made under the *Industrial Relations Act*.[929] Such an award under is an industrial instrument that provides conditions of employment for employees to whom it relates (generally determined by classifications specified in the award). It has statutory force in that it is enforceable against employers bound by the award by employees and industrial organisations concerned in the relevant industry.[930]

b. Determinations made by the Secretary or a delegate. These may relate to cohorts of employees or to individual employees.[931] A prominent example is the *Staff Specialists Determination 2015*,[932] which sets out entitlements of staff specialists relating to matters including rights of private practice, training, education and study leave and abnormal working hours, which are not dealt with in the *Staff Specialists (State) Award*. Unlike awards,

[929] *Industrial Relations Act 1996* (NSW) s 10.
[930] *Industrial Relations Act 1996* (NSW) Ch 7, Pts 1 and 2.
[931] Exhibit H.5.23, Statement of Melissa Collins (17 July 2024), [37]-[40] [MOH.0011.0024.0001 at 0006].
[932] Exhibit H.4.17 Staff Specialists Determination 2015 [MOH.9999.0081.0001].

determinations do not have statutory force, although they may be enforceable if they are incorporated into employees' employment contracts. Not all employees have conditions of employment set by determinations; many are only subject to awards.

c. Contracts of employment. These usually do not go beyond the terms of applicable awards or determinations, consistent with the fact that they are usually prepared and agreed at the local organisation level and local organisations do not have a delegation to depart from terms and conditions of employment set by the relevant awards and determinations. However, they may impose some additional obligations on employees, for example to comply with Ministry Policy Directives such as the code of conduct.

705. In the NSW Health Service context, the framework is extensive and complex. There are currently 43 awards that apply, comprising over 300 unique classifications, and involving 11 industrial organisations[933] Over 500 determinations have been approved since 2005,[934] with at least 25 relating to general cohorts of employees (as opposed to individuals or small, discrete groups).[935] There are also 60 workplace relations policies.[936]

706. Awards in New South Wales generally have limited "nominal terms" of between 12 months and three years, although they continue in force until rescinded by the Industrial Relations Commission.[937] In practice, most awards are replaced at the end of their nominal term by consent. Often these contain minimal substantive changes, if any, with the main change being to update rates of remuneration. These awards generally contain "no extra claims" clauses, which prevent parties from making claims for additional or reduced conditions of employment during the nominal term.

707. The Industrial Relations Commission is required to review each award at least once every three years, with the purpose of the review being "to modernise

[933] Exhibit H.5.22, Statement of Philip Minns (17 July 2024) [50] [MOH.0011.0024.0001 at 0018]; Exhibit H.4.30, NSW Health, *Schedule of awards and determinations applicable to NSW Health employees* [MOH.0010.0300.0001]. Thirty six of the awards are under the auspices of the Health Services Union alone: Transcript of the Commission, 17 October 2024, T5898.1-8 (Collins).
[934] Exhibit H.5.23, Statement of Melissa Collins (17 July 2024) [40] [MOH.0011.0024.0001 at 0006].
[935] Exhibit H.4.30, NSW Health, Schedule of awards and determinations applicable to NSW Health employees [MOH.0010.0300.0001].
[936] Exhibit H.5.22, Statement of Philip Minns (17 July 2024) [50] [MOH.0011.0024.0001 at 0018].
[937] *Industrial Relations Act 1996* (NSW) s 16.

awards, to consolidate awards relating to the same industry and to rescind obsolete awards".[938] However, at least in recent years, it has not engaged in a substantive review of awards on a regular or systematic basis.[939] For example, while it appears that at least some awards were reviewed in 2021 and 2022, [940] these reviews appear to have focused on particular issues raised by parties rather than conducting a wholesale review for the purposes of determining whether modernisation or consolidation should occur. This may be because of a 1998 decision of a Full Bench of the Industrial Relations Commission[941] which took a narrow view of the s 19 review process, including that it:

a. was not to be used for the purpose of ensuring that in substance an award met the needs of employers and employees in the circumstances of the relevant industry or enterprise;[942]

b. was not a mechanism for employers or employees to overcome the effects of a previous decision of the Commission or an earlier bargain;[943]

c. did not, at least generally, allow the Commission to insert new conditions into an award, even ones the Commission might think should be contained in a "modern" award of that kind;[944] and

d. was to be driven by the parties in the same way as other litigation, such that, for example, the review was to be determined based on material put before it by the parties and not by the Commission "embark[ing] upon a wide ranging investigation into the operation of a particular award or industry".[945]

708. Consequently, most of the awards applying to employees in the NSW Health Service have not been reviewed substantively for many years. Many terms of those awards date back decades. Even awards that have seen recent

[938] *Industrial Relations Act 1996* (NSW) s 19.
[939] Exhibit L.5, Statement of Melissa Collins (4 October 2024) [32] [MOH.0011.0081.0001 at 0008].
[940] Miscellaneous Workers Home Care Industry (State) Award [2022] NSWIRComm 1024; Re Motels, Accommodation and Resorts, &c. (State) Award [2021] NSWIRComm 1056; Shop Employees (State) Award [2022] NSWIRComm 1012; Crown Employees (Department of Industry) Land Information Officers Award [2021] NSWIRComm 1096; Sydney Cricket and Sports Ground Trust (Maintenance Staff) Enterprise Award 2018 [2021] NSWIRComm 1075; Marine Charter Vessels (State) Award [2022] NSWIRComm 1009; Crown Employees (Botanic Gardens and Centennial Parklands Building and Mechanical Services Employees) Award 2016 [2021] NSWIRComm 1083; Health Employees' Conditions of Employment (State) Award 2018 (Infectious Cleaning Allowance) [2021] NSWIRComm 1049.
[941] Principles for Review of Awards – State Decision 1998 [1998] NSWIRComm 661; (1998) 85 IR 38.
[942] (1998) 85 IR 38 at 44.
[943] (1998) 85 IR 38 at 45.
[944] (1998) 85 IR 38 at 45-46.
[945] (1998) 85 IR 38 at 56.

substantive updates, such as the *NSW Ambulance Paramedics (State) Award*, have been updated in a piecemeal way which has not avoided uncertainty and disputation about their meaning.[946]

709. Similarly, it has been many years since the Industrial Relations Commission gave detailed consideration to the nature of the work performed by most health professionals and its value for the purposes of assessing whether their remuneration and conditions were appropriate. These assessments typically occur in "work value" cases, which are claims (generally made by industrial organisations) for increased wages and conditions because of an increase in the value of the work performed by the relevant employees. For example, the last "work value" assessment in relation to staff specialists was in 2006.[947] Similarly, the last work value assessment in relation to most allied health professionals occurred between 2001 and 2007.[948]

10.7.2 Visiting Medical Officers

710. The terms and conditions relating to the engagement of visiting medical officers are largely set by the "VMO Determinations", that were produced by arbitrations conducted under the *Health Services Act*. They resemble awards but have contractual force, albeit that they override any inconsistent contractual provisions.[949] The Ministry has also published "model contracts" containing some terms and conditions that are additional to those set out in the VMO Determinations. There is a Policy Directive that specifies when each type of contract (sessional or fee-for-service) should be used.[950]

711. As noted above, the extant VMO Determinations have not been updated since 2014, although rates of pay have been increased from time to time.

[946] See, for example, Australian Paramedics Association (NSW) v Health Secretary in respect of New South Wales Ambulance (Virtual Clinical Care Centre Clinicians) [2024] NSWIRComm 1066.
[947] *Re Staff Specialists (State) Award* [2006] NSWIRComm 124; (2006) 152 IR 405.
[948] Re Health and Community Employees Psychologists (State) Award [2001] NSWIRComm 302; (2001) 109 IR 458; Re Health Employees Pharmacists (State) Award [2003] NSWIRComm 453; (2003) 132 IR 244; Health Employees Medical Radiation Scientists (State) Award [2006] NSWIRComm 34; NSW Health Service Health Professionals (State) Award [2007] NSWIRComm 300; (2007) 171 IR 8.
[949] *Health Services Act 1997* (NSW) s 98.
[950] Exhibit H.3.21, NSW Health, *Visiting Practitioner Appointments in the NSW Public Health System* (PD2016_052) [15.3] [MOH.0011.0004.0001 at 0027ff].

10.7.3 Views about the need for reform

712. Most stakeholders agreed there is a need for award reform and reform of the VMO Determinations. There was general consensus (except in relation to the *Public Health System Nurses' and Midwives' (State) Award)* that NSW Health awards and the VMO Determinations were outdated and no longer fit for purpose.[951] However, the reasons for this view varied. For example:

a. Philip Minns, Deputy Secretary, People, Culture and Governance, said that many awards "are outdated, ambiguous, and do not reflect current service delivery models".[952] Mr Minns gave the examples of allowances such as the infectious cleaning and nauseous linen allowances in the *Health Employees' Conditions of Employment (State) Award*, which have given rise to frequent disputes because of uncertainty about their scope.[953]

b. Melissa Collins, Acting Executive Director, Workplace Relations, considered that awards were "outdated, ambiguous, overly prescriptive and can place limits on the ability to engage and retain an agile and contemporary workforce".[954] Ms Collins gave the example of the *Public Hospital Medical Officers (State) Award*, which applies to junior medical officers, as being premised on Monday to Friday daywork in metropolitan facilities, which does not reflect the present reality of their work which is increasingly 24/7, and involves rotations to rural and regional facilities.[955]

c. Similarly, Ms Collins agreed that because it does not allow expressly for shift work or work outside of 7am to 6pm Monday to Friday (except for emergency physicians and certain "averaging" arrangements), the *Staff Specialists Award* does not accommodate the realities of 24/7 service delivery in many specialties.[956] This is a problem exacerbated by the fact that the *Staff Specialists Award* is a "salaried award", which provides a

[951] Transcript of the Commission, 17 October 2024 T5868.39-5871.3 (Hayes/Egan/Holland/Collins).
[952] Exhibit H.5.22, Statement of Philip Minns (17 July 2024) [51] [MOH.0011.0024.0001 at 0018].
[953] Exhibit H.5.22, Statement of Philip Minns (17 July 2024) [52] [MOH.0011.0024.0001 at 0018]; see also Exhibit H.5.23, Statement of Melissa Collins (17 July 2024) [58]-[59] [MOH.0011.0024.0001 at 0009-0010].
[954] Exhibit H.5.23, Statement of Melissa Collins (17 July 2024) [54] [MOH.0011.0024.0001 at p 0009]; see also Exhibit L.5, Statement of Melissa Collins (4 October 2024) [4], [29a] [MOH.0011.0081.0001 at pp 0001, 0006-0007].
[955] Exhibit H.5.23, Statement of Melissa Collins (17 July 2024) [55] [MOH.0011.0024.0001 at 0009].
[956] Transcript of the Commission, 5 August 2024 T4634.13-5635.11 (Collins); Transcript of the Commission, 17 October 2024, T5911.6-17 (Collins).

fixed annual salary for all staff specialists without separate or variable payments for on-call and recall or overtime.

d. Dr Nicholas Spooner, President of ASMOF and Director of Emergency Medicine at Wyong Hospital, described the *Staff Specialists Award* as being "out of date in regard to remuneration and other conditions", including by paying staff specialists less than other jurisdictions, not remunerating staff specialists separately (or adequately) for on-call work or overtime, not including training, education and study leave arrangements in the award (only in a determination), and not dealing with minimum "safe staffing" levels.[957]

e. Another issue raised mainly by college witnesses is the need for protected supervision and, for psychiatrists, clinical support time.[958]

f. Dominique Egan, Director of Workplace Relations and Legal Counsel at the Australian Medical Association, described the VMO Determinations as outdated; principally because they (in conjunction with the Ministry's informal determinations) do not provide competitive remuneration with other jurisdictions or the private sector, and they do not adequately compensate for on-call arrangements, after-hours or weekend work, or remote or virtual service provision.[959]

g. Gerard Hayes, Secretary of the Health Services Union, saw the awards covering the Health Services Union's members as being "out of date and uncompetitive with the industrial instruments in other Australian states", in need of consolidation, and not reflecting "modern, flexible ways of working".[960] Examples of outdated features of the awards from Mr Hayes' perspective included obsolete allowances (such as an "incinerator allowance") and the absence from awards of some qualifications and roles that now form part of the workforce.[961]

[957] Exhibit H.7.6, Statement of Dr Nicholas Spooner (17 July 2024) [28]-[41] [SCI.0011.0249.0001 at 0006-0008]; see also Transcript of the Commission, 23 July 2024 T3853.23-30 (Spooner); Transcript of the Commission, 17 October 2024 T5874.41-46 (Holland); Transcript of the Commission, 24 July 2024 T4012.31-4013.17 (Moyle); Transcript of the Commission, 24 July 2024 T4051.4-47 (Virgona).
[958] Transcript of the Commission, 18 October 2024, T5977.9-15 (Haq); Transcript of the Commission, 24 July 2024, T4051.9-19 (Virgona).
[959] Exhibit H.7.5, Statement of Dominique Egan (25 July 2024) [50]-[72] [SCI.0011.0283.0001 at 0010-0014].
[960] Exhibit L.15, Statement of Gerard Hayes (30 September 2024) [14]-[22] [SCI.0011.0464.0001 at 0003-0005].
[961] Transcript of the Commission, 17 October 2024, T5871.38-44, 5872.21-38 (Hayes). Ms Collins agreed that consolidation of the HSU awards is desirable: Transcript of the Commission, 17 October 2024 T5872.40-5873.7 (Collins).

h. Several examples of outdated features of awards relating to allied health practitioners were also highlighted in the evidence. For example, Jill Harris, Director of Radiation Therapy at Westmead and Blacktown Hospitals, pointed to the fact that the award applying to radiation therapists (the *Health Employees' Medical Radiation Scientists (State) Award*) has not been updated to recognise the fact that the tertiary qualification for radiation therapists has changed from a three-year to a four-year program.[962] Similarly, Associate Professor Lil Vrklevski observed that the *Health and Community Employees Psychologists (State) Award* has not been updated to take account of changes in the education and registration requirements for psychologists (including an increase in the standard minimum length of a university degree from four years to five years).[963] There is also a general sense that allied health awards typically lack appropriate career progression options.[964]

713. These issues with award arrangements have manifested in various ways. One is industrial disputation about the meaning of award provisions; some examples are set out above. Others include:

a. Industrial action, which has occurred in a public way throughout the course of the Special Commission across a number of health professions, with a dominant focus on wages.

b. The use of unilateral determinations by the Ministry to fill gaps in the conditions provided for by awards.[965]

c. The spread of "unauthorised non-standard arrangements", a euphemistic description of payments made, or conditions afforded to employees in excess of those provided for under the award or determinations and not approved by anyone holding a valid delegation to do so.[966]

[962] Exhibit H.7.1, Statement of Jill Harris (12 July 2024) [9]-[13] [SCI.0011.0155.0001 at 0002-0003].
[963] Exhibit H.7.5, Statement of Associate Professor Lil Vrklevski (16 July 2024) [8]-[9] [SCI.0011.0198.0001 at 0002].
[964] See, for example, Exhibit H.7.1, Statement of Jill Harris (12 July 2024) [22] [SCI.0011.0155.0001 at 0005]; Exhibit H.7.5, Statement of Associate Professor Lil Vrklevski (16 July 2024) [10]-[11] [SCI.0011.0198.0001 at 0002]; Exhibit L.13, Statement of Jerry Yik and Dr Jonathan Penm (26 September 2024) 15 [SCI.0011.0459.0001 at 0015].
[965] Exhibit H.7.1, Statement of Jill Harris (12 July 2024) [9]-[13] [SCI.0011.0155.0001 at 0002-0003].
[966] Exhibit H.5.22, Statement of Philip Minns (17 July 2024) [54] [MOH.0011.0024.0001 at 0019]; Exhibit H.5.23.2, Supplementary Statement of Melissa Collins (3 August 2024) [MOH.0011.0038.0001]; see also, for example, Exhibit H.5.18, Statement of Dr Karen Murphy (12 July 2024) [25] [MOH.0011.0019.0001 at 0007].

d. Difficulties experienced by "border" Local Health Districts, such as Northern NSW Local Health District and Southern NSW Local Health District in attracting and retaining staff because of a pay disparity with other jurisdictions.[967]

714. A consequence of the variety of views about the deficiencies in the current award framework is that different stakeholders have different perceptions of what "award reform" means or looks like. For example, the Ministry tends to view award reform predominantly as a process of simplification, consolidation and increasing flexibility for the employer to accommodate what it sees as its service delivery needs.[968] On the other hand, industrial organisations tend to view award reform predominantly as involving increased remuneration and improved conditions to appropriately compensate for what their members see as the pressure points in their daily work.[969] Some of these perspectives will overlap: for example, the changes required to accommodate the employer's changing service delivery needs can be expected to reflect the realities of what employees are actually required to work. But it is in the nature of any industrial environment that interests will diverge at some point. Any award reform process will need to navigate this industrial reality.

715. There were also different views as to what form an "award reform" process might take. Some industrial organisations advocated for, in effect, starting again with a blank sheet of paper,[970] whilst the NSW Nurses and Midwives Association was not in favour of wholesale reform of the *Nurses and Midwives Award*.[971] The Australian Medical Association and the Ministry appear to favour a "middle ground" in which parts of the existing instruments are maintained.[972]

716. All parties wished to preserve the role of bargaining in seeking to achieve award reforms but could also see at least a prospective role for the Industrial Relations

[967] Transcript of the Commission, 19 September 2024 T5416.25-5417.38 (McCosker); Transcript of the Commission, 15 August 2024 T4985.8-23, 4986.23-31 (Ayers).
[968] Exhibit L.5, Statement of Melissa Collins (4 October 2024) [60]-[61] [MOH.0011.0081.0001 at 0014].
[969] Exhibit L.5, Statement of Melissa Collins (4 October 2024) [62]-[63] [MOH.0011.0081.0001 at 0014].
[970] Exhibit L.12, Statement of Dr Nicholas Spooner (20 September 2024) [30] [SCI.0011.0448.0001 at 0006]; Exhibit L.15, Statement of Gerard Hayes AM (30 September 2024) [19] [SCI.0011.0464.0001 at 0005].
[971] Transcript of the Commission, 17 October 2024, T5910.4-17 (Candish).
[972] Transcript of the Commission, 17 October 2024, T5910.23-28 (Egan); Transcript of the Commission, 17 October 2024 T5910.38-5911.32 (Collins).

Commission in the process.[973] Several stakeholders, agreed that a legislated "sunset date" for any award reform process would be appropriate.[974]

717. The weight of the evidence supports a conclusion that there is an urgent need for a broad project of award reform in respect of NSW Health awards.

718. Many awards, on their face, are overly long, not drafted in plain English, frequently ambiguous, and replete with inconsistencies and incoherences (both internally and with other awards dealing with similar professions).[975] The number of awards dealing with allied health professions lacks any rational explanation except for history. In this respect, in a recent decision approving (by consent) increased remuneration in a number of Health Services Union awards, Justice Taylor, President of the Industrial Relations Commission, made the following pertinent observation:[976]

> *Finally, I commend the parties for their commitment to reforming these awards and to reducing the number of professional awards. There is real scope to simplify awards in this sector and to standardise conditions for similar workers, to the mutual advantage of the parties. … The Commission stands ready to assist the parties in that endeavour.*

719. There is also a lack of an obvious rationale for having several determinations which set terms and conditions of employment for the same cohorts covered by awards but outside of the award structure. Whilst that approach may have been taken to provide for those terms and conditions without then attaining statutory force through inclusion in awards, some (like training, education and study lave rights in the *Staff Specialists Determination*) have become sufficiently engrained that they are regarded as minimum conditions for staff specialists and thus they should be considered for inclusion in the *Staff Specialists Award* on this basis. These issues, though formal in nature, are important because awards should be capable of being readily understood and applied by

[973] Transcript of the Commission, 17 October 2024, T5902.4-41 (Hayes and Minns); Transcript of the Commission, 17 October 2024, T5910.9-17 (Candish); Transcript of the Commission, 17 October 2024, T5910.32-34 (Holland).
[974] Transcript of the Commission, 22 July 2024, T3755.31-38 (Halse); Transcript of the Commission, 5 August 2024, T4605.23-29 (Egan); Transcript of the Commission, 7 August 2024, T4802.7-27 (Collins).
[975] As a further example of a lack of coherence and consistency between awards, see Health Services Union NSW v Secretary, NSW Ministry of Health in respect of NSW Health Pathology and Sydney Children's Hospitals Network (Technical Officers and Hospital Scientists Dispute) [2024] NSWIRComm 1057.
[976] Re Health and Community Employees Psychologists (State) Award 2024 and other Health Awards [2024] NSWIRComm 15 at [7].

employees, union representatives and local organisations without substantial industrial knowledge and experience.

720. In addition to these issues of form, as set out above, there are important issues of substance with many awards, including their ability to reflect current work practices and changes in qualifications and registration requirements among allied health professions. They also include a lack of appropriate opportunities for career progression in some cohorts.

721. These issues can only sensibly be addressed by a wholesale review of the relevant awards, in form and in substance. While the NSW Nurses and Midwives Association resists the proposition that the *Nurses and Midwives Award* requires wholesale reform, that it may be an example of an award that is more current than others, is not a reason to exclude it from a wider review and reform project. This includes because its drafting follows a similar form and structure to other NSW Health awards, which warrants at least consideration as to whether it should be modernised; and because there is a need to ensure appropriate relativities between NSW Health awards, so that any changes to other awards may impact on the appropriate pay and conditions under the *Nurses and Midwives Award*.

722. A significant issue raised in the evidence, and by clinicians around the State as the Special Commission visited each of the Local Health Districts, was the adequacy of remuneration for health professionals in New South Wales. Comparisons were regularly made between the remuneration offered in New South Wales, and that offered in other jurisdictions.

723. There are some complexities in drawing direct comparisons between remuneration offered in New South Wales with that offered in other jurisdictions, due to the way allowances and other benefits are accounted for. However, when comparison of base rates is made, it is evident that salary range for staff specialists is the lowest of all Australian states and territories. Even accounting for the difficulties in making "like for like" comparisons with other jurisdictions, the rates of staff specialist remuneration are uncompetitive with other jurisdictions.[977]

[977] Transcript of the Commission, 7 August 2024, T4648.3-10 (Collins).

724. When base rates of pay are considered: the salary range for Junior Medical Officers starts the lowest but increases to around the middle of the range; similarly, the salary range for nurses and midwives starts the second lowest but increases to around the middle of the range; and allied health professionals at all levels are paid around the middle of the range for all states and territories.[978]

725. However, caution should be exercised in the consideration of issues of pay disparity between New South Wales and other jurisdictions. While there is immediate attraction to the objective of interjurisdictional pay parity, it must be recognised that any differences that have arisen have been influenced by differences in government policy and prevailing circumstances across the country. They, of course, include the long-standing wages "cap" that was in place in New South Wales. But they also include policy decisions taken by other governments over that same period.

726. However, whether parity is ultimately achieved or not, there can be no serious dispute that the pay and conditions of health professionals in New South Wales should be appropriate to the work performed. In seeking to identify what appropriate pay and conditions are in any circumstance, the following key considerations arise:

    a. First, that health professionals in New South Wales should be fairly and reasonably compensated for the value of their work to the system. This will require an assessment the nature of their work, the skill and responsibility involved and the contribution it makes to the system, including any changes in those qualities since the last "work value" assessment. The contribution a profession makes to the system should be viewed broadly, not as limited to questions of productivity, efficiency or savings. It should also be recognised that the value of contributions to the system may differ, and therefore that differences in pay and conditions may be justified. This concept is not adequately embodied in any of the current NSW Health awards and – at least in the eyes of the health workforce - was fundamentally undermined by the arbitrary cap imposed on public sector wage increases.

[978] Exhibit H.5.21, Statement of Richard Griffiths (16 July 2024) [30] [MOH.0011.0022.0001 at 0010]; Exhibit H.5.24, Rian Thompson, *Workforce Data Report* pp 32-35 [MOH.0010.0377.0001 at 0032-0035].

b. Second, the impact that any current or changed pay and conditions may on attraction and retention. These matters should be the subject of detailed quantitative and qualitative analysis. To the extent there is no demonstrable system-wide impact, but a demonstrable impact in certain areas or for certain pockets of employees, then again, consideration should be given to differential remuneration structures or conditions for those employees.

c. Third, the fiscal or economic impact of increasing pay and conditions. Again, any asserted impacts of this kind should be demonstrated by evidence, including economic modelling where appropriate, not by mere assertion.

10.8 Mechanisms for reform

727. There are ongoing attempts by relevant industrial parties to negotiate towards award reform, but none have so far produced that result. For example:

a. The Special Commission heard evidence that the Health Services Union and the Ministry have been holding discussions about award reform since around the beginning of 2024, with the aim being to consolidate the 36 HSU awards into a small number of "streams".[979] However, it is anticipated that that rates of pay will likely become a sticking point in these negotiations.[980]

b. The Australian Salaried Medical Officers Federation and the Ministry have been engaged "mutual gains bargaining", which commenced on 15 December 2023.[981] But this followed the Ministry filing a proposed award variation containing what appear to be relatively narrow (albeit significant) "reforms" around 18 months ago. The bargaining process still appears to be in its relatively early stages, and again it appears unlikely that issues concerning rates of pay will be the subject of agreement.[982]

[979] Transcript of the Commission, 7 August 2024, T4801.31-37 (Collins).
[980] Transcript of the Commission, 7 August 2024, T4801.39-4802.5 (Collins); Transcript of the Commission, 17 October 2024, T5902.43-5903.10 (Hayes), T5903.18-42 (Minns).
[981] Industrial Relations Act 1996 (NSW) Ch 2A.
[982] Exhibit H.5.23, Statement of Melissa Collins (17 July 2024) [89]-[98] [MOH.0011.0025.0001 at 0015-0016); Transcript of the Commission, 17 October 2024, T5892.43-5893.5 (Minns), T5911.6-17 (Collins).

c. The NSW Nurses and Midwives Association are also bargaining.[983] Leaving aside remuneration, despite the NSW Government's commitment to implement "safe staffing" levels and the commencement of that initiative in some facilities, the Ministry and the NSW Nurses and Midwives Association have not been able to agree upon how that should be translated into the *Nurses and Midwives Award*,[984] and there has been disputation about the existing clause dealing with staffing levels.[985]

d. The Australian Medical Association is preparing to commence an arbitration in relation to the VMO Determinations,[986] which suggests that any negotiations with the Ministry to date have not been successful. However, the pathway to a negotiated outcome for the Australian Medical Association is more difficult than for other industrial parties because the VMO Determinations are not currently under the auspices of the Industrial Relations Commission, although there was consensus that they should be.

728. It might be thought that the difficulty in achieving substantial award reform through negotiation is a natural product of the diverse and commonly divergent interests of industrial parties and their differing perceptions of what "award reform" looks like.

729. Another difficulty is that, despite the removal of the "wages cap", the Ministry remains bound by a New South Wales Government wages policy.[987] The current wages policy has the practical effect of capping the amount of any annual increase in total employee remuneration that may be offered by New South Wales Government agencies without identifying savings or efficiency improvements.[988] This means that any increases in employee remuneration above the caps in the wages policy, or above what can be justified by savings or efficiency improvements, cannot be agreed to by the Ministry[989] and must instead be arbitrated in the Industrial Relations Commission. Conversely, the

[983] Transcript of the Commission, T5892.43-5893.5 (Minns).
[984] Transcript of the Commission, 17 October 2024, T5878.18-5879.9 (Candish).
[985] See, for example, New South Wales Nurses and Midwives' Association v State of NSW [2024] NSWSC 636.
[986] Transcript of the Commission, 5 August 2024 T4604.9-16 (Egan).
[987] Exhibit H.3.58, *NSW Government Fair Pay and Bargaining Policy 2023* [MOH.0010.0143.0001]; Exhibit H.5.23, Statement of Melissa Collins (17 July 2024) [42]-[43] [MOH.0011.0025.0001 at 0007].
[988] Exhibit H.3.58, *NSW Government Fair Pay and Bargaining Policy 2023* at cl 3 [MOH.0010.0143.0001 at 0004].
[989] Unless the Expenditure Review Committee of Cabinet were to give approval.

industrial organisations are, understandably, not prepared to agree to substantial changes to the structure or flexibility of work allowed for by awards without what they perceive as a *quid pro quo* in the form of monetary compensation.

730. Thus, it can be seen that there are barriers to the bargaining process, by itself, achieving the necessary extent of award reform. That is not to diminish the importance of the parties' contributions to that outcome, which will be essential. But it does mean there is a need to situate bargaining within a broader process of award reform.

731. There have been models for such a process in other jurisdictions. A notable example is the award modernisation process that occurred in the federal jurisdiction in 2008 and 2009. This was a legislated process under Part 10A of the *Workplace Relations Act 1996* (Cth). In broad summary, it involved the Australian Industrial Relations Commission making a single, coherent set of "modern awards" to replace a large number of pre-reform awards and other instruments. The process had the following key features:

a. Section 576A(2) of the *Workplace Relations Act* specified certain objects that were to be met by the modernised awards, which it is worth setting out in full:

> *(2) Modern awards:*
>
> *(a) must be simple to understand and easy to apply, and must reduce the regulatory burden on business; and*
>
> *(b) together with any legislated employment standards, must provide a fair minimum safety net of enforceable terms and conditions of employment for employees; and*
>
> *(c) must be economically sustainable, and promote flexible modern work practices and the efficient and productive performance of work; and*
>
> *(d) must be in a form that is appropriate for a fair and productive workplace relations system that promotes collective enterprise bargaining but does not provide for statutory individual employment agreements; and*

> *(e) must result in a certain, stable and sustainable modern award system for Australia.*

732. Section 576B(2) of the *Workplace Relations Act* also set out certain matters that the Commission was required to have regard to in performing its award modernisation function, including:

> *(a) promoting the creation of jobs, high levels of productivity, low inflation, high levels of employment and labour force participation, national and international competitiveness, the development of skills and a fair labour market;*
>
> *(b) protecting the position in the labour market of young people, employees with a disability and employees to whom training arrangements apply;*
>
> *(c) the needs of the low-paid;*
>
> *(d) the desirability of reducing the number of awards operating in the workplace relations system;*
>
> *(e) the need to help prevent and eliminate discrimination on the grounds of race, colour, sex, sexual preference, age, physical or mental disability, marital status, family responsibilities, pregnancy, religion, political opinion, national extraction or social origin, and to promote the principle of equal remuneration for work of equal value;*
>
> *(f) the need to assist employees to balance their work and family responsibilities effectively, and to improve retention and participation of employees in the workforce;*
>
> *(g) the safety, health and welfare of employees;*
>
> *(h) relevant rates of pay in [predecessor instruments];*
>
> *(i) minimum wage decisions of the [relevant decision-maker];*
>
> *(j) the representation rights … of organisations and transitionally registered associations.*

733. The modernisation process was triggered by an "award modernisation request" made by the Minister for Employment and Workplace Relations, which set out details of the process to be followed and its timeframe (subject to an overall legislated time limit of two years).[990]

[990] See, for example, The Hon. Julia Gillard MP, Request under section 576C(1) – Award Modernisation – Consolidated Version (9 November 2009).

734. The process followed by the Australian Industrial Relations Commission in practice was, broadly, to:

a. establish a timetable for dealing with each relevant industry or occupation, including a list of priority industries and occupations that were dealt with first, in consultation with relevant peak organisations and industrial parties;

b. address a number of general issues, including the drafting of standard clauses, which would apply across all modern awards, again in consultation and having regard to submissions from relevant peak organisations and industrial parties;[991]

c. for each relevant industry or occupation:

   i. invite initial submissions and proposed draft modern awards from the relevant industrial parties;

   ii. publish an "exposure draft" modern award, developed by the Commission based on the parties' drafts and submissions, for comment; and

d. finalise the modern award based on the parties' submissions about the exposure drafts.

735. One key distinction between the federal award modernisation process and the needs of a reform project that have emerged in the evidence, is that it was an object of the federal process to neither disadvantage employees nor increase costs for employers.[992] In other words, it was a "pure" process of consolidation and modernisation, without incorporating a substantive review of whether the resulting terms and conditions were fair and reasonable.

736. An award modernisation process similar to the federal process occurred in Queensland between 2014 and 2016, dealing with all Queensland public sector awards.[993] The Queensland process was conducted under the auspices of the Queensland Industrial Relations Commission. Unlike the federal process, it permitted a consideration of the substantive fairness and reasonableness of the

[991] [2008] AIRCFB 1000.
[992] The Hon. Julia Gillard MP, Request under section 576C(1) – Award Modernisation – Consolidated Version (9 November 2009) cl 2.
[993] *Industrial Relations Act 1999* (Qld), Part 8; The Hon. Grace Grace MP, Request under section 140CA(1) – Award Modernisation – Consolidated Request arising from Variation Notice (6 June 2016).

terms and conditions in the relevant awards. However, it experienced significant delays, which later gave rise to some difficulties.[994]

737. The obvious forum for a similar process in New South Wales is the Industrial Relations Commission. It is a specialist court and tribunal, comprising judges and commissioners with substantial industrial knowledge, skill and experience. It already has a wide jurisdiction with respect to NSW Health awards and NSW Health Service employees, with legislative consideration being given to extending that jurisdiction to visiting medical officers (which, as noted above, should occur).

738. It also has an existing award modernisation function under s 19 of the *Industrial Relations Act*. However, as observed above, the narrow interpretation given to that function means any award reform process to be conducted under the auspices of the Industrial Relations Commission will require legislative amendment. The Industrial Relations Commission would also need to be adequately resourced to undertake that task; although the Special Commission has received no evidence which suggests that its existing resources are insufficient for the task.

10.9 Workforce management

739. Many topics fall under the general banner of workforce management, and NSW Health has a wide range of policy directives, guidelines and similar documents directed to those matters.

740. Three particular issues that assumed some prominence in the evidence are explored below, without seeking to be comprehensive about wide range of workforce management issues that have been raised, or to diminish the various issues raised by clinicians about their working environment and conditions.

10.9.1 Consultation between management and the clinical workforce

741. The main context in which this issue was explored in the evidence was that of Medical Staff Councils.

742. Relevantly, there is a marked contrast between the level of detail contained in the Model By-laws as to the objective and functions of Clinical Councils

[994] See, for example, Queensland Services, Industrial Union of Employees v Moreton Bay Regional Council [2022] ICQ 23.

compared with Medical Staff Councils. Other than the general specification of objectives for all of the council structures, there is no specification of the objectives or functions for Medical Staff Councils at all. Something about the scope of their functions may be inferred from the provision that Medical Staff Executive Councils (or the Medical Staff Council if there is only one) are to provide advice to the Chief Executive and Board on medical matters. But it is not clear whether this is intended to reflect the limit of Medical Staff Councils' advisory functions (or, indeed, the Medical Staff Executive Council's). The concept of "medical matters" is, in any event, a phrase so broad to be effectively meaningless given that it is capable of being understood broadly or narrowly depending on the reader's perspective.

743. The ambiguity in the Model By-laws around the role of Medical Staff Councils has had practical consequences that are well reflected in some of the events that occurred at Concord Hospital between late 2022 and mid-2024.[995]

744. Although for the purposes of exploring those issues, it is not necessary for the Commissioner to make specific findings about the rights and wrongs of everything that occurred at the Concord Hospital, it is plainly unsatisfactory for the relationship between the clinicians comprising the Hospital's Medical Staff Council and Hospital and District executives to have been able to deteriorate to the point that they did. It is also unsatisfactory that it took a vote of no confidence in the Chief Executive for the Ministry to become aware of the level of disquiet among a segment of the workforce at that hospital.[996]

745. A material feature of the disagreement that developed was the proper role of the Medical Staff Council. Associate Professor Cheung, who was the Chair of the Concord Hospital Medical Staff Council at the relevant time, viewed the role of the Medical Staff Council as including "just about everything has an effect on medical matters – so education, research, quality and safety",[997] and as having an advocacy role.[998] Associate Professor Cheung considered that this role was sufficiently broad as to authorise the Medical Staff Council to, among other

[995] See, for example, Exhibit H.5.3, Statement of Dr Andrew Hallahan (6 June 2024) [MOH.9999.1294.0001]; Exhibit H.5.32, Statement of Dr Teresa Anderson AM (30 July 2024) [MOH.0011.0034.0001]; Exhibit H.7.4, Statement of Dr Lloyd Ridley (14 July 2024) [SCI.0011.0195.0001]; Exhibit H.7.12, Statement of Clinical Associate Professor Winston Cheung (16 July 2024) [SCI.0012.0174.0001]; Transcript of the Commission, 30 July 2024 – 2 August 2024, 6 August 2024 T4297ff.
[996] Transcript of the Commission, 7 August 2024 T4846.28-4847.23 (Minns).
[997] Transcript of the Commission, 31 July 2024 T4361.41-43 (Cheung).
[998] Transcript of the Commission, 31 July 2024 T4367.47-T4368.1 (Cheung).

things, establish subcommittees dealing with matters such as workforce culture and industrial relations.[999] Associate Professor Cheung reflected his understanding of the role of the Medical Staff Council in draft terms of reference.[1000]

746. In contrast, the position of the District executives was that the proposed terms of reference went beyond the permitted scope of the Medical Staff Council's role including in their specification of the Council's functions and the establishment of subcommittees, and amounted to an attempt to usurp the functions of the Board or executive.[1001] Pausing there, it is not immediately clear how a Medical Staff Council could ever usurp those functions, even if they had strayed beyond the bounds of their intended role.

747. The disagreement about this issue culminated in the Chief Executive of the District handing a letter to Associate Professor Cheung which set out (at length) the District's concerns about the proposed terms of reference for the Medical Staff Council which incorporated Associate Professor Cheung's views as to its role, directed him to withdraw that proposal and prepare a proposal in line with the executive's interpretation, and "remind[ed]" him about the NSW Health Code of Conduct in that context.[1002] It is unsurprising that Associate Professor Cheung felt threatened by this behaviour.[1003] It was, to put it neutrally, an unfortunate and entirely unnecessary escalation point; whatever might have been intended, it should have been obvious that this action would likely have been viewed by Associate Professor Cheung as suggesting that disciplinary procedures would be weaponised against him if he continued to raise the concerns he and his fellow clinicians held regarding the executive and its approach to engagement with the clinical workforce at Concord. This perception would only have been reinforced by the disciplinary action which was subsequently initiated against him for what – at worst – was a robust expression

[999] Exhibit H.5.32.6, Concord Repatriation General Hospital Medical Staff Council - Terms of Reference [MOH.0010.0403.0001 at 0006].
[1000] Exhibit H.5.32.6, Concord Repatriation General Hospital Medical Staff Council - Terms of Reference (draft, 25 May 2022) [MOH.0010.0403.0001]; Exhibit H.7.12.14, Concord Repatriation General Hospital Medical Staff Council – (Proposed) Terms of Reference (3 March 2023) [SCI.0012.0041.0001].
[1001] Exhibit H.5.3, Statement of Dr Andrew Hallahan (6 June 2024) [30] [MOH.9999.1294.0001 at 0007]; Exhibit H.5.32, Statement of Dr Teresa Anderson AM (30 July 2024) [130] [MOH.0011.0034.0001 at 0025]; Transcript of the Commission, 1 August 2024 T4434.44-4439.23 (Hallahan); Transcript of the Commission, 6 August 2024, T4702.9-4705.9 (Anderson).
[1002] Exhibit H.7.12.15, Letter from Dr Teresa Anderson AM to Associate Professor Winston Cheung (21 April 2023) [SCI.0012.0079.0001].
[1003] Transcript of the Commission, 31 July 2024 T4408.10-36 (Cheung).

of concerns which, with reasonable justification, he felt had been ignored by the executive.

748. However, despite the deterioration in the relationship between the Medical Staff Council and the executive, it is apparent that there was little (if any) disagreement that there was a role for the Medical Staff Council to play in providing advice about the very things set out in Associate Professor Cheung's proposed terms of reference, such as: the efficient and economic operation of the hospital; standards of care and services; health needs; strategies to ensure balance in provision; and adequate arrangements for effective communication.[1004] The concern appears to have been that, somehow, the Medical Staff Council was seeking to elevate itself above an advisory role. It is not apparent that this is what was happening or could ever happen.

749. In any event, it is evident that the lack of a clear statement of the role and function of the Medical Staff Council in the Model By-laws created the environment in which the dispute arose and then escalated to the unfortunate point that it did.

750. The importance of clinicians feeling that management is listening to them is clear from the evidence,[1005] and reflects the intent behind the structures set out in the Model By-Laws. In this respect, the Medical Staff Council is one important means of consultation and feedback between medical staff and management.[1006] It also provides an opportunity for management to take advantage of the collective expertise of its clinicians in matters affecting the delivery of medical services at their hospitals. There are examples of Medical Staff Councils that are functional and effective at achieving this.[1007] However, as the Concord Hospital example demonstrates, there are also situations in which the relationship between a Medical Staff Council and management can become dysfunctional and ineffective. Clarifying the scope of the Council's role is one step towards trying to avoid a similar situation in the future.

[1004] Transcript of the Commission, 1 August 2024 T4443.11-4444.44 (Hallahan); Transcript of the Commission, 6 August 2024 T4704.22-42, T4705.44-4706.4 (Anderson).
[1005] Transcript of the Commission, 23 July 2024 T3889.41-3890.8, 3892.13-3893.20 (Nogajski); Transcript of the Commission, 2 August 2024 T4525.34-4526.4 (Richards); Transcript of the Commission, 5 August 2024 T4585.38-4586.7 (Loy); Transcript of the Commission, 5 August 2024 T4601.11-33 (Egan); Transcript of the Commission, 6 August 2024, T4733.20-27 (Anderson).
[1006] Transcript of the Commission, 15 October 2024 T5727.25-29 (Minns).
[1007] Exhibit H.5.6, Statement of Professor Michael Hensley (7 June 2024) [16] [MOH.9999.1295.0001 at 0004-0005].

751. In doing so, the structures of all councils and committees created by the Model By-Laws should be reviewed to ensure that they complement each other, and provide effective and robust means for consultation and engagement between clinicians and management at facility and district level. This should include extending the standing invitation to attend board meetings from the chair of the Executive Medical Staff Council, to the Chairs of all staff councils.

10.10 Complaints and grievances

752. NSW Health has a range of different policy directives relating to the management of workplace complaints and grievances. These include:

a. Complaints Management (PD2020_013);[1008]

b. Managing Misconduct (PD2018_031);[1009]

c. Managing Complaints and Concerns about Clinicians (PD2018_032);[1010]

d. Resolving Workplace Grievances (PD2016_046);[1011]

e. Prevention and Management of Bullying in NSW Health (PD2021_030);[1012]

f. Prevention and Management of Unacceptable Behaviours in NSW Health (PD2021_031);[1013]

g. *Incident Management* (PD2020_047);[1014] and

h. Public Interest Disclosures (PD2023_026).[1015]

753. It is a complex framework of documents, which frequently overlap. It is therefore not surprising there is evidence of significant delays, inconsistencies and departures from these policies by those in local organisations who are tasked with trying to implement them.[1016] For example, while the Managing Complaints and Concerns about Clinicians policy directive contemplates that investigations

[1008] Exhibit D.1.78, NSW Health, PD2020_013 Complaints Management (24 April 2020) [MOH.9999.0837.0001].
[1009] Exhibit B.23.119, NSW Health, PD2018_031 Managing Misconduct (7 September 2018) [MOH.0001.0391.0001].
[1010] Exhibit H.3.28 NSW Health, PD2018_032 Managing Complaints and Concerns about Clinicians (7 September 2018) [MOH.9999.0933.0001].
[1011] Exhibit H.3.18, NSW Health, PD2016_046 Resolving Workplace Grievances (18 October 2016) [MOH.0002.0047.0001].
[1012] Exhibit H.3.42, NSW Health, PD2021_030 Prevention and Management of Bullying in NSW Health (3 August 2021) [MOH.0002.0087.0001].
[1013] Referred to in Exhibit H.5.4, Statement of Nathan Rudd (6 June 2024) [7] [MOH.9999.2145.0001 at pp 0002-0003].
[1014] Exhibit D.1.34, NSW Health, PD2020_047 Incident Management (14 December 2020) [MOH.9999.0803.0001].
[1015] Exhibit B.23.118, NSW Health, PD2023_026 Public Interest Disclosures (3 October 2023) [MOH.0001.0151.0001].
[1016] Exhibit H.7.13, Statement of Dominique Egan (25 July 2024) [97]-[98] [SCI.0011.0283.0001 at 0019].

conducted under that policy will "ideally" be completed within 12 weeks,[1017] the average length of time taken to complete investigations as reported to the Australian Medical Association by two medical defence organisations was eight months.[1018] This causes understandable frustration and stress for those clinicians subject to investigations.

754. It is undoubtedly true that workplace complaints and grievances may be complex and may require time-consuming investigations. There may also be good reasons to have discrete policies dealing with, for example, reporting and managing clinical incidents compared with misconduct.

755. However, the need for such an extensive and overlapping set of policies dealing with complaints and grievances as set out above is less clear. That complex web of policies combines with a lack of sufficient central support within the Ministry to provide advice to local organisations about managing grievances or complaints, or to monitor the time taken by local organisations to conduct complaints and grievance processes.

756. Another difficulty with the current policy framework is that it appears to contain no formal avenue of escalation, review or appeal by a clinician who is unhappy with the outcome of an investigation or the process that is being or has been followed in managing a complaint or allegation of misconduct (including concerns about unreasonable delay). The only formal avenues are to make an application or appeal to the Industrial Relations Commission in relation to certain disciplinary actions once they are taken, or to make a complaint to the NSW Ombudsman. It is plausible to think that the lack of such an avenue of escalation, appeal or review contributes to clinicians feeling the need to approach industrial organisations or medical colleges to agitate on their behalf.

757. In those circumstances, it is evident that the complaints and grievance policies would benefit from simplification, and the process would be enhanced by the establishment of central support for NSW Health agencies in dealing with such matters, central monitoring of the time taken to finalise them - particularly in relation to those that extend beyond targets for completion, and the creation if

[1017] Exhibit H.3.28, NSW Health PD2018_032 Managing Complaints and Concerns about Clinicians cl 5.1 [MOH.9999.0933.0001 at 0021].
[1018] Exhibit H.7.13, Statement of Dominique Egan (25 July 2024) [98] [SCI.0011.0283.0001 at 0019].

a mechanism for staff to seek review of workplace actions or decisions, external to the local organisation.

10.11 Wellbeing

758. The health and wellbeing of any workforce is obviously important. There is an obvious imperative – not just morally but also by reason of legislative obligations – to provide a safe workplace for NSW Health staff. Health and wellbeing are also critical to workplace culture. Happy and healthy workers can be expected to take less leave, to be more productive and to keep working in the NSW health system for longer. A workplace known for a culture of promoting wellbeing will be more attractive to prospective employees.

759. There are high levels of fatigue, stress and burnout across the NSW Health workforce.[1019] These experiences were undoubtedly exacerbated by the pandemic, but they persist, and they are prevalent. The Ministry's most recent "People Matters" survey results record only 51 per cent of respondents giving a favourable response to questions about their wellbeing.[1020] While NSW Health has a range of wellbeing initiatives[1021], which are welcome, it is not apparent how, if at all, their success is monitored; the "People Matters" survey is by no means an adequate measure of staff wellbeing within the health context and should not be held out in this way. Whatever monitoring might be occurring, the evidence indicates there is still more work to do in this area.

760. One initiative that appears to have experienced success in Sydney Local Health District is establishing a position of Chief Medical Wellness Officer. Dr Bethan Richards, who occupies that position, is a Senior Staff Specialist at the Royal Prince Alfred Hospital who performs the Chief Medical Wellness Officer role part-time (0.5 FTE).[1022] When she commenced in that role in 2019, it was the first of its kind in Australia, although it is internationally recognised.[1023] Dr Richards gave evidence about an impressive range of initiatives she has

[1019] Exhibit H.2.28, NSW Health, *Allied Health Macro Workforce Trends Report* (May 2022) p 13 [MOH.0003.0234.0001 at 0015]; Exhibit H.5.29, Statement of Sarah Whitney (22 July 2024) [17]-[18] [MOH.0015.0001.0001 at 0006]; Exhibit H.6.1, Statement of the Royal Australian College of Physicians (12 July 2024) [SCI.0011.0185.0001 at 0020]; Exhibit L.23.1, Deloitte, *Medical Workforce Pressures in New South Wales* (February 2023) p 11 [SCI.0011.0490.0001 at 0011]; Exhibit L.16, Statement of Andrew Holland (1 October 2024) [19] [SCI.0011.0469.0001 at 0003-0004]; Exhibit L.17, Statement of Dr Behny Samadi (30 September 2024) [23]-[25] [SCI.0011.0465.0001 at 0005-0006]; Transcript of the Commission, 25 July 2024 T4106.24-4107.5 (Kanhutu); Transcript of the Commission, 2 August 2024 T4526.21-31, T4539.47-4540.20 (Richards).
[1020] Exhibit H.5.24, *Workforce Data Report* p 36 [MOH.0010.0377.0001 at 0036].
[1021] Exhibit L.7, Statement of Richard Griffiths (8 October 2024) [98]-[103] [MOH.0011.0083.0001 at 0022-0024].
[1022] Exhibit H.5.5, Statement of Dr Bethan Richards (7 June 2024) [3] [MOH.9999.2147.0001].
[1023] Exhibit H.5.5, Statement of Dr Bethan Richards (7 June 2024) [5] [MOH.9999.2147.0001 at 0002].

overseen within her district to improve the wellbeing of medical staff, with a focus on prevention and early detection.[1024] These initiatives cover a range of inputs into staff wellbeing, including nutrition, fatigue, stress associated with grievance and adverse events processes, mental health issues and leadership support. Dr Richards' team also collects data to monitor staff wellness, in a more granular way than the "People Matters" survey.[1025]

761. It is clear that Sydney Local Health District has made a significant investment in Dr Richards and her team. However, it also appears, at least at this early stage, that its investment is paying dividends. For example, early data gathered by Dr Richards' team is showing a reduction in levels of burnout and distress and an increase in levels of self-compassion, resilience and self-care behaviours and improvements in quality and safety outcomes.[1026] Sydney Local Health District is also the best performers among when it comes to wellbeing scores based on the most recent "People Matters" survey results.[1027]

762. Consideration should be given to the routine collection and collation of similar data sets to those collected in the Sydney Local Health District to better inform an assessment of the overall wellbeing of the workforce, within the organisation and across the system more generally. If gathered, this information should inform the wider system planning in so far as it would provide valuable information as to the extent to which services being delivered through Local Health Districts and Specialty Health Networks are viable from the perspective of the impact that delivering them is having on the existing workforce. Where problems are identified, something should be changed.

10.12 Conclusion and key recommendations

763. As of the system wide approach to planning, NSW Health should:

    a. establish a central workforce planning function, located in the Ministry, which collaborates regularly and systematically with local organisations to direct the clinical workforce establishment across the NSW health system with the objective of guiding the deployment of the human resources

[1024] Exhibit H.5.5, Statement of Dr Bethan Richards (7 June 2024) [6]-[9] [MOH.9999.2147.0001].
[1025] Transcript of the Commission, 2 August 2024 T4527.1-4529.20 (Richards).
[1026] Exhibit H.5.5, Statement of Dr Bethan Richards (7 June 2024) [10] [MOH.9999.2147.0001 at 0002].
[1027] Exhibit H.5.24, Rian Thompson, *Workforce Data Report* p 36 [MOH.0010.0377.0001 at 0036].

available within the system in a way that best meets the needs of the New South Wales population as a whole; and

b. once that function is established, prioritise a thorough, evidence-based, review of specific initiatives that should be implemented to help address current workforce shortages and maldistributions.

764. The Health Education and Training Institute's role should be expanded, with appropriate funding, to include:

a. coordinating the allocation of students to clinical placements within NSW Health facilities and services in collaboration with universities and relevant NSW Health agencies;

b. overseeing a graduate recruitment program that capitalises on the clinical placements offered within the public health system and facilitates the early recruitment of those who have held such placements immediately upon graduation and into areas of need; and

c. the establishment and delivery of specialist medical training networks for all medical specialties, prioritising those with projected shortfalls in trainee numbers compared with service and workforce demands, in collaboration with the relevant medical colleges and local organisations,

with the objective of matching the number and locations of placements and training positions with areas of future service and workforce need, and focusing upon maximising opportunities for training and recruitment in rural and regional locations.

765. There should be a legislated award reform process under the auspices of the Industrial Relations Commission of NSW (with external assistance and advice as appropriate), incorporating at least the following features:

a. a legislated set of objectives to be achieved by the process, which include:

i. simplifying and, where appropriate, consolidating the current range of awards, determinations and other instruments setting terms and conditions of employment or engagement for NSW Health workers, to provide a consistent and coherent framework of terms and conditions that is easy to understand and apply; and

ii. updating instruments so that they reflect the current and expected future service delivery and workforce needs of the NSW health system and current and expected future working conditions; and

iii. providing fair and reasonable terms and conditions of employment or engagement for workers across the NSW health system, including having regard to the value of their work to system, the impact of those terms and conditions on attraction and retention, and their fiscal and economic impacts;

b. a reasonable but expeditious timeframe in which the process is to be completed; and

c. an extension of the process to Visiting Medical Officers and the VMO Determinations.

766. The Model By-Laws for Local Health Districts and Specialty Health Networks made under ss 39 and 60 of the *Health Services Act* should be reviewed and amended with a view to clearly identifying the role and functions each council and committee established by them and ensuring that they:

a. provide an effective and robust forum for consultation and feedback between clinicians and management; and

b. are complementary of each other;

c. extend the standing invitation to attend board meetings to the chairs of all councils created by the Model By-Laws.

767. The Ministry should review its processes for dealing with workplace complaints and grievances, including with a view to:

a. simplifying and, where appropriate, consolidating its policy directives and guidelines relating to complaints, grievances, incidents and workplace behaviour;

b. establishing a central contact within the Ministry for local organisations to seek advice about conducting those processes;

c. establishing a process for monitoring the time taken by local organisations to conduct those processes; and

d. establishing a mechanism for staff to seek review of workplace actions or decisions, external to the local organisation.

768. Consideration should be given to the routine collection and collation of a granular data set directed to the wellbeing of the workforce (similar to that which the evidence reveals has been collected by the Chief Wellness Officer in the Sydney Local Health District) with a view to supporting and improving the wellbeing of the workforce within local organisations and across the system more generally.

11 AFFILIATED HEALTH ORGANISATIONS

769. This section of the outline addresses issues raised in the evidence concerning how NSW Health engages with Affiliated Health Organisations.

770. In order to explore some of the issues that arise from the Terms of Reference relating to the governance and funding of Affiliated Health Organisations, representatives of four of them were called to give evidence. Those Affiliated Health Organisations were:

a. The Royal Society from the Welfare of Mothers and Babies (Tresillian);

b. Karitane;

c. Royal Rehab Group; and

d. St Vincent's Health Network.

771. Before turning to a consideration of the issues raised in the evidence, it is convenient to first set out some background to those organisations, and the services they provide.

11.1 Royal Society for the Welfare of Mothers and Babies (Tresillian)

772. Tresillian is Australia's largest not-for-profit early parenting service. It supports new parents with issues including breastfeeding and nutrition, sleep and settling, as well as perinatal mental health.[1028] Tresillian provides services across New South Wales.[1029]

773. Tresillian was established under statute in 1919[1030] to provide early parenting services across New South Wales, and has been doing so in collaboration with the NSW Government since that time.[1031] The organisation's current by-laws were gazetted by the New South Wales Parliament in 2018.[1032]

774. Tresillian operates 20 inpatient beds at Nepean Hospital, 14 beds at Canterbury Hospital, 14 beds in a facility in Wollstonecraft, and four beds at Macksville Hospital. It also has family care centres, which operate as drop-in day services,

[1028] Exhibit D.122, Outline of Evidence of Robert Mills (11 April 2024) [2] [SCI.0008.0344.0001]; Transcript of the Commission, 18 April 2024 T2049.28-34 (Mills).
[1029] Transcript of the Commission, 18 April 2024 T2050.28-34 (Mills).
[1030] *Royal Society for the Welfare of Mothers and Babies' Incorporation Act 1919* (NSW): Exhibit D.122, Outline of Evidence of Robert Mills (11 April 2024) [3] [SCI.0008.0344.0001]; Transcript of the Commission, 18 April 2024 T2049.38-44 (Mills).
[1031] Exhibit D.122, Outline of Evidence for Robert Mills (11 April 2024) [3] [SCI.0008.0344.0001].
[1032] Exhibit D.122, Outline of Evidence for Robert Mills (11 April 2024) [3] [SCI.0008.0344.0001]; Transcript of the Commission, 18 April 2024 T2050.6-12 (Mills).

at Nepean Hospital, Canterbury Hospital and Wollstonecraft.[1033] Day services are also operated in regional locations, including Lismore, Coffs Harbour, Taree, Muswellbrook, Armidale, Griffith, Goulburn, Queanbeyan, Broken Hill, Dubbo and Moruya.[1034] "Tresillian 2U" vans operate in regional locations, which contain mobile nurseries and travel to five different small regional locations per week.[1035] Tresillian also operates telephone and virtual services in partnership with Karitane.

775. Tresillian's services are primarily funded through agreements with Sydney Local Health District.[1036] Under the 2023-24 agreement, Tresillian provided statewide residential services, a virtual parenting service, day services, a parents helpline, home visiting (including extended visits), and perinatal mental health services.[1037] The budget allocation was $14,535,000; covering services at Nepean Hospital, Canterbury Hospital, and Wollstonecraft, along with support for the parents helpline and various ancillary services.[1038]

776. In addition, Tresillian entered into separate Service Agreements with Healthy North Coast Primary Health Network and Northern New South Wales Local Health District, Albury Wodonga Health, Murrumbidgee Local Health District, Western New South Wales Local Health District, Sothern New South Wales Local Health District, Far West Local Health District, Hunter New England Local Health District, Mid-North Coast Local Health District, Nepean Blue Mountains Local Health District, and the Ministry.

777. Tresillian's Service Agreement with Sydney Local Health District is a one-year agreement, which has historically rolled over each year.[1039] Its service agreements with regional Local Health Districts and the Ministry are re-negotiated at the end of their fixed terms.[1040] However, as a matter of practice, funding has not been withdrawn for any Tresillian service under these agreements since 2015.[1041]

[1033] Transcript of the Commission, 18 April 2024 T2050.43-2051.27 (Mills).
[1034] Transcript of the Commission, 18 April 2024 T2051.37-45 (Mills).
[1035] Transcript of the Commission, 18 April 2024 T2072.16-32 (Mills).
[1036] Exhibit D.122. Outline of Evidence of Robert Mills (11 April 2024) [24] [SCI.0008.0344.0001 at 0008].
[1037] Exhibit D. 96. Service Agreement 2023-24 between SLHD and Tresillian [3.2] [SCI.0008.0113.0001 at 0014].
[1038] Exhibit D. 96. Service Agreement 2023-24 between SLHD and Tresillian [4] [SCI.0008.0113.0001 at 0019]; Transcript of the Commission, 18 April 2024 T2058.3-20 (Mills).
[1039] Transcript of the Commission, 18 April 2024 T2059.40-46 (Mills).
[1040] Transcript of the Commission, 18 April 2024 T2058.42-2059.19, T2060.1-13 (Mills).
[1041] Transcript of the Commission, 18 April 2024 T2061.26-31 (Mills).

11.2 Karitane

778. Karitane has been operating since 1923.[1042] It is a registered charity through the Australian Charities and Not-for-profits Commission, and a company limited by guarantee operating under the governance of an independent Board of Directors.[1043]

779. Karitane provides statewide and national child and family health services, including perinatal mental health, parenting support, and early intervention for families with children in the first 2000 days after birth (zero to five years).[1044] It operates 19 tertiary residential beds at Campbelltown Hospital, Randwick Parenting Centre, and Jade House, alongside a statewide toddler clinic and services at Oran Park Integrated Care Hub.[1045] Additionally, Karitane offers nursing in child and family hubs at Wolli Creek, Shellharbour, and Newcastle, sub-contracting parenting support to organisations like Mission Australia, the Benevolent Society, and Barnardos throughout New South Wales, and focusing on early intervention for families with complex care needs parenting.[1046]

780. Karitane also provides virtual residential parenting services and virtual home visiting services, which are statewide services operating through virtual means, such as phone calls, video calls, emails and webinars.[1047]

781. Families are generally referred to Karitane through general practitioners, paediatricians, psychiatrists, psychologists, and child and family health services in the Local Health Districts.[1048]

782. Karitane primarily provides its child and family health services to the public health system through Service Agreements with South Western Sydney Local Health District.[1049] Under those agreements, Karitane receives block funding for a financial year, with a range of agreed performance measures and Key Performance Indicator targets which are reported on quarterly.

[1042] Transcript of the Commission, 18 April 2024 T2002.33-34 (O'Loughlin).
[1043] Exhibit D.121, Outline of Evidence of Grainne O'Loughlin (11 April 2024) [4]-[6] [SCI.0008.0343.0001].
[1044] Exhibit D.121, Outline of Evidence of Grainne O'Loughlin (11 April 2024) [7] [SCI.0008.0343.0001 at 0001]; Transcript of the Commission, 18 April 2024 T2002.27-44 (O'Loughlin).
[1045] Transcript of the Commission, 18 April 2024, T2005.27-45, T2008.33-35, T2010.4-2012.17 (O'Loughlin).
[1046] Transcript of the Commission, 18 April 2024, T2014.39-2015.1-4, T2015.43-47 (O'Loughlin).
[1047] Exhibit D.121, Outline of Evidence for Grainne O'Loughlin (11 April 2024) [9] [SCI.0008.0343.0001 at 0002]; Transcript of the Commission, 18 April 2024 T2004.34-44 (O'Loughlin).
[1048] Transcript of the Commission, 18 April 2024 T2004.7-17 (O'Loughlin).
[1049] Exhibit D.121, Outline of Evidence for Grainne O'Loughlin (11 April 2024) [8] [SCI.0008.0343.0001 at 0001].

783. For example, the 2023-24 Service Agreement between Karitane and South Western Sydney Local Health District covers Karitane's residential unit beds at Campbelltown Hospital, the Randwick Parenting Centre, Jade House, the statewide toddler clinic, and the Oran Park Integrated Care Hub.[1050] The budget allocation for these services was $8,024,980 (excluding Patient Fees (PHI and Medicare), Karitane Donation Revenue, Karitane other own source funding, and PCIT Supplemental Ministry of Health Funding for the 2023-24 financial year).[1051]

784. In addition, Karitane has grant funding agreements directly with the Ministry for the provision of its virtual residential parenting services and virtual home visit services.[1052] The agreement relating to virtual residential parenting services is ongoing and has most recently been extended to 30 June 2025.[1053] Karitane also has a partnership agreement with South Eastern Sydney Local Health District for the provision of services at the Wolli Creek child and family hub.[1054]

11.3 Royal Rehab

785. The Royal Rehab Group provides specialist rehabilitation and disability services across various Local Health Districts in New South Wales, including services for general rehabilitation patients, and patients with spinal cord injuries and traumatic injuries. Royal Rehab has been a provider of health services in New South Wales since 1899 and was founded as a result of philanthropy.[1055]

786. Royal Rehab offers inpatient rehabilitation and community rehabilitation services, which include arranging necessary modifications to a patient's residence, connecting patients with multi-disciplinary care providers in the community, and working with organisations on the patient's behalf, such as the National Disability Insurance Agency insurers.[1056] Royal Rehab also operates its community services, including the New South Wales Spinal Outreach

[1050] D.80, Service Agreement 2023-24 between SWSLHD and Karitane [3.2] [SCI.0008.0169.0001 at 0017].
[1051] D.80, Service Agreement 2023-24 between SWSLHD and Karitane [4] SCI.0008.0169.0001 at 0024].
[1052] Exhibit D.121, Outline of Evidence of Grainne O'Loughlin (11 April 2024) [9] [SCI.0008.0343.0001 at 0002]; Transcript of the Commission, 18 April 2024, T2014.18-25 (O'Loughlin).
[1053] Transcript of the Commission, 18 April 2024 T2013.14-19 (O'Loughlin).
[1054] Exhibit D.121, Outline of Evidence of Grainne O'Loughlin (11 April 2024) [10] [SCI.0008.0343.0001 at 0002].
[1055] Exhibit D.123, Outline of Evidence of Matthew Mackay (11 April 2024) [2], [5], and [8] [SCI.0008.0341.0001]
[1056] Exhibit D.123, Outline of Evidence of Matthew Mackay (11 April 2024) [5] [SCI.0008.0341.0001]; Transcript of the Commission, 18 April 2024 T2090.46-2091.10 (Mackay).

Service[1057], providing post-hospital discharge care to spinal cord injury patients in every Local Health District across New South Wales.

787. Royal Rehab also operates a 37 bed private neurological rehabilitation hospital in Petersham, as well as a resort for people with spinal cord injury in Collaroy, which is partly funded by iCare and the National Disability Insurance Scheme.[1058] There are also seven residents with profound disabilities in long-term housing at Weemala Extended Care Service, who are provided extended care services by Royal Rehab, rather than divesting to the National Disability Insurance Agency, under a legacy agreement.[1059]

788. The funding of services provided by Royal Rehab (in its capacity as an Affiliated Health Organisation) is managed through the Northern Sydney Local Health District. However, due to disagreement between the parties as to the adequacy of the funding provided for the services being sought, the most recent Service Agreement executed between Royal Rehab and the Northern Sydney Local Health District expired on 30 June 2012.[1060] In lieu of a written service agreement, the services and funding arrangements between Royal Rehab and Northern Sydney Local Health District are based on history. These arrangements are managed through quarterly performance meetings, during which the executive staff of Royal Rehab and Northern Sydney Local Health District discuss whether key performance indicators are being met.[1061]

789. For the 2023-24 financial year, Royal Rehab's budget allocation received from the Northern Sydney Local Health District was $28,925,495.[1062] That figure included an 'own source revenue' target of $4,179,768, with the result that the total funding provided by Northern Sydney Local Health District for the 2023-24 financial year was $24,745,727.[1063]

[1057] Transcript of the Commission, 18 April 2024 T2091.21-25 (Mackay).
[1058] Transcript of the Commission, 18 April 2024 T2087.29-42, T2091.27-33 (Mackay).
[1059] Transcript of the Commission, 18 April 2024 T2090.1-44 (Mackay).
[1060] Transcript of the Commission, 18 April 2024 T2101.6-31, T2102.26-2103.2 (Mackay); Exhibit D.123. Outline of Evidence for Matthew Mackay (11 April 2024) [13]
[1061] Exhibit D.123, Outline of Evidence of Matthew Mackay (11 April 2024) [13]-[14] [SCI.0008.0341.0001 at 0003].
[1062] Exhibit D.123, Outline of Evidence of Matthew Mackay (11 April 2024) [16] [SCI.0008.0341.0001 at 0003].
[1063] Exhibit D.123, Outline of Evidence of Matthew Mackay (11 April 2024) [17] [SCI.0008.0341.0001 at 0004]; D.35. Letter from Jacquie Ferguson, NSLHD to Matthew Mackay, Royal Rehab attaching budget for Royal Rehab for 2023-24 (17 October 2023) [SCI.0008.0027.0001].

11.4 St Vincent's Health Network

790. St Vincent's Health Australia is Australia's largest not-for-profit mission-based health and aged care organisation, established by the Sisters of Charity in 1857.[1064] St Vincent's Health Australia has the longest standing community partnership with the state government for the delivery of public healthcare in New South Wales history.[1065]

791. St Vincent's Hospital Sydney Limited is a wholly owned subsidiary of St Vincent's Health Australia.[1066]

792. As noted above, St Vincent's Hospital Sydney Limited is a networked Affiliated Health Organisation in respect of two recognised establishments and services: St Vincent's Hospital, Darlinghurst and Sacred Heart Health Service, Darlinghurst - known collectively as the St Vincent's Health Network.[1067] For ease of reference in this outline, the networked Affiliated Health Organisation will be referred to as the St Vincent's Health Network.

793. The services provided by the St Vincent's Health Network include:[1068]

794. In relation to St Vincent's Hospital in Darlinghurst:

a. delivering 2.5% of the State's acute inpatient activity in addition to a comprehensive range of sub-acute and non-admitted medical and surgical services;

b. being the sole provider of heart and lung transplantation services and haematopoietic Stem Cell Transplantation for severe scleroderma;

c. being the designated provider of the following highly specialised services to patients across New South Wales: critical care services including Extracorporeal Membrane Oxygenation (ECMO) and Adult Intensive Care; transcatheter Aortic Valve Implantation; Human Immuno Virus Reference Laboratory; and Bone Marrow Transplantation and Laboratory;

[1064] Exhibit G.30, Statement of Christopher John Blake (6 June 2024) [7]-[8] [SVH.9999.0004.0001 at 0002]; Exhibit G.29, Statement of Anna Mary McFadgen (4 June 2024) [8] [SVH.9999.0002.0001 at 0002].
[1065] Transcript of the Commission, 12 June 2024, T3550.35 (Blake).
[1066] Exhibit G.30, Statement of Christopher John Blake (6 June 2024) [14] [SVH.9999.0004.0001 at 0002].
[1067] St Vincent's Hospital Sydney also operated St Joseph's Hospital in Auburn up until the hospital's closure in 2023: Exhibit G.29, Statement of Anna Mary McFadgen (4 June 2024) [12] [SVH.9999.0002.0001 at 0002].
[1068] Exhibit G.29, Statement of Anna Mary McFadgen (4 June 2024) [19] SVH.9999.0002.0001 at 0003].

d. being the only public hospital in New South Wales with a dedicated homeless health service;

e. Providing cardiology, neurology, mental health and alcohol and drug, diabetes outreach, haematology, rehabilitation, and pathology services to patients across the state, including in rural and regional areas via both virtual and outreach services, where the Local Health Districts in those areas could not otherwise provide the services; and

f. Providing inpatient, virtual and outreach services to patients across Murrumbidgee Local Health District through formalised referral pathways.

795. As a networked Affiliated Health Organisation, there is a high degree of integration between the St Vincent's Health Network and the wider public health system.[1069] It is seemingly uncontroversial that there are ongoing system benefits in those arrangements, as opposed to NSW Health attempting to replicate or duplicate the highly specialised and statewide nature of many of the services offered by the St Vincent's Health Network.[1070]

796. As the only networked Affiliated Health Organisation, interactions between the St Vincent's Health Network and the Ministry are similar to those which occur between the Ministry and Local Health Districts.[1071] Each financial year, there are Service Agreement negotiations with the Ministry, which involve meetings between senior officials of St Vincent's Health Network and Ministry.[1072] The funding under the service agreements generally reflects the level and mix of services purchased from St Vincent's Health Network by the Ministry. The St Vincent's Health Network has the opportunity to submit purchasing requests for funding above the base purchased volume of services, in the same way as Local Health Districts.[1073]

797. The St Vincent's Health Network is subject to quarterly performance review meetings with the Ministry against the NSW Health Performance Framework, which is the same performance framework applicable to Local Health Districts.

[1069] Exhibit G.29, Statement of Anna Mary McFadgen (4 June 2024) [25] SVH.9999.0002.0001 at 0005]; Exhibit G.103, Statement of Matthew Daly (6 June 2024) [28]-[31] [MOH.9999.1290.0001 at 0006].
[1070] Exhibit G.103, Statement of Matthew Daly (6 June 2024) [25] [SVH.9999.0002.0001].
[1071] Exhibit G.29, Statement of Anna Mary McFadgen (4 June 2024) [24] [SVH.9999.0002.0001 at 0005]; Exhibit G.104, Statement of Deb Willcox (6 June 2024) [28] [MOH.9999.1297.0001 at 0004].
[1072] Exhibit G.29, Statement of Anna Mary McFadgen (4 June 2024) [28] [SVH.9999.0002.0001 at 0005].
[1073] Exhibit G.29, Statement of Anna Mary McFadgen (4 June 2024) [29]-[30] [SVH.9999.0002.0001 at 0005]; Exhibit G.103, Statement of Matthew Daly (6 June 2024) [26] [MOH.9999.1290.0001 at 0005].

Since March 2024, the St Vincent's Health Network has also commenced more detailed monthly financial reporting to NSW Health due to recent financial pressures.[1074]

798. For the 2023-24 financial year, the St Vincent's Health Network received a budget of $450,988,000 from the Ministry to operate St Vincent's Hospital, Darlinghurst and Sacred Heart Health Service, Darlinghurst.[1075]

11.5 Funding Affiliated Health Organisations

799. A central theme that emerged in the evidence was the sufficiency of the funding allocated to those Affiliated Health Organisations to deliver the services required of them under their service agreements.

800. As a general proposition, the notion that Affiliated Health Organisations – which are, in substance, not-for-profit entities providing services on behalf of the public health system in New South Wales – should receive funding sufficient to cover the costs of delivering those services should not reasonably be open to debate. There is no good reason why Affiliated Health Organisations should be expected to deliver a particular level of service in return for receiving funding that does not meet the cost of doing so.

801. In this respect, it must be recognised that, whilst Affiliated Health Organisations are, by reason of their status under the *Health Services Act*, part of the public health system, they remain independent organisations with their own legal obligations. Accordingly, if they do not receive funding sufficient to cover the cost of delivering services, their long term sustainability is at risk. Whilst a series of negative results against budget for a Local Health District is not an optimal result, it does not risk the survival of the organisation, nor does it expose those responsible for directing the Local Health Districts to action for trading whilst insolvent. The same cannot be said of Affiliated Health Organisations and their directors.

802. Although the circumstances of each of the Affiliated Health Organisations that were explored in the evidence differed, each had experience of material

[1074] Exhibit G.29, Statement of Anna Mary McFadgen (4 June 2024) [34]-[35] [SVH.9999.0002.0001 at 0006].
[1075] Exhibit G.29.9, AM-9 NSW Health and SVHNS - Service Agreement 2023-24 (16 November 2023) [SVH.0009.0002.0096].

shortfalls when the amount of funding received is compared with what they contend are the costs of delivering those services required of them.

803. The proposition that Affiliated Health Organisations should receive funding sufficient to cover the cost of delivering services under service agreements is seemingly accepted by NSW Health.[1076] However, it emerged in the evidence that there is, from time to time, a divergence of view as to what that amount is, and how it should be determined.[1077]

11.5.1 Karitane

804. Karitane's position was that the funds received under its primary service agreement with South Western Sydney Local Health District was consistently insufficient to meet the cost of delivering the service volumes to be provided under the service agreement.[1078] To offset that shortfall in funding, Karitane has relied on the additional funding it receives from sources other than the Local Health District, including revenue from community and interstate programs, private health insurance, grants and philanthropy.[1079] Those shortfalls have been the subject of correspondence between the South Western Sydney Local Health District, the Ministry, and the New South Wales Government.[1080]

805. Whilst its alternate sources of funding have historically permitted Karitane to operate on a cost-neutral basis, or otherwise with only small losses, the size of the funding shortfall has increased over time.[1081] As a result, Karitane has been required to reduce or discontinue services due to funding deficits, for example the closure of the Liverpool Parenting Centre in 2018.[1082]

806. Karitane has undertaken annual efficiency reviews and processes with South Western Sydney Local Health District since 2018 and South Western Sydney Local Health District has communicated to Karitane that it would advocate to the Ministry for additional funding for Karitane if those reviews identified no

[1076] Transcript of the Commission, 29 April 2024 T2550.11-16 (Willcox).
[1077] Transcript of the Commission, 29 April 2024 T2550.24-30 (Willcox)
[1078] Exhibit D.121, Outline of Evidence of Grainne O'Loughlin (11 April 2024) [16] [SCI.0008.0343.0001 at 0002-0003]; Transcript of the Commission, 18 April 2024 T2021.10-14; T2023.18-34, T2037.13 (O'Loughlin).
[1079] Exhibit D.121. Outline of Evidence of Grainne O'Loughlin (11 April 2024) [17]-[18] [SCI.0008.0343.0001 at 0003]; Transcript of the Commission, 18 April 2024 T2025.25-2026.24 (O'Loughlin).
[1080] Exhibit D.121, Outline of Evidence of Grainne O'Loughlin (11 April 2024) [21] [SCI.0008.0343.0001 at 0004]; Exhibit D.82. Letter from Karitane to Deborah Willcox dated 18 December 2023 [SCI.0008.0293.0001].
[1081] Exhibit D.121, Outline of Evidence of Grainne O'Loughlin (11 April 2024) [19] [SCI.0008.0343.0001 at 0003]; Exhibit D.81. SWSLD Service Funding Status for Service Agreement with Karitane 2015-2024 [SCI.0008.0165.0001].
[1082] Exhibit D.121. Outline of Evidence of Grainne O'Loughlin (11 April 2024) [20] [SCI.0008.0343.0001 at 0003]; Transcript of the Commission, 18 April 2024 T2041.12-30 (O'Loughlin).

efficiency issues.[1083] Despite this communication, and multiple meetings directly with the Ministry,[1084] as of April 2024 Karitane had received no additional funding commensurate with the cost of operating the services it was contracted to deliver under its Service Agreement.[1085] This ongoing funding uncertainty is problematic in light of Karitane's obligation not to trade whilst insolvent.[1086]

807. Karitane predicted that for the 2023-24 financial year, there would be a deficit of $1.7 million in its budget. This was a substantially higher deficit than in prior years and Karitane indicated that it would be difficult to offset either through efficiency savings or alternate sources of revenue.[1087] Karitane's 2023-24 Service Agreement with South Western Sydney Local Health District also allocated a figure of just over $1 million in own source funding. However, when that target is taken into account, the shortfall between the public funding received and the cost of delivering the services required was approximately $2.7 million.[1088]

808. Karitane has raised its concerns with respect to underfunding in the covering letter of the Service Agreement with South Western Sydney Local Health District for the 2023-24 financial year,[1089] and stated that the money budgeted for in that agreement did not cover the cost of providing the services required to be delivered.[1090] However, Karitane has been advised that the South Western Sydney Local Health District does not have funding within its own budget to bridge that gap.[1091]

809. Notwithstanding the deficiencies in its budget under the agreement with South Western Sydney Local Health District, Karitane gave evidence that the funding it receives from the Ministry for its statewide virtual services meets the full cost of providing the services required under the service agreement. Significantly, the budgets set by the Ministry do not require any contribution from Karitane's

[1083] Transcript of the Commission, 18 April 2024 T2037.45-2038.9 (O'Loughlin).
[1084] Transcript of the Commission, 18 April 2024 T2038.30-2039.1 (O'Loughlin).
[1085] Exhibit D.121. Outline of Evidence for Grainne O'Loughlin (11 April 2024) [22]-[23] [SCI.0008.0343.0001 at 0004].
[1086] Exhibit D.121. Outline of Evidence for Grainne O'Loughlin (11 April 2024) [24] [SCI.0008.0343.0001 at 0004].
[1087] Exhibit D.121. Outline of Evidence for Grainne O'Loughlin (11 April 2024) [19] [SCI.0008.0343.0001 at 0003].; Transcript of the Commission, 18 April 2024 T2023.23-2024.12 (O'Loughlin).
[1088] Transcript of the Commission, 18 April 2024 T2028.10-24; T2029.4-15 (O'Loughlin).
[1089] Exhibit D.121, Outline of Evidence of Grainne O'Loughlin (11 April 2024) [15] [[SCI.0008.0343.0001 at 0002].
[1090] Transcript of the Commission, 18 April 2024 T2029.10-14 (O'Loughlin); Transcript of the Commission, 29 April 2024 T2550.38-2551.13 (Willcox).
[1091] Transcript of the Commission, 18 April 2024 T2039.16-32 (O'Loughlin).

own source funding, and Karitane has not experienced any shortfalls in its contracts with the Ministry.[1092]

11.5.2 Tresillian

810. Tresillian has also experienced consistent shortfalls between the budgets in its Service Agreements with Sydney Local Health District and the cost of delivering the services required of them under those agreements.[1093] For example, there were no funding adjustments made by way of annual escalations to account for increases to the costs of goods and services, and repairs and maintenance.[1094] The indexation applied to its agreements with the Ministry also did not keep pace with the annual growth in costs.[1095]

811. To make up for funding shortfalls, Tresillian was required to pull from its "other funding buckets",[1096] including funding from grants, philanthropy and private health fund revenue,[1097] to maintain the level of services required of it pursuant to its Service Agreement.

11.5.3 Royal Rehab

812. As noted above, Royal Rehab has not executed a Service Agreement with the Northern Sydney Local Health District since 2011/2012.[1098] That is because of ongoing disagreement between the parties as to "an equitable model of funding for the organisation in the provision of statewide services".[1099] Royal Rehab's position – like that of Karitane and Tresillian - is that the funding proffered by Northern Sydney Local Health District is insufficient to meet the cost of providing the services that are required of them.[1100]

813. Royal Rehab points to the fact that there has only been a limited uplift in Royal Rehab's overall base funding, aside from indexation applied in line with public sector wage increases,[1101] and composite escalations for the expense budget

[1092] Transcript of the Commission, 18 April 2024 T2045.29-2046.11 (O'Loughlin).
[1093] Transcript of the Commission, 18 April 2024 T2062.22-33; T2085.12-29 (Mills).
[1094] Transcript of the Commission, 18 April 2024 T2061.44-2062.39 (Mills).
[1095] Transcript of the Commission, 18 April 2024 T2062.44-2053.5 (Mills).
[1096] Transcript of the Commission, 18 April 2024 T2062.12-20 (Mills).
[1097] Transcript of the Commission, 18 April 2024 T2085.31-45 (Mills).
[1098] Transcript of the Commission, 18 April 2024 T2101.6-31 (Mackay); Exhibit D.123. Outline of Evidence for Matthew Mackay (11 April 2024) [13] [SCI.0008.0341.0001 at 0003].
[1099] Transcript of the Commission, 18 April 2024 T2102.26-2103.2 (Mackay); Transcript of the Commission, 29 April 2024 T2548.7-17 (Willcox); Transcript of the Commission, 22 April 2024 T2293.11-14 (Schembri).
[1100] Transcript of the Commission, 18 April 2024 T2103.10-23 (Mackay).
[1101] Exhibit D.123. Outline of Evidence for Matthew Mackay (11 April 2024) [20]-[21] [SCI.0008.0341.0001 at 0004]; Transcript of the Commission, 24 April 2024 T2419.22-30 (Middleton).

and revenue budget.[1102] Royal Rehab is not a party to the district service agreements on which its escalations are based and has no role in negotiating the escalation figures.[1103] It is suggested that the full wage (composite) escalation costs, particularly the superannuation component of such costs, do not flow through to Royal Rehab in the budget.[1104]

814. Whilst the size of the shortfall between the funding it receives and the cost of providing services varies from year to year, it ranges from two to four million dollars annually.[1105] That shortfall affects Royal Rehab's ability to keep its services running and to operate a statewide service.[1106]

815. Adjunct Professor Schembri, Chief Executive of Northern Sydney Local Health District, agreed that Royal Rehab had made him aware that it believes it is underfunded, and that this is the reason why Royal Rehab has refused to sign a service agreement.[1107] He also noted that Royal Rehab had made similar representations to the Minister and had met with the Ministry in relation to those issues.[1108]

816. However, Adjunct Professor Schembri contended that he did not have any data to support the claim that Royal Rehab is underfunded.[1109] In December 2023, Adjunct Professor Schembri reinforced advice from the Ministry that the best way forward for Royal Rehab was to prepare a detailed business case outlining the gaps in funding, and verbally requested that Royal Rehab prepare a business case particularising its underfunding issues for his consideration.[1110] This was followed up with a written request in April 2024.[1111] The purpose of the proposed business case was stated to enable a review Royal Rehab's model of care, the indirect and direct costs of services, the revenue model, opportunities for private insurance and compensable payments, and the gap between the current revenue and costs.[1112] Without this information, Adjunct

[1102] Transcript of the Commission, 18 April 2024 T2108.42-2109.7 (Mackay).
[1103] Transcript of the Commission, 18 April 2024 T2109.2-26 (Mackay).
[1104] Transcript of the Commission, 18 April 2024 T2112.42-2123.42 (Mackay).
[1105] Transcript of the Commission, 18 April 2024 T2112.42-2113.8 (Mackay).
[1106] Transcript of the Commission, 18 April 2024 T2116.46-2117.4 (Mackay).
[1107] Transcript of the Commission, 22 April 2024 T2284.26-40 (Schembri).
[1108] Transcript of the Commission, 22 April 2024 T2285.26-34 (Schembri).
[1109] Transcript of the Commission, 22 April 2024 T2285.9-10 (Schembri).
[1110] Transcript of the Commission, 22 April 2024 T2285.26-34 (Schembri).
[1111] Transcript of the Commission, 22 April 2024 T2285.26-34 (Schembri); Exhibit D.90. Letter from NSLHD to M Mackay (17 April 2024) [MOH.9999.1110.0001].
[1112] Transcript of the Commission, 22 April 2024 T2285.36-45 (Schembri).

Professor Schembri contended that the Northern Sydney Local Health District does not have "a true picture of the cost buckets for the service".[1113]

817. In circumstances where Adjunct Professor Schembri did not have all the information required to make an assessment of the true cost for Royal Rehab in providing the services required of it, including details of Royal Rehab's capital needs, he agreed that Northern Sydney Local Health District's assessment of how much funding would be made available to Royal Rehab was based on a historical assessment with composite escalation for goods, services, salaries and wages.[1114] At the time he gave evidence, Adjunct Professor Schembri agreed that providing Royal Rehab with written details of the information the Local Health District required to consider a request for increased funding would be useful.[1115]

818. However, Ms Willcox gave evidence that she had been advised by the Northern Sydney Local Health District that there was no substantial gap between the service provided by Royal Rehab and the funding it received from the Local Health District to deliver those services, following an independent review of Royal Rehab's costings conducted in 2023 by Taylor Fry.[1116] That review considered the reasonableness of Royal Rehab's cost allocation procedures and the accuracy of the cost reports it provided to the Local Health District.[1117] In those circumstances, and given Adjunct Professor Schembri's evidence, it is not entirely clear how the view that there was "no material shortfall" in the funding provided to Royal Rehab was formed.

11.5.4 St Vincent's Health Network

819. St Vincent's experienced material financial pressure in the 2023-24 financial year, leading to a budget shortfall.[1118] The budget shortfall reflected inflationary pressure and skills shortages requiring additional reliance on agency staff and increased workforce costs, a slower than anticipated return to efficient operating after the COVID response, and activity pressures due to increasing demand.[1119]

[1113] Transcript of the Commission, 22 April 2024 T2286.9-14 (Schembri).
[1114] Transcript of the Commission, 22 April 2024 T2292.29-2293.6 (Schembri).
[1115] Transcript of the Commission, 22 April 2024 T2287.29-35 (Schembri).
[1116] Transcript of the Commission, 29 April 2024 T2548.39-2549.4 (Willcox); Exhibit D.129, Draft Independent review of Royal Rehab cost estimates (Taylor Fry) (13 June 2023) [SCI.0008.0082.0001].
[1117] Exhibit D.129, Draft Independent review of Royal Rehab cost estimates (Taylor Fry) (13 June 2023) [SCI.0008.0082.0001].
[1118] Exhibit G.29, Statement of Anna Mary McFadgen (4 June 2024) [63] [SVH.9999.0002.0001 at 0012].
[1119] Exhibit G.29, Statement of Anna Mary McFadgen (4 June 2024) [64] [SVH.9999.0002.0001 at 0012].

There was also approximately $12 million in costs associated with decommissioning St Joseph's Hospital Auburn in 2023 which was borne solely by St Vincent's.[1120]

820. In August 2023, St Vincent's were engaged in negotiations with the Ministry in relation to the Service Agreement for the 2023-24 financial year. When seeking approval for its interim budget, St Vincent's projected a budget deficit of $43.8 million and communicated this to the Ministry.[1121] St Vincent's proposed a plan to address the deficit through both efficiency initiatives and sustainable funding allocation from the Ministry.[1122]

821. In November 2023, St Vincent's again expressed concern about the ongoing sustainability of St Vincent's provision of health services under the proposed Service Agreement, and advised the Secretary that it would have a material budget deficit for the 2023-24 financial year, with cash constraints becoming a key risk from early 2024.[1123] Relevantly, discrepancies between the modelled budget prepared by St Vincent's during the budget delay in the early months of the 2023-24 financial year, and receipt of the Service Agreement in November 2023 (5 months after the period during which the relevant services were to be delivered had actually commenced), meant that St Vincent's had to realign and re-review its budget, in part because some of the funding St Vincent's expected to receive was not forthcoming.[1124] This presented challenges in terms of St Vincent's ability stay within its budget allocation.[1125] St Vincent's requested a formal review of its funding arrangements to ensure the ongoing sustainable provision of its services to the State.[1126]

822. On 19 February 2024, St Vincent's again wrote to the Ministry advising of a projected negative cash flow position for the remainder of the 2023-24 financial year, culminating in a $60.2 million deficit.[1127] St Vincent's noted that, without urgent support in addition to the existing 2023-24 Service Agreement, St

[1120] Transcript of the Commission, 13 June 2024 T3600.21-3601.12 (McFadgen).
[1121] Exhibit G.29, Statement of Anna Mary McFadgen (4 June 2024) [66] [SVH.9999.0002.0001 at 0012].
[1122] Exhibit G.29, Statement of Anna Mary McFadgen (4 June 2024) [66] [SVH.9999.0002.0001 at 0012].
[1123] Exhibit G.48, Letter from Board Chair SVHA to Secretary NSW Health – Future Service Agreements with SVHS (15 November 2023) [SVH.0002.0001.0280 at 0281].
[1124] Transcript of the Commission, 13 June 2024, T3596.24-27 (McFadgen).
[1125] Transcript of the Commission, 13 June 2024, T3596.35-3597.11 (McFadgen).
[1126] Exhibit G.48, Letter from Board Chair SVHA to Secretary NSW Health – Future Service Agreements with SVHS (15 November 2023) [SVH.0002.0001.0280 at 0282].
[1127] Exhibit G.29.19, AM-19 Letter from Anna McFadgen to Deputy Secretary, Financial Services – SVHNS Financial Support 2023-24 (19 February 2024) [SVH.9999.0002.0255 at 0256]; Transcript of the Commission, 13 June 2024 T3603.8-35 (McFadgen).

Vincent's would be unable to pay its staff and creditors in the fourth quarter of 2023-24.[1128] St Vincent's identified a number of efficiency improvement initiatives underway to respond to the cost pressures within the hospital, which were expected to deliver an annualised $24 million in efficiency gains; and sought supplementary funding of $60 million from NSW Health to address uncertainty in the forecast position to the end of June 2024.[1129] This request assumed that the $24 million in efficiency savings would not be achieved within the 2023-24 budgetary period.[1130]

823. St Vincent's was able to secure an additional one-off subsidy of $30 million in February 2024 on condition that St Vincent's implement a financial recovery plan, submit monthly performance reports and recoup the amount of the subsidy through efficiency initiatives in the 2024-25 financial year.[1131] St Vincent's was of the view that the subsidy would be inadequate to close the hole in its budget, noting that it had requested double the subsidised amount in its letter of 19 February 2024.[1132] It was also concerned that, accounting for the requirement to recoup the $30 million subsidy in the next financial year, St Vincent's would have a deficit of approximately $100 million going into the 2024-25 financial year.[1133]

824. On 25 March 2024, St Vincent's Hospital Sydney indicated to the Secretary that it was not in a position to execute its 2023-24 Service Agreement without a commitment from NSW Health to formally discuss the role of St Vincent's within the State healthcare system and negotiate a longer-term agreement.[1134] This reflected St Vincent's concerns in relation to a funding gap.[1135] In particular:

    a. St Vincent's was concerned that the amount of money that was to be delivered through the funding arrangement for the 2023-24 financial year

[1128] Exhibit G.29.19, AM-19 Letter from Anna McFadgen to Deputy Secretary, Financial Services – SVHNS Financial Support 2023-24 (19 February 2024) [SVH.9999.0002.0255 at 0256].
[1129] Exhibit G.29.19, AM-19 Letter from Anna McFadgen to Deputy Secretary, Financial Services – SVHNS Financial Support 2023-24 (19 February 2024) [SVH.9999.0002.0255 at 0257].
[1130] Transcript of the Commission, 13 June 2023 T3612.14-23 (McFadgen).
[1131] Exhibit G.29, Statement of Anna Mary McFadgen (4 June 2024) [67] [SVH.9999.0002.0001 at 0012]; Exhibit G.29.19, AM-19 Letter from Anna McFadgen to Deputy Secretary, Financial Services – SVHNS Financial Support 2023-24 (19 February 2024) [SVH.9999.0002.0255]; Exhibit G.29.20, AM-20 Letter from Secretary NSW Health to Anna McFadgen - Response to SVHNS Financial Support 2023-24 (28 February 2024) [SVH.9999.0002.0259].
[1132] Transcript of the Commission, 13 June 2023 T3613.32-40 (McFadgen).
[1133] Transcript of the Commission, 13 June 2023 T3616.18-46 (McFadgen).
[1134] Transcript of the Commission, 12 June 2024 T3550.2-44 (Blake); Exhibit G.29.22, AM-22 Letter from Chair SVHA to Secretary NSW Health – Funding Agreement with SVHS (25 March 2024) [SVH.9999.0002.0262].
[1135] Transcript of the Commission, 12 June 2024 T3551.6-10 (Blake).

would be insufficient to meet the costs of delivering the service required to be delivered under the agreement.[1136] This included the inflating capital maintenance and workforce costs and St Vincent's ability to deliver services in the longer term if the funding was not continuing at pace with this inflation.[1137]

b. St Vincent's was concerned about the ongoing uncertainty regarding its funding, which was preventing it from undertaking any long-term planning or having any confidence with respect to its longer-term role in the public health system.[1138] St Vincent's feared that it would be forced to cease operating if it didn't have sufficient funding, because the Board would not be able to commit to continued operations of a hospital that could not pay its expenses.[1139]

825. The 2023-24 Services Agreement with the Ministry of Health was ultimately executed, with the request that the longer-term arrangements be planned and negotiated.[1140] The Ministry decided that this issue would be worked through as part of the purchasing process for the 2024-25 financial year.[1141]

11.5.5 Other matters impacting on the funding of Affiliated Health Organisations

826. While each of the Affiliated Health Organisations that were the subject of evidence identified a variety of reasons for not receiving adequate funding to cover the costs of delivering the services required under their Service Agreements, four key matters emerged regarding how the Ministry and Local Health Districts engaged with them.

a. The service agreement process

827. The evidence supports a conclusion that the current processes for negotiating Service Agreements with Affiliated Health Organisations should be revised to ensure transparency in budget allocations and support service planning by Affiliated Health Organisations.

[1136] Transcript of the Commission, 12 June 2024 T3551.36 (Blake).
[1137] Transcript of the Commission, 12 June 2024 T3551:45-3552.9 (Blake).
[1138] Transcript of the Commission, 12 June 2024 T3550.35-44 (Blake).
[1139] Transcript of the Commission, 12 June 2024 T3550.15-27; T3553:4 (Blake).
[1140] Transcript of the Commission, 12 June 2024 T3552.23-27 (Blake).
[1141] Exhibit G.103, Statement of Matthew Daly (6 June 2024) [17]-[18] [MOH.9999.1290.0001 at 0004].

828. Despite the general position that (with the exception of the St Vincent's Network) Local Health Districts were responsible for managing Affiliated Health Organisations, there was a lack of clarity as to how budgets were set and whether the relevant Local Health District or the Ministry that was ultimately responsibility for them.[1142] For example:

a. while Karitane was of the view that it was the South Western Sydney Local Health District who *allocated* the funding under its service agreements,[1143] both South Western Sydney Local Health District and the Ministry advised Karitane that it was the other who *set* the budget.[1144]

b. both the Ministry and Northern Sydney Local Health District took the position that they were not responsible for facilitating increases to Royal Rehab's funding,[1145] with Royal Rehab being referred to the Local Health District by the Ministry for funding discussions; yet the Local Health District advised Royal Rehab that any increase in funding needed to come from the Ministry.[1146] To this end, the Local Health District offered support to Royal Rehab in putting together a business case for the Ministry of Health to seek more funding.[1147]

829. It is not entirely clear why such a lack of clarity should exist; it is likely contributed to by adherence to the devolved structure of decision-making that does not effectively account for the unique circumstances of Affiliated Health Organisations. As noted by Karitane, in practice, funding is *allocated* to an Affiliated Health Organisation by the relevant Local Health District. However, in the context of fully allocated Local Health District budgets, supplemental or increased funding for Affiliated Health Organisations necessitates a commensurate increase in funding to the Local Health District.

830. Further, the true level of "negotiation" in relation to yearly budget allocation is not readily apparent. Whilst there may be meetings between the Local Health District and the Affiliated Health Organisation, the evidence supports a conclusion that there is no real process of "negotiation" as to the funding to be

[1142] Transcript of the Commission, 18 April 2024 T2039.39-2040.10 (O'Loughlin); T2116.32-2117.15 (Mackay).
[1143] Transcript of the Commission, 18 April 2024 T2039.3-14 (O'Loughlin).
[1144] Exhibit D.121, Outline of Evidence for Grainne O'Loughlin (11 April 2024) [25] [SCI.0008.0343.0001 at 0004].
[1145] Transcript of the Commission, 18 April 2024 T2116.32-2117.15 (Mackay).
[1146] Transcript of the Commission, 18 April 2024 T2114.19-26; T2116.32-2117.15 (Mackay).
[1147] Transcript of the Commission, 18 April 2024 T2116.38-43 (Mackay).

provided to the Affiliated Health Organisation to provide the services for which the funding is being provided.[1148] To an extent, the experience of some Affiliated Health Organisation was similar to that of some Local Health Districts and their own funding "negotiations" with the Ministry.

831. However, dealing with Affiliated Health Organisations in that way fails to adequately account for the fact that, whilst statutorily part of the public health system, they are neither a NSW Health nor a government agency. That failure is reflected in the manner in which Local Health Districts, and Ministry generally, responded to the suggestion that Affiliated Health Organisations were underfunded.

832. For example, in response to Royal Rehab providing details of its funding shortfalls to Northern Sydney Local Health District,[1149] it was told that it was "being looked after" and was "lucky" to receive the funding it was allocated, because the Local Health District did not pass on the efficiency targets that Local Health Districts are required to achieve.[1150] A similar sentiment was present in the evidence of Mr Daly, who suggested that Affiliated Health Organisations such as Royal Rehab were "shielded" from the efficiency targets passed on from NSW Treasury to NSW Health by the Local Health District that funded them,[1151] and that this would require "the sacrifice of other Local Health District activity".[1152] None of those responses engage with the fundamental issue; that is, whether Affiliated Health Organisations are receiving a level of funding that is adequate to cover the cost of delivering services that they are required to deliver under Service Agreements.

833. The short-term nature of the agreements identified by others also impact on the ability of Affiliated Health Organisations to engage in long-term planning.[1153] For example, St Vincent's pointed to the example of a public hospital it operated in Victoria which is funded through a 20-year agreement, with annual priorities set within the term of each financial year as well as an annual capital funding

[1148] See, for example, Exhibit D.123, Outline of Evidence for Matthew Mackay (11 April 2024) [15] [SCI.0008.0341.0001 at 0003]; Transcript of the Commission, 18 April 2024 T2107.57-2108.11, T2117.17-28, T2125.7-29 (Mackay); Transcript of the Commission, 22 April 2024 T2283.23-2284.24 (Schembri).
[1149] Transcript of the Commission, 18 April 2024 T2112.42-2113.8 (Mackay).
[1150] Transcript of the Commission, 18 April 2024 T2113.20-24, T2114.7-17 (Mackay).
[1151] Transcript of the Commission, 29 April 2024 T2519.1-16 (Daly).
[1152] Transcript of the Commission, 29 April 2024 T2523.26-34 (Daly).
[1153] Transcript of the Commission, 18 April 2024 T2060.1-13 (Mills); Transcript of the Commission, 12 June 2024 T3549.41-47 (Blake); Transcript of the Commission, 13 June 2024 T3623.34-3624.3 (McFadgen).

allocation.[1154] In St Vincents' view, there were clear advantages to this type of longer arrangement, principally being the level of confidence for long-term planning. It also provided additional confidence for the Board of St Vincent's, which has governance obligations relating to solvency.[1155]

834. In addition to the uncertainty created by short-term funding, in some instances when service agreements are due for renewal funding for Affiliated Health Organisations ceases until a new service agreement is entered into, notwithstanding services continue to be provided. [1156] As a result of this approach, at the beginning of each financial year whilst negotiations were underway, Tresillian had been left to pay at least $2 million out of its own reserves to pay staff wages in circumstances where it continued to provide services during a period where it received no funding.[1157] Notwithstanding that funding may be ultimately received, the cessation of funding during that period puts unnecessary financial pressure on a not-for-profit organisation. It is difficult to conceive of any good reason why such a state of affairs should arise. One explanation for it may be that, notwithstanding that equivalent agreements between the Local Health District and Ministry cover a financial year – they are regularly signed well into the year in respect of which they apply. However, none of that is within the control of an Affiliated Health Organisation and steps should be taken to ensure that the practice ceases.

835. That such circumstances arise is yet another example of Affiliated Health Organisations being approached as if they were NSW Health or government agencies; rather than independent organisations. Moving forward, the approach taken to engaging with Affiliated Health Organisations must reflect that reality.

b. "Own source" funding

836. The budgets allocated to some Affiliated Health Organisations include "own source funding" targets - being funds derived by that organisation from sources other than NSW Health agencies – such as philanthropy, private patient

[1154] Transcript of the Commission, 12 June 2024 T3548.4-35 (Blake).
[1155] Transcript of the Commission, 12 June 2024 T3548.32-42 (Blake).
[1156] Exhibit D.122, Outline of Evidence for Robert Mills (11 April 2024) [26] [SCI.0008.0344.0001 at 0008-0009]; Transcript of the Commission, 18 April 2024 T2060.33-2061.10 (Mills).
[1157] Exhibit D.122, Outline of Evidence for Robert Mills (11 April 2024) [26] [SCI.0008.0344.0001 at 0008-0009]; Transcript of the Commission, 18 April 2024 T2060.33-2061.24 (Mills).

revenue or grants. Other Affiliated Health Organisations had to use those funding streams to supplement the shortfall in funding received pursuant to service agreements. Whichever scenario, it was clear from the evidence that a significant amount of privately sourced funding was used to ensure the sustainability and viability of public health services operated by Affiliated Health Organisations.

837. For example, Karitane's 2023-24 Service Agreement with South Western Sydney Local Health District allocated a figure of just over $1 million in own source funding. This own source funding was to be derived from Karitane's alternate revenue streams, including philanthropy, grants and private health insurance, and, in Karitane's view, was a mechanism for propping up the services to be provided under the Service Agreement.[1158]

838. Similarly, Royal Rehab's agreement with Northern Sydney Local Health District also incorporated an amount of 'own source funding', which was derived from patient fee revenue, and was deducted from the funding provided by the Local Health District for the services in the agreement.[1159] For the 2023-24 financial year, the 'own source revenue' target was $4,179,768, and related predominantly to patient payments, including from private health insurance and compensable motor vehicle insurance.[1160] According to Royal Rehab, the allocated 'own source funding' target was not the subject of discussion or negotiation and was pre-determined by the Local Health District using a methodology unknown to Royal Rehab.[1161]

839. Pausing there, the inclusion of own source revenue targets is consistent with budget allocations between the Ministry and Local Health Districts.

840. Although not subject to "own source revenue" targets, Tresillian had to pull resources from its "other funding buckets",[1162] including funding from grants, philanthropy and private health fund revenue,[1163] to bridge the shortfall between the cost of delivering the services required of it and the funding provided to it

[1158] Transcript of the Commission, 18 April 2024 T2042.7-10 (O'Loughlin).
[1159] Exhibit D.123, Outline of Evidence for Matthew Mackay (11 April 2024) [17] [SCI.0008.0341.0001 at 0004]; Exhibit D.35, Letter from Jacquie Ferguson, NSLHD to Matthew Mackay, Royal Rehab attaching budget for Royal Rehab for 2023-24 (17 October 2023) [SCI.0008.0027.0001]; Transcript of the Commission, 18 April 2024 T2126.16-24 (MacKay).
[1160] Transcript of the Commission, 22 April 2024 T2288.28-33 (Schembri).
[1161] Exhibit D.123, Outline of Evidence for Matthew Mackay (11 April 2024) [17] [SCI.0008.0341.0001 at 0004].
[1162] Transcript of the Commission, 18 April 2024 T2062.12-20 (Mills).
[1163] Transcript of the Commission, 18 April 2024 T2085.31-45 (Mills).

for that purpose. St Vincent's has been required to subsidise service delivery as a result of the inadequacies in funding pursuant to its service agreement by accessing funding from philanthropic sources.[1164] However, this was difficult from a governance perspective, because its philanthropic funding is predominantly tied to research, education, ongoing professional development, and capital development projects, and is not available to supplement any part of the Network experiencing funding shortfalls.[1165]

841. There is arguably a distinction to be drawn between own source revenue that is unrelated to the services provided pursuant to a Services Agreement (such as philanthropy, grants, private patient fees), and patient fees received in relation to services provided in furtherance of the Service Agreement. To the extent that the Affiliated Health Organisation is fully funded to provide a service,[1166] it is reasonable that any patient fees received that relate to that service are accounted for.

842. However, to the extent that an Affiliated Health Organisation is required to utilise other own source revenue streams to meet the costs of delivering services under a Service Agreement that are otherwise unfunded (in the sense that the funding provided does not cover the cost of delivery), the justification for requiring those organisations to resort to "own source funding" falls away. For example, there is no apparent reason why philanthropic funds donated to not-for-profit organisations should be utilised to subside the delivery of public health services in circumstances where funding provided by the State does not meet the cost of delivering them. It is one thing to direct that kind of funding to additional or other services that are not captured by a Services Agreement,[1167] it is quite another for those funds to be directed to meeting shortfalls in State funding.

c. Activity based funding model

843. Consistently with the position of several Local Health Districts, some Affiliated Health Organisations highlighted the limitations of the activity based funding

[1164] Transcript of the Commission, 13 June 2024 T3592:41 (McFadgen).
[1165] Transcript of the Commission, 13 June 2024 T3594.2-13 (McFadgen).
[1166] Transcript of the Commission, 22 April 2024, T2288.45-47 (Schembri).
[1167] Transcript of the Commission, 29 April 2024 T2520.18-46 (Daly).

model to accurately capture the cost of delivering highly specialised and complex care.[1168]

844. In apparent recognition of the limitations of the activity based funding model insofar as it is applied to determining funding to Affiliated Health Organisations, Royal Rehab has historically received an annual "transitional grant".[1169] Even with the additional funding from transitional grants, Royal Rehab had been required to use its own source funding to patch "holes" in service delivery that are not recognised or funded by the Local Health District.[1170]

845. Consistent with the experience of Royal Rehab, perceived funding deficiencies stemming from activity based funding have also put pressure on St Vincent's to change its model of care and work with other community services to secure alternative funding in order to continue providing public hospital services.[1171] Relevantly, due to St Vincent's concentration of complex patients requiring highly specialised services, the deficiencies of the activity based funding model were said to be more concentrated; making a significant contribution toward the network's budgetary challenges.[1172]

11.5.6 Capital funding

846. Some Affiliated Health Organisations also highlighted a lack of funding for capital investment and maintenance, which can create financial pressure for Affiliated Health Organisations, which are required to self-fund capital upgrades, maintenance and replacements needed for the delivery of services under service agreements. In this respect, Royal Rehab identified the tension in current arrangements that expect it to operate as if it were a public facility, despite having to fund its own capital requirements whilst paying the State for a wide range of services incidental to its operations; including technology service charges, training services, pathology and eHealth.[1173]

[1168] Exhibit G.29, Statement of Anna Mary McFadgen (4 June 2024) [58]-[59], [62] [SVH.9999.0002.0001 at 0010-0011]; Transcript of the Commission, 18 April 2024 T2122.5-12 (MacKay); Transcript of the Commission, 13 June 2024 T3591.22-3592.1, T3589.41-3591.5, T3604.33-45 (McFadgen).
[1169] Transcript of the Commission, 18 April 2024 T2109.45-2110.43; 2111.27-30 (Mackay); Transcript of the Commission, 29 April 2024 T2548.7-17 (Willcox).
[1170] Transcript of the Commission, 18 April 2024 T2107.13-27 (Mackay).
[1171] Transcript of the Commission, 13 June 2024 T3592:32 (McFadgen).
[1172] Transcript of the Commission, 13 June 2024 T3591:37; T3605:1 (McFadgen).
[1173] Exhibit D.123, Outline of Evidence for Matthew Mackay (11 April 2024) [23] [SCI.0008.0341.0001 at 0005]; Transcript of the Commission, 18 April 2024 T2115.38-2116.4 (Mackay).

847. Similarly, the uncertainty of capital funding was of significant concern to St Vincent's in light of its substantial recurring capital costs for which it does not have the ability to plan long-term. When representatives of St Vincent's gave evidence in June 2024, much of its infrastructure had been maintained at its own cost but was reaching end of life and requiring investment similar to that received by other public facilities of a similar age and size.[1174] The lack of capital infrastructure investment was a principal factor in the closure of St Joseph's Hospital in Auburn, which had been operated by St Vincent's as a public hospital since 1882.[1175] The decision to decommission St Joseph's Hospital was made in June 2023 following a significant period of financial loss and concerns that the physical infrastructure could no longer support the level of contemporary care expected by patients and the community.[1176]

848. This lack of capital investment had continued under St Vincent's 2023-24 service agreement with the Ministry of Health, under which it was allocated a total of $105,000 in capital funding pursuant to NSW Health's asset replacement and refurbishment program. This amount was manifestly insufficient to maintain the infrastructure and equipment of St Vincent's public hospital in line with community expectations about the level of care which could be offered by the Network.[1177] Due to the limited capital funding received by St Vincent's, it needed to use operational funding to supplement its capital, including asset management and facilities maintenance.[1178]

849. For St Vincent's, security of capital funding was critical to enable the planning of services in the longer term, and to allow planning of refurbishment and investment in assets.[1179] Without this security, there was a tendency toward a 'break and fix' cycle, whereby capital investment only went toward end of life equipment and infrastructure to prevent a discontinuation of services.[1180] St Vincent's was subject to the same capital planning process applied to all Local Health Districts and Specialty Health Networks, which involved the

[1174] Exhibit G.29, Statement of Anna Mary McFadgen (4 June 2024) [53] [SVH.9999.0002.0001 at 0009].
[1175] Exhibit G.29, Statement of Anna Mary McFadgen (4 June 2024) [70], [75] [SVH.9999.0002.0001 at 0013-0014].
[1176] Exhibit G.29, Statement of Anna Mary McFadgen (4 June 2024) [71]-[74] [SVH.9999.0002.0001 at 0013-014].
[1177] Exhibit G.29, Statement of Anna Mary McFadgen (4 June 2024) [53] [SVH.9999.0002.0001 at 0008].
[1178] Transcript of the Commission, 13 June 2023 T3614.36-45 (McFadgen).
[1179] Transcript of the Commission, 12 June 2024 T3549.5-20 (Blake).
[1180] Transcript of the Commission, 12 June 2024 T3549.22-33 (Blake).

consideration of any capital bids as part of the annual budget and prioritisation process within the Ministry.[1181]

850. The evidence supports a conclusion that the existing processes for Affiliated Health Organisations to secure capital funding would benefit from improved transparency and certainty to promote longer-term capital planning. Capital investment is an essential part of healthcare service delivery and for Affiliated Health Organisations, several, of which operate facilities and equipment solely or primarily for the public health system, there are significant budgetary and governance implications if they are unable to maintain the capital required to operate their services. Those risks flow to the public system as a whole, which is heavily reliant on those organisations for the delivery of a range of services, including highly specialised services.

11.6 Management and funding services delivered by Affiliated Health Organisations

851. There are a range of different arrangements under which Affiliated Health Organisations receive funding, including:

a. Service agreement directly with the Ministry of Health, for instance the agreement between the Ministry of Health and Tresillian and Karitane in relation to their virtual residential parenting service; and/or

b. Service agreements with each Local Health District under which the Affiliated Health Organisation, for instance the multiple agreements between Tresillian and each Local Health District in which it operates its Family Care Centres; and/or

c. A service agreement with the Local Health District in which the Affiliated Health Organisation is based and/or delivers the majority of its services, for instance the agreement between Royal Rehab and Northern Sydney Local Health District.

852. In the 2023-24 financial year Tresillian provided services pursuant to at least 11 Local Health District-level Service Agreements, as well as additional Service Agreements with the Ministry of Health. A number of the Local Health District

[1181] Exhibit G.104, Statement of Deb Willcox (6 June 2024) [33] [MOH.9999.1297.0001 at 0005].

Service Agreements had been continued from previous financial years by way of complex deeds of variation negotiated between Tresillian and each Local Health District.[1182] There was added complexity in that the Ministry funded a number of Tresillian regional centres, pursuant to a Service Agreement with the Ministry, whilst the specifics of service delivery were set out in separate Service Agreements with each Local Health District in which the statewide service was intended to operate. [1183]

853. The numerous split funding arrangements led to inconsistencies and issues around security of staff for Tresillian.[1184] It also increased the administrative burden on that organisation in dealing with multiple Local Health Districts and the Ministry.[1185] The administrative burden of that volume of Service Agreements was increased by the time-limited nature of many of those agreements. [1186]

854. Local Health Districts enjoy obvious advantages in being able to assess the needs of their respective communities more directly than Ministry.[1187] However, where a service is being delivered statewide, there appears to be clear benefit in that service being administered by the Ministry (with appropriate input from each of the Local health Districts through the planning process described elsewhere in this outline as to the nature and extent of the particular services to be provided within their respective footprints), rather than the existing arrangement.[1188]

855. In circumstances where a service is being delivered statewide, and well beyond the borders of the Local health District responsible for administering that service – the significance of that local knowledge is less apparent.[1189] That is particularly so give that Local Health Districts where those services are to be delivered could (and should) still form an integral part of the process with respect to service planning and identifying population need within their own

[1182] Transcript of the Commission, 18 April 2024 T2053.32-36 (Mills).
[1183] Transcript of the Commission, 18 April 2024 T2053.38-2054.4; T2057.23-43; T2083.31-2084.15 (Mills).
[1184] Exhibit D.122, Outline of Evidence of Robert Mills (11 April 2024) [26] [SCI.0008.0344.0001 at 0008-0009].
[1185] Transcript of the Commission, 18 April 2024 T2058.39 (Mills).
[1186] Transcript of the Commission, 18 April 2024 T2058.42-2059.19 (Mills).
[1187] Transcript of the Commission, 29 April 2024 T2573.2-23 (Danos).
[1188] Transcript of the Commission, 18 April 2024 T2086.18-27 (Mills); T2118.26-47 (MacKay); T2126.32-36 (MacKay); Transcript of the Commission, 13 June 2024 T3570.16-38 (McFadgen); Exhibit D.121, Outline of Evidence for Grainne O'Loughlin (11 April 2024) [26] (Willcox).
[1189] Cf Transcript of the Commission, 29 April 2024 T2525.17-2526.19 (Daly).

locality, there would not appear to be any impediment to the Ministry of Health being the administrator, negotiator and funder of the service agreements for statewide services.

856. In this respect, Ms Willcox saw "absolute efficiency and logic" in Affiliated Health Organisations that provide services across a range of Local Health Districts having a single service agreement with the Ministry of Health, rather than through a particular Local Health District, or with each of the different Local Health District where they operate services.[1190]

857. However, Ms Willcox also noted that, under the current system, the Affiliated Health Organisations were embedded in Local Health District[1191]

858. As noted by Ms Willcox, this would appear to be a more efficient manner of implementing agreements for statewide services, by limiting the number of negotiated service agreements between Local Health Districts in relation to the same services, but which have the potential to have inconsistencies with respect to funding and governance. Similarly, for those statewide services which are currently managed by a single LHD, there are benefits to be gained from the centralised oversight of NSW Health with respect to population need and service gaps, as well as increased budgetary flexibility.

859. Such an approach would also support wider, strategic, system planning. At present, there is limited centralised or collaborative service planning relating to the services provided by Affiliated Health Organisations. The evidence suggests that the expansion of services operated by Affiliated Health Organisations, and the implementation of new measures to meet service gaps, is generally Affiliated Health Organisation-led and based on internal planning and strategy.[1192]

860. Karitane gave evidence that, whilst its annual internal strategic planning process involved Karitane's Board of Directors consulting with NSW Health on strategic plans and reforms, this was limited to ensuring that the strategic priorities and reforms were aligned and was not a collaborative process.

[1190] Transcript of the Commission, 29 April 2024 T2551.15-24 (Willcox).
[1191] Transcript of the Commission, 29 April 2024 T2553.5-17 (Willcox).
[1192] See, for example, Transcript of the Commission, 18 April 2024 T2044.32-41 (O'Loughlin), T2055.42-2056.5 (Mills); Transcript of the Commission, 24 April 2024 T2419.35-2420.10 (Middleton).

Karitane also indicated that, where it identified a gap in service delivery and funding was available, it would open the required service. This type of expansion of services was not subject of any centralised planning, though Karitane would consult with the relevant local Local Health District and other stakeholders to ensure the services it was operating were symbiotic and did not duplicate existing services.[1193]

861. The St Vincent's Health Network, as a networked Affiliated Health Organisation, is in a somewhat different position to other Affiliated Health Organisations given its greater level of integration within the Ministry. In this respect, the St Vincent's Health Network was involved in the Ministry of Health's clinical service planning process in the same capacity as other Local Health Districts, including participating forums, committees, structures and processes involved in clinical planning.[1194] St Vincent's also had joint planning committees with its neighbouring Local Health Districts and local primary health networks. St Vincent's has met regularly with these committees throughout the year and undertaken joint needs assessments and analyses to inform the provision of services to the collective catchment.[1195] The local Head of Strategy and Planning at St Vincent's was also part of the statewide planning network administered by the Ministry of Health, which had oversight of planning data that may impact the planning of Local Health Districts.[1196]

862. Mr Mackay, Chief Executive of Royal Rehab Group, expressed the view that the limitation of the current operational mode, whereby service planning and funding for spinal cord injury rehabilitation falls under the jurisdiction of only one Local Health District, was not sufficient to ensure services were distributed in areas of need across the state.[1197] Mr Mackay suggested that a hub and spoke model involving a statewide spinal cord injury and rehabilitation service would create better outcomes for patients.[1198]

863. Karitane, Tresillian and St Vincent's agreed that there would be benefits to centralising decision-making relating to service planning and funding within

[1193] Transcript of the Commission, 18 April 2024 T2044.32-41 (O'Loughlin).
[1194] Transcript of the Commission, 13 June 2024 T3567.32-3568.6, T3573.2 (McFadgen).
[1195] Transcript of the Commission, 13 June 2024 T3568.17-32; T3569.38-44 (McFadgen).
[1196] Transcript of the Commission, 13 June 2024 T3569.19-28 (McFadgen).
[1197] Transcript of the Commission, 18 April 2024 T2117.33-2118.24 (Mackay).
[1198] Transcript of the Commission, 18 April 2024 T2118.18-24 (Mackay).

NSW Health. In particular, Karitane and Tresillian gave evidence that a centralised model would yield better results with respect to equitable, transparent, timely, and data-driven resource allocation and funding, and would ensure the locations of Affiliated Health Organisation services met specific identified needs.[1199]

864. St Vincent's agreed that there was significant benefit to the centralisation of health in New South Wales, to enable coordination, cohesion and service provision planning, particularly in the context of scarce resources in the health system.[1200] Increasing centralisation presented opportunities for collaboration and the scaling of novel ideas and new models of care, as well as the identification of gaps in the services offered across the state.[1201] In St Vincent's view, a system-wide focus on prevention and diversion was an essential part of service planning, including in the identification of opportunities for system reform and where scarce resources may be best allocated.[1202]

11.7 Schedule 3 of the *Health Services Act*

865. Schedule 3, Column 2 of the *Health Services Act* has not kept up to date with the changing service offerings of the Affiliated Health Organisations listed in Column 1, including with respect to services and establishments for which Affiliated Health Organisations have received funding pursuant to service agreements with LHDs and the Ministry of Health. Whilst this has had limited practical impact for some Affiliated Health Organisations, others have been left with additional operational costs and liability risks, creating an apparent inconsistency in the treatment of Affiliated Health Organisations within the public health system.

866. For Karitane, the recognised establishments and services in Schedule 3 Column 2 do not reflect the full range of its current service offerings pursuant to service agreements with the State, instead encapsulating only "[c]hild and family health services at Carramar, Fairfield, Liverpool and Randwick".[1203] That description does not recognise the services Karitane provides at Campbelltown

[1199] Exhibit D.121, Outline of Evidence for Grainne O'Loughlin (11 April 2024) [26] [SCI.0008.0343.0001 at 0005]; Transcript of the Commission, 18 April 2024 T2086.18-27 (Mills).
[1200] Transcript of the Commission, 13 June 2024 T3570.16-38 (McFadgen).
[1201] Transcript of the Commission, 13 June 2024 T2571.3-15 (McFadgen).
[1202] Transcript of the Commission, 13 June 2024 T3574.6-24 (McFadgen).
[1203] *Health Services Act 1997* (NSW) Sch 3.

Hospital and at the Oran Park Integrated Care Hub, nor the fact that Karitane is required to provide these services pursuant to its 2023-24 service agreement with South Western Sydney Local Health District. It also does not include the virtual residential parenting service or virtual home visit service funded directly by the Ministry of Health, nor any perinatal, infant and child mental health services which Karitane is also funded to provided.[1204] Karitane also has not operated a service in Liverpool since 2018, though this location remains on the Schedule.[1205]

867. The Chief Executive of Karitane, Ms Grainne O'Loughlin, was not aware of any changes being made to Schedule 3 in relation to Karitane since she commenced in the role in 2014.[1206] This is despite the discrepancies being raised with NSW Health by both Karitane and the Health Services Association.[1207]

868. Tresillian's recognised establishments and services pursuant to Schedule 3 Column 2 are location-based and include "Tresillian Family Care Centres at Belmore, Broken Hill, Coffs Harbour, Dubbo, Lismore, Penrith, Queanbeyan, Taree, Willoughby and Wollstonecraft".[1208] However, again, this list of recognised establishments and services is not consistent with each of the services Tresillian is presently funded to provide by either NSW Health or the Local Health Districts. In the past, Tresillian has had some success in seeking amendments to Schedule 3, adding its Lismore Centre, and Broken Hill, Dubbo, Taree, Queanbeyan, and Coffs Harbour locations to Schedule 3, Column 2 in 2018 and 2020 respectively.[1209] This was achieved through email correspondence to the NSW Health legal branch attaching a copy of the relevant service agreements and seeking that the Schedule be updated accordingly.[1210]

[1204] Transcript of the Commission, 18 April 2024 T2017.39-44 (O'Loughlin).
[1205] Exhibit D.121, Outline of Evidence of Grainne O'Loughlin (11 April 2024) [12] [SCI.0008.0343.0001 at 0002].
[1206] Transcript of the Commission, 18 April 2024 T2017.46-2018.8 (O'Loughlin).
[1207] Transcript of the Commission, 18 April 2024 T2018.10-15 (O'Loughlin).
[1208] *Health Services Act 1997* (NSW) Sch 3.
[1209] Exhibit D.122. Outline of Evidence of Robert Mills (11 April 2024) [7] [SCI.0008.0344.0001 at 0003]; Exhibit D.100, Health Services Amendment (Royal Society for the Welfare of Mothers and Babies) Order 2020 under the *Health Services Act 1997* (NSW) (18 March 2020) [SCI.0008.0117.0001]; Exhibit D.101, Email correspondence between Robert Mills and Ministry of Health (A/Principal Solicitor) re Tresillian amendment to Sch 3 *Health Services Act 1997* (NSW) [SCI.0008.0118.0001_R].
[1210] Transcript of the Commission, 18 April 2024 T2068.17-2069.7 (Mills).

869. However, in 2021, when Tresillian subsequently expanded its service to include seven further sites in line with its service agreement with the Ministry of Health, the Ministry of Health refused to add these locations to Schedule 3,[1211] advising Tresillian that it would be required to make a business case to be assessed through the Prevention and Response to Violence, Abuse and Neglect Branch or the Health and Social Policy Branch of the Ministry. This was the first occasion that such an approach had been adopted in relation to Schedule 3.[1212]

870. Tresillian has sought to have Schedule 3 amended to accurately reflect its services that are delivered under service agreements with NSW Health agencies, without success. In February 2022, a proposal from Tresillian that its Column 2 services be amended to remove the locations of services and insert a more generic reference to "Tresillian Family Care Centres" in a similar way to the Column 2 descriptors for the NSW Service for the Treatment and Rehabilitation of Torture and Trauma Survivors and Royal Rehab was rejected.[1213] In December 2022, an alternate proposal that Column 2 for Tresillian be amended to include "Tresillian Family Care services in NSW conducted under written agreements with the NSW Ministry of Health, the Health Administration Corporation or a Local Health District" was also rejected.[1214]

871. Having regard to correspondence issued at the time by the then Minister for Health, it is apparent that the reasons for rejecting Tresillian's proposals were as follows:

    a. In relation to the February 2022 proposal, that for services to be included in the Schedule, an Affiliated Health Organisation was required to have recurrent or ongoing funding (rather than time limited funding, such as the 2-year funding agreement for Tresillian's seven additional sites).[1215]

[1211] Exhibit D.122, Outline of Evidence of Robert Mills (11 April 2024) [7] [SCI.0008.0344.0001 at 0003].
[1212] Exhibit D.122, Outline of Evidence of Robert Mills (11 April 2024) [8] [SCI.0008.0344.0001 at 0003]; Transcript of the Commission, 18 April 2024 T2071.7-38 (Mills).
[1213] Exhibit D.122, Outline of Evidence of Robert Mills (11 April 2024) [9] [SCI.0008.0344.0001 at 0003]; Exhibit D.105, Letter from Minister Hazzard to Robert Mills, Tresillian AHO re iCare insurance cover (28 February 2022) [SCI.0008.0123.0001].
[1214] Exhibit D.122, Outline of Evidence of Robert Mills (11 April 2024) [12]-[13] [SCI.0008.0344.0001 at 0004-0005]; Exhibit D.109, Letter from Minister Hazzard to Ms Dowling, Health Services Association B22/1127 dated 20 December 2022 [SCI.0008.0127.0001].
[1215] Exhibit D.122, Outline of Evidence of Robert Mills (11 April 2024) [11] [SCI.0008.0344.0001 at 0004]; Exhibit D.105, Letter from Minister Hazzard to Robert Mills, Tresillian AHO re iCare insurance cover (28 February 2022) [SCI.0008.0123.0001]; Transcript of the Commission, 18 April 2024 T2073.29-2074.19 (Mills).

b. In relation to the December 2022 proposal, that there were "inherent issues" with the proposal,[1216] including that, if implemented, the amendment to the Schedule would create funding uncertainty for Tresillian's existing recognised services.[1217]

872. The suggestion that, to be included in Column 2, services must receive recurrent funding does not sit comfortably with what has occurred in practice, or the statutory regime. In this respect, as noted above - Affiliated Health Organisations are largely funded pursuant to periodic service agreements, which carry no guarantee of future funding of themselves.[1218] There are also a number of services noted in Schedule 3 despite having permanently ceased operations, including Karitane's Liverpool parenting centre and Tresillian's Willoughby centre, and thus receive no funding despite their inclusion.[1219] Further, and significantly, s 129 of the *Health Services Act* contemplates that an Affiliated Health Organisation may not receive a subsidy in relation to a recognised establishment or service.[1220]

873. There are material consequences for Affiliated Health Organisations if their services are not recorded in Schedule 3. For example, the Ministry of Health's 'Accounts and Audit Determination for Public Health Entities in NSW' requires that Affiliated Health Organisations participate in the NSW Treasury Managed Fund insurance scheme (iCare) and not enter into other insurance contracts, unless otherwise approved by the Treasurer.[1221] The determination is generally included in service agreements as a "key condition" of the subsidy.[1222]

874. Despite the requirements of the determination, in 2021, Tresillian was advised by the Ministry that its iCare Certificate of Currency could not be amended to cover services or establishments which were not included in Schedule 3, even

[1216] Exhibit D.109, Letter from Minister Hazzard to Ms Dowling, Health Services Association B22/1127 (20 December 2022) [SCI.0008.0127.0001].
[1217] Exhibit D.122, Outline of Evidence of Robert Mills (11 April 2024) [13]-[14] [SCI.0008.0344.0001 at 0005]; Transcript of the Commission, 18 April 2024 T2077.46-2078.28 (Mills).
[1218] Exhibit D.122, Outline of Evidence of Robert Mills (11 April 2024) [11] [SCI.0008.0344.0001 at 0004]; Exhibit D.105, Letter from Minister Hazzard to Robert Mills, Tresillian AHO re iCare insurance cover (28 February 2022) [SCI.0008.0123.0001]; Transcript of the Commission, 18 April 2024 T2074.47-2075.34; T2078.23-2079.6 (Mills).
[1219] Transcript of the Commission, 18 April 2024 T2074.3-16 (Mills).
[1220] The inclusion of the words "if any" in subsections (a) and (b) clearly contemplate that a decision may be made not to pay any subsidy in relation to a recognised establishment or service. That tells strongly against the notion that inclusion in Schedule 3 gives rise to a requirement to pay "recurrent funding".
[1221] Exhibit D.95, NSW Ministry of Health - Accounts and Audit Determination for Public Health Entities in NSW – effective 9 March 2020 [SCI.0008.0112.0001 at 0010]; Transcript of the Commission, 18 April 2024 T2065.19-46 (Mills).
[1222] Transcript of the Commission, 18 April 2024 T2065.6-17 (Mills); see, for example, Exhibit D.80, Service Agreement 2023-24 between SWSLHD and Karitane [1.1.4] [SCI.0008.0169.0001 at 0008]; Exhibit D.96, Service Agreement 2023-24 between SLHD and Tresillian [1.1.4] [SCI.0008.0113.0001 at 0006].

where those services and establishments were funded by NSW Health pursuant to a service agreement. The rationale for this advice was that, under the *Health Services Act*, an Affiliated Health Organisation is only recognised in respect of their services or institutions listed in Column 2 of the Schedule.[1223]

875. The Ministry and iCare's position was confirmed in February 2022, and again in December 2022, when Minister Hazzard advised Tresillian that unified iCare coverage of its services would only be possible if all the services were listed in Column 2 of the Schedule.[1224] Minister Hazzard suggested that additional insurance costs in relation to the services not included in Column 2 of Schedule 3 were a matter "to raise with the relevant funding entities as part of funding negotiations about the cost of services".[1225]

876. The position adopted to date produces the unusual circumstance that Affiliated Health Organisation operated hospital beds funded by NSW Health and located within public hospitals are not listed as recognised services in Column 2 of Schedule 3, nor subject to iCare insurance coverage.[1226] In practical terms, the Affiliated Health Organisation in that circumstances is not considered to be part of the public health system, as it does not fall within the scope of s 6 of the *Health Services Act*, yet was purporting to admit inpatients to a facility it operated within a public hospital.[1227] That circumstances is at least undesirable, and exposes the Affiliated Health Organisation to material risk if an adverse incident were to occur.[1228]

877. It also placed an additional financial burden on Affiliated Health Organisations in that situation.[1229] For example, Tresillian's iCare Certificate of Currency for 2023-24 expressly noted that Tresillian is only insured for its recognised

[1223] Exhibit D.122, Outline of Evidence of Robert Mills (11 April 2024) [8] [SCI.0008.0344.0001 at 0003]; Exhibit D.102, Email correspondence between Robert Mills and Ministry of Health re Coverage Tresillian - ACT, Wagga and Macksville (November 2021) [SCI.0008.0119.0001]; Transcript of the Commission, 18 April 2024 T2070.11-33 (Mills).
[1224] Exhibit D.122, Outline of Evidence of Robert Mills (11 April 2024) [10], [16] [SCI.0008.0344.0001 at 0004, 0006]; Exhibit D.105, Letter from Minister Hazzard to Robert Mills, Tresillian AHO re iCare insurance cover (28 February 2022) [SCI.0008.0123.0001].
[1225] Exhibit D.122, Outline of Evidence for Robert Mills (11 April 2024) [16] [SCI.0008.0344.0001]; Exhibit D.109, Letter from Minister Hazzard to Ms Dowling, Health Services Association B22/1127 (20 December 2022) [SCI.0008.0127.0001]; Transcript of the Commission, 18 April 2024 T2079.8-20 (Mills).
[1226] Exhibit D.122, Outline of Evidence of Robert Mills (11 April 2024) [22] [SCI.0008.0344.0001 at 0007]; Transcript of the Commission, 18 April 2024 T2075.36-46 (Mills).
[1227] Exhibit D.103, Email correspondence between Robert Mills and Anette Marley, MOH re Tresillian schedule 3 column 2 update dated 8 September 2022 [SCI.0008.0120.0001 at 0005].
[1228] Transcript of the Commission, 18 April 2024 T2075.36-2076.16 (Mills).
[1229] Although there was evidence that suggests that the experience of Affiliated Health Organisations in this respect is not uniform, and different approaches have been adopted in relation to different organisations: see, for example, Exhibit D.122, Outline of Evidence of Robert Mills (11 April 2024) [21] [SCI.0008.0344.0001 at 0007]; Exhibit D.56, Standard iCare Insurance Certificate of Currency for NSW Health Template (27 June 2023) [SCI.0008.0046.0001]; Transcript of the Commission, 18 April 2024 T2080.26-28 (Mills); Transcript of the Commission, 18 April 2024 T2018.33-39 (O'Loughlin).

establishments and services as listed in Schedule 3.[1230] Accordingly, it was required to pay separate workers compensation, public liability and property insurance for its NSW Health funded services which were not listed in Column 2 of the Schedule, totalling $80,397 in 2023.[1231] Tresillian had not received any additional funding in its service agreements to compensate for these additional insurance costs.[1232]

878. In May 2023, following a meeting between Tresillian and the new Minister for Health, Mr Ryan Park, a New South Wales Health Services Association Working Group was established to enable direct liaison between NSW Health and Tresillian and the Health Services Association, on issues relating to Schedule 3, and other Affiliated Health Organisation related matters.[1233] At a meeting of that group in January 2024, Mr Mills was advised that – from the perspective of the NSW Health Legal Branch – there were no concerns with adding Tresillian's services at Macksville Hospital and Campbelltown Hospital to Column 2 of Schedule 3, but rather it was a policy decision.[1234] To date, no changes to Schedule 3 have been made.

879. Schedule 3 should reflect an accurate description of the Affiliated Health Organisations, and their recognised services and establishments. There is no good reason why that should not occur, and that the schedule should not be kept up to date at all times. Accordingly, immediate steps should be taken to review and update Schedule 3 to the *Health Services Act* to ensure that it accurately reflects each of the Affiliated Health Organisations, and their recognised services and establishments.

880. Concomitant with that approach – where a new service is established, there should be clear advice given by the Ministry or Local Health District to the Affiliated Health Organisation as to whether that service is intended to form part of the organisations recognised services (and thus form part of the public health

[1230] Exhibit D.122, Outline of Evidence of Robert Mills (11 April 2024) [21] [SCI.0008.0344.0001 at 0007]; Exhibit D.39, iCare Certificate of Currency for NSW Health and Royal Society for the Welfare of Mothers and Babies 1 July 2023-30 June 2024 (27 June 2023) [SCI.0008.0002.0001]; Transcript of the Commission, 18 April 2024 T2080.6-24 (Mills).
[1231] Exhibit D.122, Outline of Evidence of Robert Mills (11 April 2024) [20] [SCI.0008.0344.0001 at 0007]; Exhibit D.112, Various certificates of currency for Tresillian (issued by various iCare, Gallagher Basset and Ansvar Insurance) (27 May 2023) [SCI.0008.0131.0001]; Transcript of the Commission, 18 April 2024 T2079.22-36 (Mills).
[1232] Transcript of the Commission, 18 April 2024 T2079.38-47 (Mills).
[1233] Transcript of the Commission, 18 April 2024 T2081.32-47 (Mills).
[1234] Exhibit D.122, Outline of Evidence of Robert Mills (11 April 2024) [19]; Transcript of the Commission, 18 April 2024 T2082.24-46 (Mills).

system), or whether in delivering that service the Affiliated Health Organisation does so otherwise than in that capacity. Clear communication about those issues is imperative to enable the organisation to consider whether to provide the service on that basis and if, in doing so, the funding to be provided for that service is sufficient to meet its costs of doing so.

11.8 Conclusion and key recommendations

881. Each Affiliated Health Organisation should enter into a single service agreement with the Secretary – in much the same way as is currently contemplated for networked Affiliated Health Organisations – and negotiations with those organisations regarding funding and the nature and location of services to be delivered under those agreements should principally occur at Ministry level.

882. Planning around what services are to be provided by each Affiliated Health Organisation and where those services are to be provided should form an integral part of the wider service planning process identified above and discussed elsewhere in this outline.

883. On an annual basis, and in conjunction with the planning and identification of the services to be provided by each Affiliated Health Organisation under their respective Service Agreements, Schedule 3 to the *Health Services Act* should be reviewed to ensure that it accurately records the recognised services and establishments of each of them and amended to the extent necessary to reflect those services.

884. A structured process should be implemented to promptly resolve any dispute between the Ministry and an Affiliated Health Organisation regarding the extent to which funding offered is sufficient to meet the cost of delivering the level of service required under a proposed service agreement. Whatever process might be adopted, it must be independent, able to be unilaterally triggered by either the Affiliated Health Organisation or the Ministry in the event of a dispute, and capable of meaningfully regulating the “purchaser/provider” nature of the relationship to be reflected in any subsequent service agreement.

12 PROCUREMENT

885. That the current procurement framework within NSW Health is complex is, perhaps, unsurprising given the scale of the New South Wales public health system and the extent of its procurement activities.[1235] For example, in the 2022/23 financial year, NSW Health spent approximately $7.45 billion on the procurement of goods and services.[1236] This represented approximately 25 per cent of NSW Health's total expenses for that financial year.[1237]

886. Roles and responsibilities in relation to procurement activities are spread across the system, from Ministry to local facility level. The whole system is subject to a range of legislative requirements, New South Wales government-level policies and oversight by the central NSW Procurement Board. Reflecting this dispersed structure is a wide range of policies, guidelines and procedures governing the procurement processes, and the systems through which those processes are conducted.

887. Despite the challenges that emerge in such a large and complex system – and accepting that improvements can be made - there are many aspects of NSW Health's procurement activities that work well at the day-to-day operational level and provide strong support for the wider system. Some of those strengths were demonstrated during the COVID-19 pandemic, even if those events themselves highlighted further lessons that can be learned.[1238]

888. A core concept that emerged in relation to procurement is that of "value-based healthcare" – which, in substance, means delivering the highest value healthcare for a given cost, and with a focus on patient outcomes. "Value" is a prominent theme in New South Wales Government and NSW Health strategies and frameworks relating to procurement, and it is uncontroversial that delivering the highest value healthcare for the money expended should be a priority in any procurement process.

[1235] This section of the outline is focussed on the procurement of goods and services rather than in relation to workforce (such as the engagement of locums and agency nurses), which is considered elsewhere.
[1236] See, for example, Exhibit B.5, Statement of Michael Gendy (31 January 2024) [46(a)] [MOH.0001.0434.0001 at 0012].
[1237] Exhibit B.36, *NSW Health Annual Report 2022-23* (November 2023) p 138 (total expenses excluding losses of approximately $29.5 billion) [SCI.0001.0059.0001 at 0147].
[1238] See, for example, Exhibit B.5, Statement of Michael Gendy (31 January 2024) [28], [58]-[59] [MOH.0001.0434.0001 at 0006, 0020].; Exhibit B.11, Statement of Carmen Rechbauer (12 February 2024) [113] [MOH.9999.0009.0001 at 0031].

889. The corollary of an inefficient or ineffective procurement process is likely to be wastefulness, whether in the form of wasted costs or wasted resources. An important condition for avoiding waste in procurement is monitoring and evaluating the performance of suppliers against meaningful criteria. As set out below, the evidence supports a conclusion that those processes can be strengthened.

890. In that context, the key issues relating to procurement within the wider system that emerged in the evidence do not relate to the system's capacity to respond to events of urgency and scale, or conversely with the general day-to-day processes of procurement, although no doubt those areas would benefit from a continued process of enhancement. Rather, the key issues arise at a higher level: for example, how the system regards, evaluates and puts into practice the concepts of value, and how it measures and monitors procurement outcomes, including as against those concepts.

12.1 Roles and responsibilities in relation to procurement activities

12.1.1 NSW Procurement Board

891. Any procurement of goods or services by or on behalf of a NSW "government agency" is subject to Part 11 of the *Public Works and Procurement Act 1912* (NSW).[1239] The definition of "government agency" is expansive[1240] and captures NSW Health agencies.

892. The *Public Works and Procurement Act* establishes the NSW Procurement Board.[1241] The Board's functions include overseeing the procurement of goods and services by and for government agencies and developing and implementing policies regarding the same.[1242]

893. Government agencies are obliged to comply with any directions or policies issued by the Board, the terms of any accreditation granted to them, and "the principles of probity and fairness".[1243] A government agency "is also to ensure it obtains value for money in the exercise of its functions in relation to the

[1239] *Public Works and Procurement Act 1912* (NSW) s 163.
[1240] *Public Works and Procurement Act 1912* (NSW) s 162.
[1241] *Public Works and Procurement Act 1912* (NSW) s 164.
[1242] *Public Works and Procurement Act 1912* (NSW) s 172.
[1243] Which are not defined: *Public Works and Procurement Act 1912* (NSW) s 176(1).

procurement of goods and services".[1244] Contraventions or proposed contraventions of certain Board directions or policies are enforceable.[1245]

894. The NSW Procurement Board established an accreditation scheme pursuant to the *Public Works and Procurement Act.*[1246] The Health Administration Corporation holds such an accreditation at "Level 2",[1247] which means it is authorised to procure goods and services of any value without reference to the Board.[1248]

895. The NSW Procurement Board has also issued a range of mandatory directions and policies in accordance with the *Public Works and Procurement Act,* as well as a range of non-binding guidelines. These are summarised in the NSW Government *Procurement Policy Framework*.[1249] They relate to such matters as:

a. non-discrimination, and general use of open approaches to market for procurement;[1250]

b. prioritising procurement from small and medium enterprises and regional businesses,[1251] including specific targets relating to information and communications technologies ("ICT") and digital procurement;[1252]

c. payment terms for small businesses;[1253]

d. prioritising procurement from Aboriginal businesses;[1254]

e. environmental sustainability;[1255]

f. dealing with unsolicited proposals;[1256] and

[1244] *Public Works and Procurement Act 1912* (NSW) s 176(3).
[1245] *Public Works and Procurement Act 1912* (NSW) ss 176D-176F.
[1246] Exhibit B.23.16, NSW Government, *Procurement Policy Framework* (April 2022) pp 6, 43-45, 144 [MOH.0001.0132.0001 at 0006, 0043-0045, 0144]. Those directions are in addition to various legislative obligations that apply directly to procurement activities, such as those that arise under the *Modern Slavery Act 2018* (NSW).
[1247] Exhibit B.23.25, NSW Health, *Corporate Governance & Accountability Compendium* (September 2023) pp 12.05-12.06 [MOH.0001.0297.0001 at 0125-0126]; Exhibit B.23.15, Audit Office of NSW, *Ensuring Contract Management Capability in Government – HealthShare NSW* (31 October 2019) p 1 [MOH.0001.0013.0001 at 0005]; Exhibit B.5, Statement of Michael Gendy (31 January 2024) [17]-[19] [MOH.0001.0434.0001 at 0004].
[1248] Exhibit B.23.16, NSW Government, *Procurement Policy Framework* (April 2022) p 144 [MOH.0001.0132.0001 at 0144].
[1249] Exhibit B.23.16, NSW Government, *Procurement Policy Framework* (April 2022) [MOH.0001.0132.0001].
[1250] Exhibit B.23.95, NSW Procurement Board, *Procurement (Enforceable Procurement Provisions) Direction* 2019 [MOH.0001.0121.0001].
[1251] Exhibit B.23.18, NSW Government, Small and Medium Enterprise and Regional Procurement Policy [MOH.0001.0417.0001].
[1252] Exhibit B.23.19, NSW Government, *ICT/Digital SME procurement commitments* (19 December 2022) [MOH.0001.0334.0001].
[1253] Exhibit B.23.20, NSW Government, *Small Business Shorter Payment Terms Policy* [MOH.0001.0416.0001].
[1254] Exhibit B.23.21, NSW Government, *Aboriginal Procurement Policy* (January 2021) [MOH.0001.0277.0001].
[1255] Exhibit B.23.22, NSW Government, *NSW Government Resource Efficiency Policy* (2019) [MOH.0001.0324.0001].
[1256] Exhibit B.23.96, NSW Department of Premier and Cabinet, *Unsolicited Proposals* (C-2017-05) (22 December 2017) [MOH.0001.0428.0001]; Exhibit B.23.97, NSW Government, *Unsolicited Proposals Guide for Submission and Assessment* (May 2022) [MOH.0001.0427.0001].

g. a mandated contracting framework for ICT procurement.[1257]

896. These are in addition to various legislative obligations that apply directly to procurement activities, such as those under the *Modern Slavery Act 2018* (NSW).

12.1.2 Health Administration Corporation

897. While the Health Administration Corporation technically holds the accreditation to undertake procurement in respect of NSW Health, that function is largely exercised through HealthShare, and eHealth in relation to procurements valued up to $30 million (per annum in the case of eHealth).[1258] Procurement of goods or services exceeding $30 million must be approved by the Chief Procurement Officer.[1259]

a. HealthShare

898. The predecessor of HealthShare – known as Health Support Services – was established in 2007 to provide shared services for NSW Health entities, including linen, food, payroll, warehousing, procurement and recruitment services, as well as some ICT services.[1260]

899. In 2012, Health Support Services was renamed HealthShare NSW, and created as an "administrative unit" of a "division" of the Health Administration Corporation.[1261] HealthShare became the vehicle for the Secretary's provision of the relevant services under s 126B of the *Health Services Act*, and the HealthShare Board was delegated its governance and oversight as an appointed body for the purposes of s 126C. That general structure remains in place.

900. Since 10 November 2008, public health organisations have been directed by the Minister to acquire all procurement, contract management and contract negotiation services from HealthShare, and its predecessor.[1262] That direction

[1257] Exhibit B.23.99, NSW Procurement Board, *Mandated use of ICT Purchasing Framework* (PBD-2021-02) (1 July 2021) [MOH.0001.0341.0001].
[1258] Exhibit B.23.25, NSW Health, *Corporate Governance & Accountability Compendium* (September 2023) pp 12.05-12.06 [MOH.0001.0297.0001 at 0215-0216];
[1259] Exhibit B.5, Statement of Michael Gendy (31 January 2024) [75a] [MOH.0001.0434.0001 at 0026].
[1260] See, for example, Exhibit B.23.36, Dr Mary Foley, Director-General, NSW Health, *Future Arrangements for Governance of NSW Health* (2011) p 27 [MOH.0001.0309.0001 at 0029].
[1261] Exhibit B.23.37, *Delegation of functions – HealthShare NSW Board* (29 November 2012) recital B [MOH.0001.0308.0001].
[1262] Exhibit B.23.39, Order pursuant to s 126G of the *Health Services Act 1997* (10 November 2008) [MOH.0001.0404.0001]. See also Exhibit B.23.35, NSW Health, Accounts and Audit Determination for Public Health Entities in NSW (9 March 2020) p 26 (cl 4.1a) i.2) [MOH.0001.0278.0001 at 0027].

is binding on public health organisations other than affiliated health organisations, which can choose whether or not to acquire services from HealthShare.[1263]

901. Public health organisations are required to pay a "recovery charge" to HealthShare for its services unless otherwise approved by the Secretary.[1264] Procurement contract and tendering services are charged at a fixed price[1265] while a volume-based charge is applied to the acquisition of goods through the centralised "Onelink" warehouse.[1266] This volume-based charge includes components for the item itself, warehousing operations, and freight cost.[1267] HealthShare is funded primarily on this "cost-recovery" model through intra-health service charges, together with a recurrent subsidy.[1268]

902. HealthShare's procurement-related activities are the responsibility of its Procurement and Supply Chain directorate.[1269] These activities fall into the following main categories.

    a. Leading the process for establishing and renewing of whole-of-Health and whole-of-government (health-related) arrangements for purchasing goods and services.[1270] This includes developing a procurement plan, preparing tender documentation (assuming, as is usual, that the procurement is to be by way of an approach to market), preparing evaluation criteria and an evaluation plan, conducting the tender and evaluation process, and preparing and finalising the contract, in accordance with the NSW Health Procurement Policy and Procedures and other relevant policies and procedures.[1271] The result is generally a "Standing Offer Arrangement" between the relevant supplier and the Health Administration Corporation, which sets out the terms and conditions on which contracts may be formed between the supplier and individual NSW Health entities.[1272]

[1263] *Health Services Act 1997* (NSW), ss 126G, 126H(2).
[1264] Exhibit D.95, NSW Ministry of Health, A*ccounts and Audit Determination for Public Health Entities in NSW* (9 March 2020) p 27 (cl 4.1c)) [SCI.0008.0112.0001 at 0028].
[1265] See also, for example, Exhibit B.1, Statement of Margot Mains (29 January 2024) [36] [MOH.0001.0260.0001 at 0013].
[1266] Exhibit B.11, Statement of Carmen Rechbauer (12 February 2024) [28] [MOH.9999.0009.0001 at 0009].
[1267] Exhibit B.11, Statement of Carmen Rechbauer (12 February 2024) [28(b)] [MOH.9999.0009.0001 at 0009].
[1268] Exhibit B.11, Statement of Carmen Rechbauer (12 February 2024) [25] [MOH.9999.0009.0001 at 0009].
[1269] Exhibit B.11, Statement of Carmen Rechbauer (12 February 2024) [33] [MOH.9999.0009.0001 at 0012].
[1270] Exhibit B.11, Statement of Carmen Rechbauer (12 February 2024) [43] [MOH.9999.0009.0001 at 0014].
[1271] Exhibit B.11, Statement of Carmen Rechbauer (12 February 2024) [61]-[67] [MOH.9999.0009.0001 at 0017-0021].
[1272] See, for example, Exhibit B.23.40, Template Standing Offer Agreement (13 December 2022) [MOH.0001.0367.0001].

b. Conducting procurements referred to it by other NSW Health entities as being outside their authority (generally, procurement valued in excess of $250,000 and outside a whole-of-government or whole-of-Health contract).[1273] This involves a similar process to establishing a whole-of-government or whole-of-Health contract, but the result is a single contract with the relevant NSW Health entity as the counterparty rather than the Health Administration Corporation.[1274]

c. Contract management and administration of whole-of-Health and whole-of-government (health-related) contracts.[1275]

d. Procuring, warehousing and delivery of a wide range of medical and surgical consumables used in NSW Health facilities through the "Onelink" warehouse - a centralised warehouse from which HealthShare distributes consumables.[1276] The stock levels in the Onelink warehouse are maintained by HealthShare[1277], and it procures three million different medical and surgical consumables worth $200 million annually and delivers these to 400 sites every day.[1278] HealthShare also maintains a product catalogue and various supply chain information systems for use by NSW Health entities.[1279]

e. Providing assistance and advice to other NSW Health staff, particularly at the local level, regarding procurement matters.[1280]

f. The development of procurement strategy and reform, including category strategies as described above.[1281]

b. eHealth

903. eHealth was established from 1 July 2014, as another "unit" within the Health Administration Corporation.[1282] Its purpose was to centralise ICT services for NSW Health, which at that time were spread between Area Health Services, the

[1273] Exhibit B.11, Statement of Carmen Rechbauer (12 February 2024) [31(c)], [61]-[67] [MOH.9999.0009.0001 at 0011, 0017-0021].
[1274] Exhibit B.11, Statement of Carmen Rechbauer (12 February 2024) [MOH.9999.0009.0001].
[1275] Exhibit B.11, Statement of Carmen Rechbauer (12 February 2024) [49]-[56] [MOH.9999.0009.0001 at 0015-0016].
[1276] Transcript of the Commission, 23 February 2024, T895.36-896.14, T921.33-923.6 (Rechbauer).
[1277] Transcript of the Commission, 23 February 2024, T921.33-923.6 (Rechbauer).
[1278] Exhibit B.11, Statement of Carmen Rechbauer (12 February 2024) [34] [MOH.9999.0009.0001 at 0012].
[1279] Exhibit B.11, Statement of Carmen Rechbauer (12 February 2024) [31f] [MOH.9999.0009.0001 at 0011].
[1280] Exhibit B.11, Statement of Carmen Rechbauer (12 February 2024) [35]-[36] [MOH.9999.0009.0001 at 0012].
[1281] Exhibit B.11, Statement of Carmen Rechbauer (12 February 2024) [86]-[102] [MOH.9999.0009.0001 at 0024-0029].
[1282] Exhibit B.23.124, eHealth Determination of Functions (2 June 2023) Recital A [MOH.0001.0312.0001].

Ministry and formerly Health Support Services.[1283] Its current functions include planning, strategy development, project development, support and maintenance of ICT for NSW Health, as well as the provision of network and storage facilities, and ICT hardware and software.[1284]

904. Similar to HealthShare, NSW Health entities (other than affiliated health organisations) are obliged to acquire ICT goods and services offered by eHealth from eHealth.[1285] In practice, these extend to most ICT infrastructure, corporate / business systems (such as payroll, recruitment and finance systems), clinical systems (such as electronic patient records, imaging, pharmacy and ambulance systems), and virtual care systems.[1286]

905. eHealth's ordinary operations are funded in a similar way to HealthShare: partly through recurrent funding from the Ministry, but primarily through service charges levied on NSW Health entities using its services, either on a fixed or consumption basis.[1287] Statewide programs and projects may receive separate capital funding.[1288]

906. eHealth:

    a. negotiates and manages whole-of-Health contracts for ICT goods and services, by establishing "Master" or "Head" agreements with suppliers pursuant to which NSW Health entities may then contract;[1289]

    b. negotiates on behalf of NSW Health entities contracts for ICT goods and services outside whole-of-Health or whole-of-government contracts and above their financial authority, which (in accordance with the NSW Health Procurement Policy) is $150,000;[1290] and

    c. is involved in the development of strategies and reforms relating to ICT in NSW Health.[1291]

[1283] Exhibit B.23.36, Dr Mary Foley, Director-General, NSW Health, *Future Arrangements for Governance of NSW Health* (2011) p 24 [MOH.0001.0001.0309.0001 at 0026].
[1284] Exhibit B.23.124, eHealth Determination of Functions (2 June 2023) [2] [MOH.0001.0312.0001].
[1285] Exhibit B.23.39, Order pursuant to s 126G of the *Health Services Act 1997* (10 November 2008) cl 3 [MOH.0001.0404.0001]; Exhibit B.23.35, NSW Ministry of Health, *Accounts and Audit Determination for Public Health Entities in NSW* (9 March 2020) p 26 (cl 4.1a) iii.) [MOH.0001.0278.0001 at 0027].
[1286] Exhibit B.6, Statement of Dr Zoran Bolevich (31 January 2024) [9], [53] [MOH.0001.0433.0001 at 0002 and 0026-0027].
[1287] Exhibit B.6, Statement of Dr Zoran Bolevich (31 January 2024) [15]-[17] [MOH.0001.0433.0001 at 0003-0004].
[1288] Exhibit B.6, Statement of Dr Zoran Bolevich (31 January 2024) [17(a)], [18] [MOH.0001.0433.0001 at 0004].
[1289] Exhibit B.6, Statement of Dr Zoran Bolevich (31 January 2024) [46]-[48] [MOH.0001.0433.0001 at 0024].
[1290] Exhibit B.6, Statement of Dr Zoran Bolevich (31 January 2024) [42(b)] [MOH.0001.0433.0001 at 0022].
[1291] Exhibit B.6, Statement of Dr Zoran Bolevich (31 January 2024) [26]-[32] [MOH.0001.0433.0001 at 0005-0021].

907. It is also required to approve any laptop or desktop purchases within NSW Health of any value, for standardisation reasons.[1292]

12.1.3 Ministry

908. Aside from procurement activities it may undertake for its own purposes, the Ministry has what has been described as a "strategic" role in relation to procurement.[1293] That role broadly reflects the Ministry's function as "system manager".[1294]

909. The Ministry's Strategic Procurement Branch is involved in implementing the procurement-related elements of NSW Health's current strategic plan, which is called *Future Health: Guiding the next decade of health care in NSW 2022-2032* ("Future Health Plan").[1295] It also has responsibility for overseeing the current "Procurement Reform Program".[1296]

910. The Ministry is responsible for developing and overseeing the general framework of policies, procedures and guidelines applying to procurement across NSW Health. The most notable of these are the PD2023_028 *NSW Health (Goods and Services) Procurement Policy*[1297] ("NSW Health Procurement Policy") and *NSW Health Procurement Procedures (Goods and Services) June 2022 Version 1*[1298] ("NSW Health Procurement Procedures"). A wide range of separate, specific policies also bear on the procurement function.[1299]

911. NSW Health's role in developing these policies and procedures includes ensuring they are consistent with relevant policies and directions from the NSW Procurement Board and the scope of the Health Administration Corporation's

[1292] Exhibit B.6, Statement of Dr Zoran Bolevich (31 January 2024) [43] [MOH.0001.0433.0001 at 0022-0023].
[1293] Exhibit B.5, Statement of Michael Gendy (31 January 2024) [22] [MOH.0001.0434.0001 at 0004-0005].
[1294] Exhibit B.5, Statement of Michael Gendy (31 January 2024) [9], [10], [20] [MOH.0001.0434.0001 at 0002-0004].
[1295] Exhibit B.23.23, NSW Health, Future Health: Guiding the next decade of healthcare in NSW 2022-2023 (May 2022) [MOH.0001.0320.0001].
[1296] Exhibit B.5, Statement of Michael Gendy (31 January 2024) [30]-[31] [MOH.0001.0434.0001 at 0006-0007].
[1297] Exhibit B.23.13, NSW Health, *NSW Health (Goods and Services) Procurement Policy* (June 2022) (PD2023_028) [MOH.0001.0366.0001].
[1298] Exhibit B.23.14, NSW Health, *NSW Health (Goods and Services) Procurement Policy,* Version 1.0 (PD2023_028) (June 2022) [MOH.0001.0366.0001].
[1299] Some examples include: Exhibit B.23.28, NSW Health, *Disclosure of Contract Information* (PD2018_021) (26 June 2018) [MOH.0001.0148.0001]; Exhibit B.23.29, NSW Health, *Conflicts of Interest and Gifts and Benefits* (PD2015_045) (27 October 2015) [MOH.0001.0145.0001]; Exhibit B.23.30, NSW Health, *NSW Health Code of Conduct* (PD2015_049) (16 December 2015) [MOH.0001.0359.0001]; Exhibit B.23.31, NSW Health, *Corrupt Conduct - Reporting to the Independent Inquiry Against Corruption (ICAC)* (PD2016_029) (5 July 2016)[MOH.0001.0298.0001]; Exhibit B.23.32, NSW Health, *Procurement Cards within NSW Health* (PD2022_038) (2 September 2022) [MOH.0001.0149.0001]; Exhibit B.23.43, NSW Health, *Asset Management* (PD2022_044) (19 September 2022) [MOH.0001.0150.0001]; Exhibit B.23.46, *NSW Health Uniforms Policy* (PD2019_012) (22 March 2019) [MOH.0001.0369.0001]; NSW Health, *Early Response to High Consequence Infectious Disease* (PD2023_008), referred to in Exhibit B.5, Statement of Michael Gendy (31 January 2024) [53(d)-(e)] [MOH.0001.0434.0001 at 0017-0018].

accreditation.[1300] The Ministry liaises with stakeholders such as NSW Treasury as required for this purpose.[1301] Public health organisations are required to comply with the NSW Health Procurement Policy and Procedures as a condition of the financial subsidies they receive.[1302]

912. The Chief Procurement Officer has a range of functional responsibilities under the NSW Health Procurement Policy. These responsibilities are focused on procurement outside the ordinary course and, as noted above, include approving procurement at or over $30 million in value and establishing whole-of-Health contracts, as well as granting exemptions to existing procurement requirements.[1303]

913. Third, the Ministry oversees compliance with procurement requirements and functions by other entities within the system.[1304] The main way in which this appears to occur is through the setting and monitoring of "key performance indicators" relating to procurement in the Service Agreements between the Secretary and Local Health Districts, specialty networks and affiliated health organisations, and Statements of Service with HealthShare, eHealth, NSW Health Pathology and Health Infrastructure.[1305] Those key performance indicators relating to procurement in Service Agreements are focused on cost savings (for example, "Annual procurement savings target achieved"), standardisation (for example, "Reducing free text orders catalogue compliance", "Reducing off-contract spend" and "Use of Whole of Health contracts"), and environmental sustainability (for example, reducing the use of certain chemicals and diverting waste from landfill).[1306]

12.1.4 Pillar organisations

914. Two of the pillar organisations – the Agency for Clinical Innovation and the Clinical Excellence Commission – also play a role in procurement, although less directly and routinely.

[1300] Exhibit B.5, Statement of Michael Gendy (31 January 2024) [4] [MOH.0001.0434.0001].
[1301] Exhibit B.5, Statement of Michael Gendy (31 January 2024) [22b] [MOH.0001.0434.0001 at 0005].
[1302] See, for example, Exhibit B.23.100, NSW Health, Financial Requirements and Conditions of Subsidy (Government Grants) for the year ending 30 June 2023 (21 June 2022) p 24 (cl 3.5) [MOH.0001.0318.0001 at 0025].
[1303] Exhibit B.23.13, *NSW Health Procurement (Goods and Services) Policy* (4 October 2023) pp ii, 30 (cl 8.9) [MOH.0001.0037.0001 at 0003, 0034].
[1304] Exhibit B.5, Statement of Michael Gendy (31 January 2024) [22f], [35] [MOH.0001.0434.0001 at 0005, 0008].
[1305] Exhibit B.5, Statement of Michael Gendy (31 January 2024) [51]-[55] [MOH.0001.0434.0001.0017-0019].
[1306] See, for example, Exhibit B.23.181, Southern NSW Local Health District Service Agreement 2023-24 (26 October 2023) p 27 [MOH.0001.0456.0001 at 0028].

a. Agency for Clinical Innovation

915. It is clear that the Agency for Clinician Innovation and the Office of Health and Medical Research have a significant role in identifying, assessing, developing and implementing clinical and technical innovations within NSW Health.[1307] Outside of that context, the Agency's role in procurement is less clear.

916. Whilst the Agency may become involved in tender evaluation processes for the procurement of goods and services, it does so on an ad hoc basis, and dependent upon whether members of the technical evaluation committee for the tender decide to involve it.[1308] Mr Gendy identified the Agency as having the role of monitoring data on patient outcomes by reference to those that may have been identified as significant in the relevant tender evaluation process.[1309] But according to Adjunct Professor Levesque, the Agency is not in charge of this kind of monitoring and does not perform it in a systematic way, although changes in relevant outcomes may appear incidentally in data gathered for other purposes.[1310]

917. Despite its Performance Agreement containing a wide-ranging and detailed set of 65 "deliverables", none of those appears to relate to the Agency's involvement in the procurement of goods and services, except for a generic reporting requirement relating to its own procurement.[1311] There is no substantive reference to the Agency's role in procurement in its two most recent strategic plans.[1312] There is no reference to the Agency at all in the NSW Health Procurement Policy or Procedures. Adjunct Professor Levesque's statement, which comprehensively described the Agency's important role in relation to clinical innovations and models of care, used the word "procurement" only once, in the context of saying:

> *Procurement practices can prevent local innovations from being taken to a stage where they are commercially viable.*[1313]

[1307] See for example, Exhibit B.3, Statement of Adjunct Professor Jean-Frédéric Levesque (30 January 2024) [66]-[85]. [MOH.0001.0435.0001 at 0021-0033].
[1308] Transcript of the Commission, 23 February 2024 T905.22-907.20 (Rechbauer), Transcript of the Commission, 26 February 2024 T1133.5-1134.40 (Levesque).
[1309] Transcript of the Commission, 23 February 2024 T1010.14-34 (Gendy).
[1310] Transcript of the Commission, 26 February 2024 T1133.5-1134.40 (Levesque).
[1311] Exhibit B.23.49, Agency for Clinical Innovation Performance Agreement 2023-24 (31 October 2023) [MOH.0001.0284.0001 at 0001].
[1312] See for example, Exhibit B.23.56, Agency for Clinical Innovation, *Strategic Plan 2019-22* [MOH.0001.0281.0001].
[1313] Exhibit B.3, Statement of Adjunct Professor Jean-Frédéric Levesque (30 January 2024) [112f] [MOH.0001.0435.0001 at 0040].

918. In short, it is not apparent that NSW Health – including the Agency for Clinical Innovation itself – presently perceives the Agency to have any regular or routine role in NSW Health's procurement processes, outside of implementing clinical innovations sponsored by the Agency.

b. Clinical Excellence Commission

919. By reason its core responsibilities, the Clinical Excellence Commission becomes involved in procurement activities from time to time. For example, it:

a. leads responses to urgent, system-level medicine, medical device, chemical and equipment shortages (including because of supply chain disruptions) to ensure clinical quality and safety;[1314] and

b. participates in particular statewide procurement projects, such as the NSW Medicines Formulary, the Single Digital Patient Record and medical device reforms.[1315]

920. The involvement in procurement processes by the Clinical Excellence Commission appears to be largely ad hoc, although regular meetings between the Clinical Excellence Commission and HealthShare to discuss supply chain issues appear to have been introduced in the wake of COVID-19.[1316] Like the Agency for Clinical Innovation, the Clinical Excellence Commission does not have a regular or routine role in procurement processes. For example, there does not appear to be any policy or procedure requiring tender evaluation committees for clinical goods or services to seek quality and safety input from the Clinical Excellence Commission, and the Clinical Excellence Commission does not have a "standing" membership of those committees.[1317]

12.1.5 Local organisations

921. A significant amount of the procurement activity in NSW Health occurs at the level of Local Health Districts, Specialty Health Networks and other "local" health organisations such as NSW Health Pathology and NSW Ambulance. That is where most goods and services used in NSW Health's day-to-day

[1314] Exhibit B.2, Statement of Adjunct Professor Michael Nicholl (29 January 2024) [23]-[30] [MOH.0001.0262.0001 at 0006].
[1315] Exhibit B.2, Statement of Adjunct Professor Michael Nicholl (29 January 2024) [31]-[33], [38]-[65] [MOH.0001.0262.0001 at 0007-0012].
[1316] Exhibit B.5, Statement of Michael Gendy (31 January 2024) [63] [MOH.0001.0434.0001 at 0021].
[1317] Transcript of the Commission 23 February 2024 T907.12-15 (Rechbauer).

operations are purchased. For simplicity, these organisations are referred to in this sub-section as "local organisations". They include pillar organisations when purchasing for their own purposes.

922. The key threshold requirements for procurement at this level are:

a. If the goods or services to be procured are valued at $10,000 or less, the local organisation may procure them from any supplier, provided they meet all applicable quality, safety, security and regulatory requirements and their cost is reasonable and consistent with normal market rates.[1318]

b. If the goods or services to be procured are valued at more than $10,000 and are available under a whole-of-government or whole-of-Health contract, or a whole-of-government prequalification scheme or procurement list (essentially, a list of suppliers approved to supply particular goods or services to New South Wales government agencies), the local organisation must use that arrangement.[1319]

c. If the goods or services to be procured are not available under a whole-of-government or whole-of-health contract, or a whole-of-government prequalification scheme or procurement list, the following apply:

i. If the goods or services to be procured are valued at more than $10,000 up to $30,000, the local organisation may procure the goods or services itself, by obtaining one written quote.[1320]

ii. If the goods or services are valued at more than $30,000 up to $250,000 ($150,000 in the case of ICT goods or services), the local organisation may procure the goods or services itself, generally by an approach to market.[1321] The nature of the approach to market required, and other requirements for the procurement (including whether a procurement plan and an evaluation plan are required, and the extent of the approach to market documentation required),

[1318] Exhibit B.23.13, *NSW Health Procurement (Goods and Services) Policy* (4 October 2023) cl 4.5 [MOH.0001.0037.0001 at 0013].
[1319] Exhibit B.23.13, *NSW Health Procurement (Goods and Services) Policy* (4 October 2023) cl 5.1, 5.2 [MOH.0001.0037.0001 at 0014].
[1320] Exhibit B.23.13, *NSW Health Procurement (Goods and Services) Policy* (4 October 2023) cl 6.1.1 [MOH.0001.0037.0001 at 0017-0018].
[1321] Exhibit B.23.13, *NSW Health Procurement (Goods and Services) Policy* (4 October 2023) cl 6.4 [MOH.0001.0037.0001 at 0019-0020].

depend on the outcome of a risk assessment conducted using the NSW Health "risk assessment tool".[1322]

iii. If goods or services are valued at more than $250,000 ($150,000 in the case of ICT goods or services), the local organisation must refer the procurement to HealthShare or eHealth as described above.

923. The systems used by local organisations to undertake their procurement in practice are varied and complex. Some local organisations, but apparently not all, have developed their own guides or manuals in an effort to make the processes easier to follow.[1323] Most local organisations have their own internal procurement teams, which carry out some procurement tasks themselves and otherwise provide support to staff with that responsibility at the facility level.[1324] They also have their own delegations for procurement matters.[1325] The staff with delegations to perform procurement at the local level, and who in fact do so, include clinical staff such as Nurse Unit Managers, Nurse Practitioners and clinical educators.[1326]

924. Given the range, complexity and multi-layered nature of the policies, processes and systems applying to the procurement of goods and services within NSW Health, and the apparent lack of centralised guidance at a practical systems level, it is not surprising that staff at the local facility level have experienced uncertainty, confusion and frustration when attempting to procure items outside of routine products such as medical consumables.[1327] That is especially so

[1322] Exhibit B.23.13, *NSW Health Procurement (Goods and Services) Policy* (4 October 2023) cl 6.2 – 6.18 [MOH.0001.0037.0001 at 0020-0026].
[1323] See for example, Exhibit B.23.145, Illawarra Shoalhaven Local Health District, *ISLHD Purchasing Manual* [MOH.0001.0446.0001]; Exhibit B.23.146, Illawarra Shoalhaven Local Health District, *Purchasing Matrix* [MOH.0001.0447.0001]; Exhibit B.23.163, South Western Sydney Local Health District, *SWSLHD Major Procurement Requirements and Guidelines: Tenders, Expressions of Interest, Contracts and State Contract Equipment Purchases* (10 May 2017) [MOH.0001.0270.0001]; Exhibit B.23.179, Southern NSW Local Health District, *Southern NSW LHD Procurement Guide* (September 2023) [MOH.0001.0457.0001]; See also Exhibit B.1, Statement of Margot Mains (29 January 2024) [28] [MOH.0001.0260.0001 at 0011].
[1324] See for example, Exhibit B.1, Statement of Margot Mains (29 January 2024) [29]-[31] [MOH.0001.0260.0001 at 0012]; Exhibit B.4, Statement of Dr Teresa Anderson AM (31 January 2024) [21] [MOH.0001.0260.0001 at 0011]; Exhibit B.7, Statement of Sonia Marshall (5 February 2024) [19]-[20] [MOH.0001.0261.0001 at 0006]; Exhibit B.8, Statement of Mark Spittal (6 February 2024) [28] [MOH.0001.0263.0001 at 0007]; Exhibit B.9, Statement of Margaret Bennett (9 February 2024) [21] [MOH.9999.0007.0001 at 0007]. See also Exhibit B.23.121, South Western Sydney Local Health District, Procurement Team Structure [MOH.0001.0399.0001].
[1325] See for example, Exhibit B.23.109, Illawarra Shoalhaven Local Health District, *Delegations Framework* (February 2021) [MOH.0001.0337.0001]; Exhibit B.23.114, Sydney Local Health District, *Delegations of Authority Manual* (June 2021) [MOH.0001.0412.0001]; Exhibit B.23.161, South Western Sydney Local Health District, *Delegations Manual*; Exhibit B.23.180 (September 2023) [MOH.0001.0268.0001], Exhibit B.23.180, Southern NSW Local Health District, *Delegations of Authority Manual* (28 November 2023) [MOH.0001.0453.0001]. See also Exhibit B.8, Statement of Mark Spittal (6 February 2024) [31] [MOH.0001.0263.0001 at 0007].
[1326] See for example, Exhibit B.14, Statement of Kylie Tastula (12 February 2024) [25] [SCI.0003.0001.0009 at 0012-0013]; Transcript of the Commission 19 February 2024, T416.18-29 (Tastula).
[1327] See for example, Exhibit B.14, Statement of Kylie Tastula (12 February 2024) [12]-[25] [SCI.0003.0001.0009 at 0012]; Transcript of the Commission 19 February 2024, T416.18-29 (Tastula).

when staff responsible for undertaking that procurement are busy clinicians. It is also not surprising in these circumstances that inconsistencies have arisen between the particular processes following in different local organisations, which have resulted in different procurement timeframes or outcomes in different places.[1328] It is undoubtedly frustrating for a clinician in one facility to see their colleagues in a different facility procuring the same item more quickly or efficiently when they both require that item for the same purpose.[1329] And it is not surprising that some witnesses at the local level find visibility and data access between different levels of the procurement structure to be lacking.[1330]

925. No doubt some complexity is inevitable in a system the size and scope of NSW Health, which straddles centralisation and devolution, and where procurement is subject to a range of legislative and New South Wales government-level requirements as well as Ministry-level ones. It might also be that NSW Health's ongoing procurement reforms, including the "Procurement Academy" training course and the future implementation of the "SmartChain" platform described below, will help with streamlining and simplification.[1331] But there are undoubted benefits in NSW Health continuing to:

    a. consolidate its procurement policies, processes and systems where practicable;

    b. provide clear, practical guidance to staff at all levels of the system to the steps they need to take to procure different kinds of goods and services; and

    c. ensure that assistance is readily available if staff experience difficulties.

12.2 Recent and ongoing procurement reforms

926. The Special Commission's assessment of NSW Health's procurement framework has occurred in the context in which NSW Health has been conducting its own "reform" of that framework. The four "workstreams" in that reform are:

[1328] See for example, Exhibit B.14, Statement of Kylie Tastula (12 February 2024) [21], [24] [SCI.0003.0001.0009 at 0012].
[1329] See for example, Exhibit B.14, Statement of Kylie Tastula (12 February 2024) [24] [SCI.0003.0001.0009 at 0012]; Transcript of the Commission 19 February 2024, T409.12-27, 410.29-411.13 (Tastula).
[1330] See for example, Exhibit B.1, Statement of Margot Mains (29 January 2024) [73]-[74] [MOH.0001.0260.0001 at 0021-0022]; Exhibit B.4, Statement of Dr Teresa Anderson AM (31 January 2024) [120] [MOH.0001.0258.0001 at 0021].
[1331] See for example, Transcript of the Commission, 23 February 2024, T991.17-26 (Gendy).

a. **"Operating Model"**: This workstream is said to involve the implementation of a new "Operating Model" that:[1332]

> *will expand and empower the procurement workforce statewide with additional resources, a new Contract Management Framework, refined contract implementation process, improved governance and greater role clarity, all supported by the NSW Health Procurement Policy and Procedures.*

This appears to have included an investment in substantial additional staffing in contract implementation and management roles across HealthShare, eHealth and NSW Health Pathology.[1333] The new Operating Model also appears to have involved clarifying roles and responsibilities of existing procurement staff, new procurement "dashboards" for procurement spending, and updates to the "risk assessment tool".[1334]

b. **NSW Medicines Formulary:** This is a "holistic framework governing the procurement and usage of pharmaceuticals" used for NSW public hospital inpatients and NSW Ambulance patients.[1335] In practice, what this appears to have involved is a consolidation of 27 different formularies and 60 different governance groups for reviewing formulary submissions into one, with one peak governing body, as well as reducing the number of medicines in the formulary by more than two-thirds.[1336]

c. **DeliverEASE:** This is a reform focused on the medical consumables supply chain. In addition to simplifying ordering for those consumables with the STARR application described above, DeliverEASE also allows for easier tracking of inventory,[1337] and the standardisation of storeroom layouts across NSW Health facilities.[1338] Future developments include implementing a predictive ordering system that will seek to predict how much stock of a particular item should be ordered at a particular time

[1332] Exhibit B.5, Statement of Michael Gendy (31 January 2024) [30(a)], [64(a)] [MOH.0001.0434.0001 at 0006, 0021]. See also Exhibit B.11, Statement of Carmen Rechbauer (12 February 2024) [113] [MOH.9999.0009.0001 at 0031].
[1333] Exhibit B.5, Statement of Michael Gendy (31 January 2024) [64(a)] [MOH.0001.0434.0001 at 0021-0022].
[1334] Exhibit B.5, Statement of Michael Gendy (31 January 2024) [95(b)] [MOH.0001.0434.0001 at 0034].
[1335] Exhibit B.5, Statement of Michael Gendy (31 January 2024) [30(b)], [64(b)] [MOH.0001.0434.0001 at 0006, 0022]; Exhibit B.2, Statement of Adjunct Professor Michael Nicholl (29 January 2024) [38]-[65] [MOH.0001.0262.0001 at 0007-0012].
[1336] Exhibit B.5, Statement of Michael Gendy (31 January 2024) [95(a)(iii)-(iv)] [MOH.0001.0434.0001 at 0033].
[1337] Exhibit B.5, Statement of Michael Gendy (31 January 2024) [30(c)], [64(c)] [MOH.0001.0434.0001 at 0006, 0022]. See also, Exhibit B.1, Statement of Margot Mains (29 January 2024) [69] [MOH.0001.0260.0001 at 0020]; Transcript of the Commission, 1 February 2024, T667.31-668.10 (Chiumento).
[1338] Transcript of the Commission, 23 February 2024, T993.36-994.16 (Gendy); Transcript of the Commission, 21 February 2024, T668.12-28 (Chiumento).

based on historical ordering patterns.[1339] It is not proposed to implement any automated stock counting system because of concerns about its practicability.[1340] DeliverEASE had not yet been rolled out in all Local Health Districts at the time of the Special Commission's hearings in February 2024, but was proposed to be fully rolled out by June 2024.[1341]

d. **SmartChain:** The aim of SmartChain is to create a single, statewide, end-to-end procurement platform for all procurement and supply chain activities in NSW Health, including pricing, ordering and inventory monitoring.[1342] SmartChain will include five modules. One of those – "Traceability", which is a tracking system for implantable and prosthetic products and devices used for patients[1343] – has commenced rollout and is planned to be fully rolled out by December 2024.[1344]

12.3 Value-based procurement

12.3.1 Conceptions of "value"

927. As observed above, the concept of "value" is prominent in NSW Government and NSW Health objectives and strategies that apply to procurement.

928. For example, one of the five objectives of procurement identified in the NSW Government *Procurement Policy Framework* – and the one that is said to be "the overarching consideration for government procurement" – is "value for money".[1345] This is consistent with one of the statutory objectives of the NSW Procurement Board, which is "to ensure best value for money in the procurement of goods and services by and for government agencies".[1346] The Framework goes on to say:

> *Value for money is not necessarily the lowest price, nor the highest quality good or service. It requires a balanced assessment of a range of financial*

[1339] Transcript of the Commission, 23 February 2024, T996.41-998.17 (Gendy).
[1340] Transcript of the Commission 23 February 2024, T998.179-31 (Gendy).
[1341] Exhibit B.5, Statement of Michael Gendy (31 January 2024) [64d] [MOH.0001.0434.0001 at 0022].
[1342] Exhibit B.5, Statement of Michael Gendy (31 January 2024) [30d], [64e], [65] [MOH.0001.0434.0001 at 007, 0022],
[1343] See for example, Exhibit B.11, Statement of Carmen Rechbauer (12 February 2024) [114] [MOH.9999.0009.0001 at 0031]; Transcript of the Commission, 21 February 2024 T669.8-671.26 (Chiumento).
[1344] Exhibit B.5, Statement of Michael Gendy (31 January 2024) [66] [MOH.0001.0434.0001 at 0023].
[1345] Exhibit B.23.16, NSW Government, *Procurement Policy Framework* (April 2022) p 9 [MOH.0001.0434.0001 at 0006, 0022-0023].
[1346] Public Works and Procurement Act 1912 (NSW) s 171(b).

> *and non-financial factors, such as: quality, cost, fitness for purpose, capability, capacity, risk, total cost of ownership or other relevant factors.*[1347]

929. NSW Health translates the concept of value for money into a health setting through the concept of "value-based healthcare".[1348] This is reflected in one of the "key objectives" in the Future Health Plan, which is to "[d]rive value-based healthcare that prioritises outcomes and collaboration".[1349] "Value-based healthcare" is said to mean:

> *continually striving to deliver care that improves the health outcomes that matter to patients, patient experiences of receiving care, clinician experiences of providing care as well as the effectiveness and efficiency of care.*[1350]

930. This is said to require a shift in focus away from the incentives to increase technical efficiency that are inherent in volume- or activity based funding, towards "care that focuses on outcomes".[1351]

931. The definition of value-based healthcare in the Future Health Plan incorporates into its conception of value both *outcomes* and *experiences*, and both *patient* and *clinician* experiences. Some other NSW Health documents reflect this definition. For example, the Agency for Clinical Innovation's *Value-based surgery: Clinical practice guide* published in November 2023 says:

> *In NSW, value-based healthcare means continually striving to deliver care that improves:*
>
> - *health outcomes that matter to patients*
> - *the experience of receiving care*
> - *experiences of providing care*
> - *effectiveness and efficiency of care.*
>
> *Value-based healthcare requires a collaborative approach to ensure best outcomes for patients and the best value for the system.*[1352]

[1347] Exhibit B.23.16, NSW Government, *Procurement Policy Framework* (April 2022) p 9 [MOH.0001.0132.0001 at 0009].
[1348] Exhibit B.5, Statement of Michael Gendy (31 January 2024) [40] [MOH.0001.0434.0001 at 0009-0010].
[1349] Exhibit B.23.23, Future Health: Guiding the next decade of health care in NSW 2022-2032 (May 2022) p 16 [MOH.0001.0320.0001 at 0034].
[1350] Exhibit B.23.23, Future Health: Guiding the next decade of health care in NSW 2022-2032 (May 2022) pp 16-17 [MOH.0001.0320.0001 at 0034-0035].
[1351] Exhibit B.23.23, Future Health: Guiding the next decade of health care in NSW 2022-2032 (May 2022) p 16 [MOH.0001.0320.0001 at 0034-0035].
[1352] Exhibit B.23.64, *Value-based surgery: Clinical practice guide* (November 2023) p 4 [MOH.0001.0282.0001 at 0007]. See also Exhibit B.59, NSW Health, *Leading Better Value Care* p 3 [SCI.0003.0021.0001 at 0003].

932. Dr Teresa Anderson, then Chief Executive of Sydney Local Health District, gave a similar explanation of value-based health outcomes:

> *So this is really about making sure that we get value out of the contracts, not just in terms of savings, financial savings, but improved outcomes for our patients and the experience of our staff, helping to streamline the processes for our staff.*[1353]

933. Other definitions of value-based healthcare focused mainly on "outcomes. For example, the NSW Health Procurement Procedures refer to value-based healthcare as taking "an outcomes-based approach".[1354] Alira Health, in a report titled *Value-Based Procurement in Australia* commissioned for the Medical Technology Association of Australia ("MTAA") – which advocates for a "value-based" approach to procurement – defines value-based healthcare as "the improved health outcomes for patients versus the total costs of delivering care", and value-based procurement as having a corresponding meaning.[1355] Paul Dale, Director, Policy of the MTAA, described value-based healthcare as "delivering the outcomes that matter to patients as efficiently as possible", although he also referred to the experience of the patient.[1356] Ms Rechbauer ultimately described the concept as requiring consideration not just of price but of "all other aspects that go into being able to provide safe products for patients".[1357] And Mr Gendy described his understanding of value-based healthcare as:

> *Value based health care for me is all about patient outcomes and the primary focus of that is the outcomes that we can achieve for our patients. Everything that we do is all for our patients.*[1358]

934. Mr Gendy emphasised that "value" was not synonymous with "price".[1359] However, Mr Gendy did see value as interacting with economic efficiency: for example, procurement reforms with the effect of reducing cost and freeing up staff would in turn allow money and staff time to be redirected to better achieving patient outcomes.[1360] Similarly, Mr Dale said that while value-based healthcare

[1353] Transcript of the Commission, 21 February 2024, T726.41-727.4 (Anderson).
[1354] Exhibit B.23.14, NSW Health Procurement Procedures (Goods and Services) June 2022 Version 1 p 37 (cl 6.13.2) [MOH.0001.0366.0001 at 0037].
[1355] Exhibit B.18, Alira Health, Value-Based Procurement in Australia p 6 [SCI.0003.0001.0048 at 0053].
[1356] Transcript of the Commission, 20 February 2024 T612.11-18 (Dale).
[1357] Transcript of the Commission, 23 February 2024 T916.10-16 (Rechbauer).
[1358] Transcript of the Commission, 23 February 2024 T1002.11-14 (Gendy).
[1359] Transcript of the Commission, 23 February 2024 T1002.16-23 (Gendy).
[1360] Transcript of the Commission, 23 February 2024 T1002.15-1003.14 (Gendy).

must be patient-centric, “there's an efficiency component as well, so delivering the maximum outcome for the resources that you are using”.[1361]

935. What these conceptions of value-based healthcare have in common is the aim of delivering the most valuable healthcare for a given cost. There is consensus, at this level of generality, that this *should* be the aim of any procurement expenditure (and probably any expenditure) in the health system. The aim should not merely be to achieve the lowest price for the type of good or service to be acquired.

936. A clear conception of what exactly “value” involves in this context, or a process for identifying it, is more elusive. There is consensus that it must involve, at some level, achieving good patient outcomes. What counts as a “good” patient outcome generally is not specified. On the one hand, it appears to be accepted that the concept should not be limited to an objectively successful clinical outcome. It may also build in, for example, whether the provision of care achieved what (if anything) the patient *wanted* to achieve from it, and whether the patient is, in the end, *happy* with how they were treated. That may interact with patient *experience*, which appears explicitly in some of the conceptions of value-based healthcare in the evidence.

937. On the other hand, at least some conceptions of “value” in the evidence accept that it should not be limited to the experience of a particular patient (and those with an interest in their individual care, such as their family), without reference to the position of the broader system. That may include the interests of clinicians involved in providing the relevant care, and the broader community which may be affected by allocating resources in one way and not another.

938. It would seem appropriate for an overarching concept of value in healthcare to include consideration of value not just to an individual patient and those with a direct stake in their care but also to other stakeholders in the system including clinicians and the broader community where relevant. But it is not possible for the Special Commission to formulate a definition of “value” that should be applied to every instance of procurement in NSW Health. This is because the key metrics that determine “value” in a particular procurement process are likely

[1361] Transcript of the Commission, 20 February 2024 T612.18-20 (Dale).

to depend on the nature of the good or service to be procured and the context in which the process occurs. What is important, though, is that there is a systematic approach to identifying and specifying the components of "value" that ought to be pursued in a given instance of procurement, by reference to a clearly articulated overarching concept.

939. The evidence leads to the conclusion that NSW Health is not presently taking a systematic approach to operationalising "value" within its procurement processes.

12.3.2 Operationalising "value" in procurement

940. Despite an extensive range of policies, procedures, guidelines, frameworks and similar documents relating to procurement, none describes *how* "value" is to be pursued in a given procurement process.

941. The main way in which value appears to be addressed in NSW Health's current procurement processes is through the criteria applied in evaluating tenders. These criteria are set out in a procurement plan. They may, depending on the subject matter of the tender, include "value" related criteria such as the extent to which the product or service will achieve certain patient outcomes. Expertise is brought to bear on these criteria during the tender evaluation process through clinicians or other subject matter experts participating as members of the tender evaluation committee or providing feedback to contract managers or clinical product managers who are expected to pass on that feedback.[1362]

942. However, there does not appear to be any documented method or system by which value-related criteria are to be determined and incorporated into a procurement plan or tender evaluation process. In this respect, Ms Rechbauer was not aware of whether there was any formal process by which tender evaluation committees weighted value-based considerations such as patient outcomes,[1363] nor whether such considerations were recorded or communicated, but said the brief produced for her approval – as one of the

[1362] Transcript of the Commission, 23 February 2024 T901.13-904.42 (Rechbauer); T1007.15-1009.35, T1013.35-38 (Gendy);
[1363] Transcript of the Commission, 23 February 2024 T910.3-911.9 (Rechbauer).

individuals with responsibility for signing off the award of a contract – would not include that level of detail.[1364]

943. In any event, at a practical level, the effect of Ms Rechbauer's evidence was that the methods of incorporating clinical feedback into HealthShare's tender evaluation were dependent upon whether clinicians happened to have provided feedback to the relevant category managers or clinical product managers which was passed on and taken into account in the tender evaluation process;[1365] and upon whether clinicians happened to be available and selected as Local Health District representatives on tender evaluation committees.[1366] While clinicians at the District level may be involved in tender processes, they do not ordinarily have input in the negotiation of a contract, which can lead to practical problems.[1367] Similarly, as set out above, whether the Agency for Clinical Innovation or the Clinical Excellence Commission became involved in a particular tender process was similarly ad hoc: and seemingly up to the individual tender evaluation committee to decide.[1368]

944. The situation described above leaves open the possibility that some tenders are being conducted in a way embeds value-based healthcare principles. But the absence of a documented and systematic approach to embedding value-based considerations in the process means there is no processes, plans or structures in place to ensure that this occurs in each instance.

945. There are further difficulties with the approach to value-based procurement described by Ms Rechbauer and Mr Gendy. For example, because it focuses on the tendering process, it misses procurement that occurs by other means. No specific guidance is given, for example, to employees procuring lower-value goods or services on PCards or VCards. There is also no guidance given to local organisations procuring goods or services on established whole-of-Health or whole-of-government contracts, even though that may still involve selecting between different suppliers or types of products.

[1364] Transcript of the Commission, 23 February 2024 T910.3-911.9 (Rechbauer).
[1365] Transcript of the Commission, 23 February 2024 T902.41-904.42 (Rechbauer).
[1366] Transcript of the Commission, 23 February 2024 T904.44-907.40 (Rechbauer).
[1367] Transcript of the Commission, 21 February 2024 T702.7-35 (Kokkinakos); Transcript of the Commission, 21 February 2024 T727.21-728.13 (Anderson).
[1368] Transcript of the Commission, 23 February 2024 T905 (Rechbauer).

946. It may well be that any detailed process for considering value-based healthcare principles in the context of these kinds of purchases is not practicable. It is, obviously, necessary to strike a balance between the ideal of incorporating value-based considerations into every procurement process, and the practical reality of much procurement having to be performed by busy clinicians or other staff at a local level as an adjunct to their main work. There are also areas, for example corporate business systems, where a value-based assessment might naturally be less prominent. But it is not apparent that the Ministry or HealthShare have considered these issues in any meaningful way outside the context of tender processes.

947. There are also limited structures for supplier engagement and feedback. In this respect, suppliers report receiving limited guidance and "buy-in" within NSW Health for advancing value-based product offerings.[1369] Attempts to do so have been met, both in HealthShare and at the District level, with a continued "strong focus" on achieving the lowest price or cost.[1370]

948. Mr Gendy described two pathways by which a supplier could bring to the attention of NSW Health an advance or development in medical technology that could benefit NSW patients: by a representative of the supplier raising it with a clinician within the system, or during the process of "refreshing" standing offer agreements, which enables new technologies to be added through the supplier panel.[1371] Both of these processes appear to be somewhat ad hoc, although he also referred to proposal to introduce "supplier forums" to promote dialogue between NSW Health representatives and representatives of particular suppliers in relation to future directions (as opposed to the supplier performance meetings that presently occur on a regular basis).[1372]

949. It is perhaps not wholly surprising that HealthShare has not engaged systematically with embedding value-based healthcare into its procurement processes, because the key performance indicators set out in its Statement of Service do not require it to do so in a substantive way.

[1369] Exhibit B.16, Statement of Paul Dale (14 February 2024) [4.1]-[4.3] [SCI.0003.0001.0022 at 0023-0024].
[1370] Exhibit B.16, Statement of Paul Dale (14 February 2024) [2.1.1.1] [SCI.0003.0001.0022 at 0023]; Transcript of the Commission, 20 February 2024 T617.30-618.39 (Dale).
[1371] Transcript of the Commission, 23 February 2024 T1015.1-35 (Gendy).
[1372] Transcript of the Commission, 23 February 2024 T1014.12-37 (Gendy); Transcript of the Commission, 23 February 2024 T913.6-20 (Rechbauer).

950. While one of the "achievement statements" in its current Statement of Service is that "[s]uccessful [value-based healthcare] initiatives are scaled and applied at a local and state level", only one of the three "actions" directed to that achievement relates to procurement, which requires HealthShare to:

> *Complete a refresh of all Procurement category strategies with input from across the system including identification of opportunities to drive better value and eliminate inefficiencies.*[1373]

951. There is no guidance as to what constitutes "better value", and therefore no capacity to measure effectively whether HealthShare has successfully taken this action.

952. There are some other local initiatives in particular Local Health Districts that seek to interpose conceptions of value-based healthcare into their local procurement processes. For example, South Western Sydney Local Health District has established a Strategic Advisory Procurement Board, which is tasked with advising and decision-making on "strategic and value based procurement of goods and services including redevelopment activity, asset replacement, and ICT".[1374] One of the matters that the Board must review in considering a procurement proposal is "healthcare centred solutions with clinical engagement and evaluation".[1375] How this works in practice is that the District's "category managers" with responsibility for procurement in a particular category (for example, clinical products, prostheses, or corporate services) present a proposal for a new procurement arrangement, or changing an existing procurement arrangement, and the Board is expected to consider not only the financial cost of the arrangement but also whether it will achieve "value" in the sense of, for example, achieving patient outcomes, the needs of clinicians and infection control purposes (depending on the nature of the good or service in question).[1376] The Board has at least two members with a clinical

[1373] Exhibit B.23.129, *HealthShare NSW Statement of Service 2023-24* (9 February 2024) p 19 (cl 6.1.1.1.20) [MOH.9999.0010.0001 at 0020].
[1374] Exhibit B.23.122, South Western Sydney Local Health District, *Terms of Reference – SWSLHD Strategic Procurement Advisory Board (SPAB)* (October 2022) [cl 6] [MOH.0001.0423.0001 at 0002].
[1375] Exhibit B.23.122, South Western Sydney Local Health District, *Terms of Reference – SWSLHD Strategic Procurement Advisory Board (SPAB)* (October 2022) [cl 7] [MOH.0001.0423.0001 at 0002].
[1376] Transcript of the Commission 22 February 2024 T802.46-803.41 (Marshall).

background,[1377] and category managers generally will have consulted with relevant clinical staff before presenting a proposal.[1378]

953. However, the extent to which the Strategic Advisory Procurement Board is effective in implementing value-based healthcare in South Western Sydney Local Health District's procurement processes is not entirely clear. For example, Mitchell Clancy, District Procurement Manager of South Western Sydney Local Health District – who is the Chair of the Board – gave this evidence when asked about the concept of value for money:[1379]

> *Look, predominantly it is just about money and ensuring that there might be potential savings but also reviewing any potential value-adds that might have been tendered as part of that process, so it might be - as part of procurement activity a tenderer might provide education and training and extra potential support that might be considered additional to what was normal practice.*

954. When asked specifically about his understanding of value-based healthcare and value-based procurement, and whether he looked at non-financial benefits in that context, Mr Clancy's response remained focused on savings and efficiencies:

> *Yes, we do look at things like work, workforce efficiencies, which we do consider a saving or efficiency for our district as part of that process.*[1380]

955. This is not a criticism of Mr Clancy. It is understandable, in the environment of intense budgetary pressure that prevails within NSW Health, that a local procurement manager would be focused mainly on financial savings and efficiencies. That makes it even more important that the Ministry and HealthShare communicate clearly what they mean by "value-based healthcare" to those with day-to-day responsibility for procurement at the local organisation level, and most importantly, provide adequate guidance to those individuals about how to translate that concept into their practical work.

956. In any event, while local initiatives are welcome, the pursuit of value-based healthcare must be embedded in a systematic way at the Ministry level if it is to

[1377] Exhibit B.23.122, South Western Sydney Local Health District, *Terms of Reference – SWSLHD Strategic Procurement Advisory Board (SPAB)* (October 2022) [cl 2] [MOH.0001.0423.0001 at 0001].
[1378] Transcript of the Commission, 22 February 2024 T801.23-3 (Marshall).
[1379] Transcript of the Commission, 22 February 2024 T774.10-23 (Clancy).
[1380] Transcript of the Commission, 22 February 2024 T774.29-33 (Clancy).

be effectively achieved. That cannot occur by local organisations setting up their own approaches to "value". Of course, what counts as "value" may vary depending on local considerations, and processes will need to be adapted to the needs and governance structures of particular local organisations. But if there is truly to be a consistent, system-wide transformation of procurement spending (and health spending generally) away from a focus on lowest cost and to a focus on a broader concept of value – as the Future Health Plan contemplates – the Ministry must provide clear and effective guidance on what that means and involves both in principle and in practice. This would seem to fall directly within the scope of the Ministry's role as "system manager".

957. There are examples of a more detailed and systematic approach to implementing value-based healthcare in other NSW Health contexts. The Agency for Clinical Innovation's *Value-based surgery: Clinical practice guide* is an example.[1381] That document describes a specific process for implementing value-based care in surgical practice, including matters such as consultation requirements. A similar approach could be taken, at least as a starting point, for implementing a more rigorous approach to value-based healthcare in the procurement context.

958. Unless a systematic and system-wide approach to embedding value-based healthcare is taken under effective leadership from the Ministry and HealthShare, the pursuit of value-based healthcare in procurement will remain aspirational, at least at a day-to-day level.

12.4 Equity in procurement

959. "Strengthen equitable outcomes and access for rural, regional and priority populations" is another "key objective" in NSW Health's Future Health Plan.[1382] NSW Health's *NSW Regional Health Strategic Plan 2022-2032* is dedicated to NSW Health's "vision" of "[a] sustainable, equitable and integrated health system delivering outcomes that matter most to patients and the community in regional, rural and remote NSW".[1383] NSW Health defines "equitable" in this

[1381] Exhibit B.23.64, NSW Agency for Clinical Innovation, *Clinical Practice Guide Value-Based Surgery* (November 2023) [MOH.0001.0282.0001].
[1382] Exhibit B.23.23, Future Health: Guiding the next decade of health care in NSW 2022-2032 (May 2022) p 8 [MOH.0001.0320.0001 at 0008].
[1383] Exhibit B.23.24, NSW Health, *NSW Regional Health Strategic Plan 2022-2032* (February 2023) [MOH.0001.0372.0001 at 0014].

context to mean that "the fairness to access healthcare irrespective of your postcode, background or culture".[1384]

960. The practical means of achieving equity in procurement within NSW Health agencies is somewhat unclear. There are no substantive references to equity in the NSW Health Procurement Policy or Procedures, or any of its other policies and procedures relating to procurement, except as between suppliers.[1385] There is no specific reference to procurement in the Regional Health Plan, except in the context of environmental sustainability.[1386] Aside from referring to the general objectives in the Future Health Plan and Regional Health Plan, the only reference to equity in HealthShare's Statement of Service is in the context of measuring "timely and equitable access" to services, the only specified action for which is developing and implementing dashboards for the Patient Transport Service (that is, nothing to do with procurement).[1387] Equity is not a concept that appears at all in HealthShare's most recent strategic plan.[1388]

961. This is not to say that NSW Health does not take seriously the concept of equity at a general level. Several important initiatives have been implemented in the area of equity generally that have involved procurement activities, including its work on virtual health care.[1389] The recent NSW Medicines Formulary project also had as one of its aims equity of access to medicines for all patients in New South Wales.[1390] But it is not a concept that seems to have been analysed or operationalised with any rigour in the context of NSW Health's ordinary procurement processes.

962. One reason for this lack of specific attention to the concept of equity in procurement may be because it appears to be assumed that increasing centralisation of procurement will inevitably lead to greater equity. This

[1384] Exhibit B.23.24, NSW Health, *NSW Regional Health Strategic Plan 2022-2032* (February 2023) p 14 [MOH.0001.0372.0001 at 0014].
[1385] Exhibit B.23.13, NSW Health Procurement (Goods and Services) Policy (4 October 2023) [cl 6.14] [MOH.0001.0037.0001 at 0021]; Exhibit B.23.14, NSW Health Procurement Procedures (Goods and Services) Version 1 (June 2022) [cl 6.17.4] [MOH.0001.0366.0001 at 0046].
[1386] Exhibit B.23.24, NSW Health, *NSW Regional Health Strategic Plan 2022-2032* (February 2023) pp 63, 67 [MOH.0001.0372.0001 at 0063, 0067].
[1387] Exhibit B.23.129, HealthShare NSW, *Statement of Service 2023-24* (9 February 2024) [cl 2.1.1.1.10] [MOH.9999.0010.0001 at 0018].
[1388] Exhibit B.23.38, HealthShare NSW, *Strategic Plan 2020-2024* (13 October 2020) [MOH.0001.0328.0001].
[1389] See, for example, Exhibit B.23.67, NSW Health, *NSW Virtual Care Strategy 2021-2026* (February 2022) [MOH.0001.0371.0001].
[1390] See, for example, Exhibit B.2, Statement of Adjunct Professor Michael Nicholl (29 January 2024) [40a] [MOH.0001.0262.0001 at 0008].

appeared particularly in Mr Gendy's evidence, which included, for example, the following observation:[1391]

> *Centralised procurement also enables greater savings to be achieved by harnessing system purchasing power to obtain whole-of-health volume discounts from suppliers, which enables equitable procurement across geographic areas.*

963. Similarly, Ms Rechbauer referred (albeit in the context of other shared services) to increasing "service equity across metropolitan and regional LHDs" by increasing centralisation and standardisation of those services.[1392]

964. This thinking manifests most clearly at a practical level by the priority given in NSW Health's procurement processes to developing and purchasing on statewide contracts. In her oral evidence, Ms Rechbauer was insistent that statewide contracts achieve "the best price for the state" and thereby "maximise equity across the system over time".[1393] The proposition that statewide contracts will achieve the best price across the system appears to be based on the logic that the state (represented by HealthShare) has greater purchasing power, and therefore greater negotiating power, than individual Districts or other local organisations negotiating separately.[1394]

965. This proposition has some superficial attraction. All else equal, a higher-volume purchaser can be expected to have greater purchasing power, and by reason of that power a capacity to achieve a lower price. But it is not apparent that the underlying premise holds in the context of the wider public health system in this State. When negotiating at a statewide level, HealthShare is really negotiating on behalf of a conglomerate of local organisations with disparate characteristics. When it asks suppliers to offer a single price in that context, it is asking them, in reality, to give equal treatment to small, remote Districts and facilities that are more difficult to serve and would have much less power negotiating alone, as to large metropolitan Districts and facilities with comparatively greater power. Viewing the situation in that way, it might be expected that rather than achieving the *lowest* price, a statewide contract is

[1391] Exhibit B.5, Statement of Michael Gendy (31 January 2024) [87] [MOH.0001.0434.0001 at 0030].
[1392] Exhibit B.11, Statement of Carmen Rechbauer (12 February 2024) [125]-[126] [MOH.9999.0001 at 0034].
[1393] Transcript of the Commission, 23 February 2024, T894.10-33 (Rechbauer).
[1394] See, for example, Transcript of the Commission, 23 February 2024, T894.45-895.11 (Rechbauer).

more likely to achieve a price *in between* that which would be offered to the larger metropolitan Districts and facilities and that which would be offered to the smaller remote Districts and facilities.

966. This would accord with the perception of some metropolitan Districts that they could achieve lower prices for at least some procurement if they negotiated alone.[1395] NSW Health does not address this issue in any systematic way. Mr Gendy said that if a District approached him with evidence that it was worse-off under a statewide contract than it would be if it contracted alone, then he would "look at how we can adjust that", although his view remained that the system as a whole would be better-off because of the statewide contract.[1396] Similarly, Ms Rechbauer's evidence was that there may be occasions on which a supplier is permitted to offer a lower price to a particular local organisation under a statewide contract, but this would need to come through HealthShare, and would be determined by HealthShare on an ad hoc basis having regard to "how that will impact the system".[1397] The extent to which this actually occurs, or how it is determined whether or to what extent differential pricing "will impact the system", is not apparent.

967. There are also problems in the other direction. For example, in relation to goods supplied through the Onelink warehouse, non-metropolitan Local Health Districts bear the cost of transporting goods from the warehouse to their facilities.[1398] Further, there is evidence that some suppliers are unwilling or unable (at least in a timely way) to supply to rural and remote facilities despite being under statewide contracts.[1399] In these circumstances, statewide contracts do not appear to be achieving equity.

968. It is possible to envisage different ways of seeking to achieve equity in procurement across geographical locations. One may be to allow for differential

[1395] See, for example, Exhibit B.4, Statement of Dr Teresa Anderson AM (31 January 2024) [114] [MOH.0001.0258.0001 at 0030]; Exhibit B.7, Statement of Sonia Marshall (5 February 2024) [46] [MOH.0001.0261.0001 at 0011]; Transcript of the Commission, 21 February 2024, T746.46-747.26 (Anderson); Transcript of the Commission, 22 February 2024, T781.44-782.44 (Clancy); Transcript of the Commission, 22 February 2024, T813.38-815.14 (Marshall).
[1396] Transcript of the Commission, 23 February 2024, T1006.41-1007.13 (Gendy).
[1397] Transcript of the Commission, 22 February 2024, T887.4-889.16 (Rechbauer); Transcript of the Commission, 23 February 2024, T895.13-30 (Rechbauer).
[1398] See, for example, Exhibit B.8, Statement of Mark Spittal (6 February 2024) [69]-[71] [MOH.0001.0263.0001 at 0015-0016]; Exhibit B.9, Statement of Margaret Bennett [55] [MOH.9999.00002.0001 at 0061]; Transcript of the Commission, 23 February 2024, T896.44-897.30 (Rechbauer).
[1399] Exhibit B.8, Statement of Mark Spittal (6 February 2024) [71] [MOH.0001.0263.0001 at 0016]; Exhibit B.9, Statement of Margaret Bennett (9February 2024) [53] [MOH.9999.0007.0001 at 0015].

pricing under statewide contracts but to provide additional funding to more remote Districts that are disadvantaged by this arrangement to compensate. Another may be simply to allow those Districts that think they can achieve lower prices by negotiating alone to do so – with the effect, at least in theory, of freeing up funding allocated to those Districts to be allocated elsewhere.

969. It may be that statewide contracts with a uniform pricing structure are, in fact, the best available means of achieving equity in procurement at a system-wide level. There may also be other benefits to standardisation which can only be achieved by such an arrangement. But these matters cannot just be assumed, without proper modelling and analysis against the possible alternatives. By integrating such modelling and analysis into its procurement strategies, NSW Health would also take an important step towards embedding considerations of equity into its procurement processes in a more meaningful way.

970. Ultimately, the principal object of centralised procurement should be to ensure that NSW Health achieves the best value for money spent. Considerations of equity are obviously important; for example, procurement activities must ensure that necessary equipment and consumables are practically available to all sections of the public health system that require them. However, HealthShare should not strive to achieve common pricing for any item across the entire system if doing so results in more money being spent system wide on that particular item than would be the case under an alternative arrangement under which large metropolitan hospitals pay less than rural and remote hospitals for what might be an overwhelming majority of the particular items purchased throughout the life of the arrangement.

971. Only through careful modelling will it be possible for HealthShare to determine which arrangement will deliver greatest value to the entire system. If that arrangement does involve rural and remote Local Health Districts paying more for a particular item, it would appear logical that equity should be delivered through the adjustments to the funding provided to the Local Health Districts rather than seeking to equalise pricing through procurement in a manner that unnecessarily sacrifices systemwide value.

12.5 Measuring the effectiveness of procurement

972. Any gains that may be made through improvements in processes, including through embedded principles of value, are at risk of being lost through inadequate performance monitoring and management of suppliers. These post-procurement processes of monitoring and evaluation – often referred to as being within the realm of "contract management" are "a crucial part of the procurement lifecycle".[1400]

973. That contract management function is generally conducted by the entity with responsibility for the contract. This means whole-of-Health or whole-of-government contracts relevant to NSW Health are ostensibly managed by HealthShare, except those relating to ICT, which are managed by eHealth.[1401] HealthShare also has a role in managing contracts for which it tenders on behalf of a local organisation (generally contracts exceeding $250,000 in value).[1402] Local contracts are otherwise managed by the relevant local organisation.

974. An immediate difficulty is that those responsibilities of HealthShare and eHealth are not clearly formalised or outlined. Neither the HealthShare Board's delegation of functions[1403] nor eHealth's determination of functions[1404] refers expressly to contract management as one of their functions or responsibilities. It is not a concept that appears in either organisation's most recent strategic plans except, in eHealth's case, for a high-level reference to seeking to achieve "a more adaptive approach to vendor management".[1405] At least on their face, none of HealthShare's "Procurement and Supply Chain KPIs" in its most recent Statement of Service measure its effectiveness in contract management,[1406] and the only references to contract management in the document relate to data analysis against whole-of-government targets (such as those relating to environmental waste, travel and fleet management).[1407] The section of the NSW

[1400] Transcript of the Commission, 23 February 2024, T1013.3-4 (Gendy).
[1401] Exhibit B.11, Statement of Carmen Rechbauer (12 February 2024) [49] [MOH.9999.0009.0001 at 0015]; Exhibit B.6, Statement of Dr Zoran Bolevich (31 January 2024) [69] [MOH.0001.0433.0001 at 0029]; Transcript of the Commission, 23 February 2024, T1010.36-1011.5 (Gendy).
[1402] Exhibit B.11, Statement of Carmen Rechbauer (12 February 2024) [31(c)], [119] [MOH.9999.0009.0001 at 0011, 0032]; Transcript of the Commission, 22 February 2024, T880.15-23 (Rechbauer).
[1403] Exhibit B.23.37, Delegation of Functions of the Healthcare Board (24 November 2012) [MOH.0001.0308.0001].
[1404] Exhibit B.23.124, eHealth Determination of Functions (2 June 2023) [MOH.0001.0312.0001].
[1405] Exhibit B.23.66, eHealth Strategy for NSW Health 2016-2026 (undated) p 12 [MOH.0001.0254.0001 at 0016]. See also Exhibit B.23.38, HealthShare Strategic Plan 2020-2024 (13 October 2020) [MOH.0001.0328.0001].
[1406] Exhibit B.23.129, HealthShare NSW Statement of Service 2023-24 (9 February 2024), p 13 [MOH.9999.0010.0001 at 0014].
[1407] Exhibit B.23.129, *HealthShare NSW Statement of Service 2023-24* (9 February 2024) [cl. 5.2.2.3.10] [MOH.9999.0010.0001 at 0019].

Health Procurement Policy dealing with contract management is mostly addressed to local agencies, with little reference to HealthShare or eHealth.[1408]

975. However, the NSW Health Procurement Procedures contemplate HealthShare and eHealth being involved in contract management, and set out quite detailed procedures that those responsible for contract management are supposed to follow (including monitoring performance).[1409] But it does not seem adequate that given a core function of those organisations is procurement, that their role in the critical areas of contract and supplier performance management should be articulated only in a procedural document.

976. In any event, the evidence supports a conclusion that the "contract management" functions of HealthShare and eHealth need to be strengthened. In this respect while HealthShare has regular meetings with suppliers,[1410] there is presently no substantive system-wide monitoring of the extent to which suppliers are complying with key performance indicators in their respective contracts.[1411] Instead, issues with suppliers generally make their way to HealthShare only when raised from the local organisation or facility level, which generally occurs only when the problem has become serious.[1412] Even in those circumstances, the perception among at least some local-level witnesses was that HealthShare's responsiveness is variable, and it may take a "hands-off" role unless it receives complaints from multiple facilities or local organisations.[1413] This causes difficulty because the practical reality seems to be that local organisations are less influential with statewide suppliers than HealthShare.[1414]

977. An ad hoc process of this kind does not seem conducive to achieving effective compliance with suppliers' performance targets.

[1408] Exhibit B.23.13, *NSW Health PD2023_028 NSW Health (Goods and Services) Procurement Policy* (4 October 2023) [cl. 7] [MOH.0001.0037.0001 at 0026-0031].
[1409] Exhibit B.23.14, NSW Health Procurement Procedures (Goods and Services) (June 2022) Version 1 pp 51-67 [s. 7] [MOH.0001.0366.0001 at 0051-0067].
[1410] See for example, Transcript of the Commission, 23 February 2024 T902.11-19 (Rechbauer).
[1411] Transcript of the Commission, 23 February 2024, T1011.20-22 (Gendy); Transcript of the Commission, 23 February 2024, T902.41-904.42 (Rechbauer).
[1412] See for example, Transcript of the Commission, 20 February 2024, T640.18-26 (Misevska); Transcript of the Commission, 20 February 2024, T775.39-47 (Clancy). See also Transcript of the Commission, 23 February 2024, T920.41-921.31, T938.34-939.29 (Rechbauer); Transcript of the Commission, 23 February 2024, T1011.7-13 (Gendy).
[1413] See for example, Transcript of the Commission, 21 February 2024, T757.36-758.4, 769.42-770.5 (Swingler); Transcript of the Commission, 21 February 2024, T715.26-32 (Kokkinakos); cf Transcript of the Commission, 22 February 2024, T777.15-21 (Clancy).
[1414] See for example, Transcript of the Commission, 21 February 2024, T715.13-32 (Kokkinakos).

978. To the extent there is monitoring of supplier key performance indicators by HealthShare, those with responsibility for procurement at the local level do not receive adequate feedback or have adequate visibility of data about the performance of statewide suppliers, or even, at least in some cases, what their key performance indicators are.[1415] This is important because ultimately, those suppliers are supplying to the local organisations, and the effects of poor performance are felt at the local level, financially and potentially clinically.[1416]

979. Despite the importance given to "value" as an objective of procurement in NSW Health, there appears to be no process for measuring or evaluating the value actually achieved by a procurement activity, including whether it in fact meets any value-based criteria included in the tender evaluation process. Ms Rechbauer did not know whether there was any process for monitoring particular outcomes that may have been important in the decision-making for a procurement activity, or whether local organisations were instructed to do so.[1417] Similarly, Mr Gendy said he, as Chief Procurement Officer, was not involved in monitoring the effectiveness of procurement in achieving patient outcomes, including those outcomes that may have been featured in the tender evaluation process.[1418]

980. The NSW Health Procurement Procedures, which provide the most detailed guidance to local organisations about their contract management responsibilities, do not refer expressly to monitoring whether a contract has achieved value in a relevant sense. What they require is that contract managers monitor and review "contractual performance measures".[1419] It follows that the extent to which value-based criteria are monitored at the local level can be expected to depend on whether those criteria are translated into contractual performance measures. It is unclear whether, and if so the extent to which, that occurs.

[1415] See for example, Exhibit B.1, Statement of Margot Mains (29 January 2024) [88] [MOH.0001.0260.0001 at 0025; Exhibit B.7, Statement of Sonia Marshall (5 February 2024) [52] [MOH.0001.0261.0001 at 0012]; Transcript of the Commission, 20 February 2024, T588.10-21 (Vinton); Transcript of the Commission, 21 February 2024, T660.40-661.8, T672.18-673.25 (Chiumento); cf Transcript of the Commission 22 February 2024, T777.5-13 (Clancy).
[1416] See for example, Transcript of the Commission, 21 February 2024, T672.18-673.25 (Chiumento); Transcript of the Commission, 21 February 2024, T732.47-733.16, T743.45-744.21 (Anderson).
[1417] Transcript of the Commission, 23 February 2024, T920.22-39 (Rechbauer).
[1418] Transcript of the Commission, 23 February 2024, T1010.18-22 (Gendy).
[1419] Exhibit B.23.14, NSW Health Procurement Procedures (Goods and Services) Version 1 (June 2022) [cl 7.6.1] [MOH.0001.0366.0001 at 0061-0062.

981. In any event, again, it cannot be left to local organisations to operationalise a system-wide objective that everyone agrees should be a focus of procurement.

982. Those limitations in NSW Health's contract management processes continue to exist notwithstanding the NSW Auditor-General reported to Parliament in October 2019 that, among other things, HealthShare "is not applying the capability needed to effectively manage high-value (over $250,000) goods and services contracts", and was not complying with the directions given to it by the Ministry in relation to contract management for over 80 per cent of the contracts it managed.[1420] The Auditor-General specifically found that "HealthShare's contract management practices are limited by inadequate performance monitoring", noting that HealthShare had advised it did "not have the capacity to closely manage individual contract performance, and even if it did, it does not have the information to do so".[1421] The Auditor-General also noted HealthShare's advice that its contract management approach "primarily involves HealthShare contract managers relying on information they receive from contract users and suppliers".[1422]

983. The main action that NSW Health appears to have taken in response to the Auditor-General's report has been to implement the new "Operating Model" as part of NSW Health's recent and ongoing procurement reforms.[1423] Mr Gendy referred "a new Contract Management Framework" forming part of that new operating model.[1424] However, that new framework will result in effective contract and performance management is not immediately apparent, other than that it has involved the Ministry funding 76 additional full-time equivalent staff over two years across Districts, HealthShare, eHealth and NSW Health Pathology to perform contract management.[1425] Such investment is undoubtedly important. But it is not obvious that just increasing staffing levels

[1420] Exhibit B.23.5, Audit Office of NSW, Ensuring contract management capability in government – HealthShare NSW (31 October 2019) p 2 .0001.0013.0001 at 0006].
[1421] Exhibit B.23.15, Audit Office of NSW, Ensuring contract management capability in government – HealthShare NSW (31 October 2019) pp 3, 19-21 [MOH.0001.0013.0001 at 0007, 0023-0025].
[1422] Exhibit B.23.15, Audit Office of NSW, Ensuring contract management capability in government – HealthShare NSW (31 October 2019) pp 3, 19-21 [MOH.0001.0013.0001 at 0007, 0023-0025].
[1423] Transcript of the Commission, 23 February 2024, T960.9-24 (Rechbauer).
[1424] Exhibit B.5, Statement of Michael Gendy (31 January 2024) [30(a)] [MOH.0001.0434.0001 at 0006].
[1425] Exhibit B.5, Statement of Michael Gendy (31 January 2024) [64(a)] [MOH.0001.0434.0001 at 0021-0022]; Transcript of the Commission, 23 February 2024, T1012.43-1013.4 (Gendy).

will assist in the absence of clear and effective structures and procedures for the systematic management of contracts across NSW Health.

12.6 Conclusion and key recommendations

984. NSW Health should develop and implement a systematic approach to embedding value-based healthcare in its procurement processes, including developing and implementing clear and specific processes for:

a. determining the components of "value" that are to be pursued in a particular procurement process;

b. evaluating different options for procurement, including tenders, against each of those components of value; and

c. consulting as appropriate with clinicians, consumers, community members, suppliers and subject matter experts (including the Agency for Clinical Innovation and the Clinical Excellence Commission), in procurement processes.

985. NSW Health should develop and implement a systematic approach to monitoring the performance of suppliers of goods and services at a system-wide level, including developing and implementing clear and specific processes for:

a. formulating clear and measurable key performance indicators, including with reference to value-based criteria applied in the procurement process;

b. monitoring those key performance indicators, including designating clear lines of responsibility for performing that monitoring; and

c. obtaining feedback from and providing feedback to local organisations, including users of the relevant goods or services, in a regular and systematic way.

13 INNOVATION

986. The concept of innovation encapsulates “something new, such as an invention, or the practice of developing and introducing new things” and in the health sector it describes “new technologies or treatment, renewal or transformation of clinical practice, or the introduction of new ways of working”.[1426]

13.1 Types of innovation

987. The Terms of Reference refer to innovation in three contexts: clinical innovations, workforce innovations, and funding innovations. Each of those broad categories overlap significantly, but it is useful to first identify the concepts that broadly fall within each of them.

13.1.1 Clinical Innovations

988. Broadly stated, a clinical innovation is a new technique, method, process or treatment that is administered directly to patients.[1427] It can include new therapeutics, new models of care, and technical innovations.

a. New therapeutics

989. Clinical innovations include new and advanced therapeutics. Some examples of such therapies that are being developed, including in New South Wales, include:[1428]

a. Bacteriophage therapy for patients with drug resistant infections;

b. Gene therapies administered through viral vector delivery to treat genetic diseases; and

c. Immune effector cell therapies for the treatment of blood cancers. These involve harvesting and reinfusing a patient’s own blood cells after they have been modified so that they target and kill cancer cells.

b. New models of care

990. A model of care is the way in which health services are arranged and provided either generally or for a specific cohort.[1429] Models of care are intended to

[1426] Exhibit B.23.50, Agency for Clinical Innovation Strategy 2023-2026 (2023) [MOH.0001.0350.0001 at 0003].
[1427] Exhibit B.003, Statement of Adjunct Professor Jean-Frederic Levesque (30 January 2024) [61] [MOH.0001.0435.0001 at 0018].
[1428] Exhibit B.003, Statement of Adjunct Professor Jean-Frederic Levesque (30 January 2024) [64] [MOH.0001.0435.0001 at 0019-0020]; Exhibit N3.10, Statement of Dr Olivia Hibbitt (18 June 2024) [13] [MOH.0006.0008.0001 at 0003].
[1429] Exhibit B.3, Statement of Adjunct Professor Jean-Frederic Levesque (30 January 2024) [44] [MOH.0001.0435.0001 at 0013].

provide guidance for clinicians and to reduce unwarranted clinical variation, although only a few are mandated by specific policy directives.[1430]

991. New models of care may involve changes in the providers, processes, timeframes or settings for service provision, and are developed using research evidence and data as well as clinician and consumer experience.[1431]

992. The Agency for Clinical Innovation works with groups of clinicians and managers to develop new models of care and to help standardise existing models of care operating in health facilities.[1432] In this respect, an "alternate models of care" initiative is currently underway to identify models that support allocative and/or technical efficiency, such as through "hospital in the home" models and decreasing low-value diagnostic tests and surgical procedures.[1433]

c. Technical innovations

993. An internationally accepted broad definition of new health technology encompasses "interventions that substantially change the way care is delivered (which) may take the form of a new test, device, therapy or program".[1434] Consistent with this broad definition, technical innovations include new or improved products or processes with technological features that differ significantly from what was previously available.[1435]

994. Virtual and digitally enabled care are key technical innovations that have been deployed across the state to facilitate timely management of patients.[1436] Local Health Districts have also developed tailored virtual solutions for their communities, in particular to provide services to patients who might otherwise

[1430] Exhibit B.3, Statement of Adjunct Professor Jean-Frederic Levesque (30 January 2024) [45] [MOH.0001.0435.0001 at 0013]; Transcript of the Commission, 26 February 2024 T1051.32-38 (Levesque).
[1431] Exhibit B.3, Statement of Adjunct Professor Jean-Frederic Levesque (30 January 2024) [44]-[45] [MOH.0001.0435.0001 at 0013]; Transcript of the Commission, 26 February 2024 T1050.33-1051.26 (Levesque).
[1432] Transcript of the Commission, 26 February 2024 T1051.40-1052.8 (Levesque). For example, Current models of care in use or under development through the Agency for Clinical Innovation include the Emergency Care Assessment and Treatment program and models for spinal cord injury, menopause and rehabilitation: Exhibit N3.12, Supplementary Statement of Adjunct Professor Jean-Frederic Levesque (19 June 2024) [21]-[28] [MOH.0006.0038.0001 at 0005-0006]
[1433] Exhibit B.003, Statement of Adjunct Professor Jean-Frederic Levesque (30 January 2024) [53]-[56] [MOH.0001.0435.0001 at 0015-0016]; Exhibit B.023.063, Critical Intelligence Unit In brief – Alternate models of providing health care, [MOH.0001.0287.0001 at 0005]; Exhibit B.023.064, Agency for Clinical Innovation Clinical Practice Guide Value Based Surgery, [MOH.0001.0282.0001 at 0007-0008].
[1434] Exhibit N3.10, Statement of Dr Olivia Hibbitt (18 June 2024) [5] [MOH.0006.0008.0001 at 0002].
[1435] Exhibit B.003, Statement of Adjunct Professor Jean-Frederic Levesque (30 January 2024) [61] [MOH.0001.0435.0001 at 0018].
[1436] Transcript of the Commission, 26 February 2024, T1073.46-1074.34 (Levesque).

have limited access and provide professional support to staff in rural and remote facilities.[1437]

995. Other examples of technical innovations include implantable medical devices (such as transcatheter aortic valve implantation) and point of care testing equipment used for pathology assays (primarily in facilities with no on-site laboratory).[1438]

13.1.2 Workforce innovations

996. Workforce innovations include establishing new roles that enable greater workforce flexibility,[1439] recruitment and retention strategies,[1440] financial incentives and scholarships for rural training opportunities,[1441] and changes to scope of practice. They may also include programs that support health practitioners to relocate to regional and rural locations and facilitate the transition for them and their families to settle into a new community,[1442] and the NSW Health Key Worker Accommodation program.[1443]

997. The NSW Rural Generalist Single Employer Pathway is a particular example of a highly successful workforce innovation that incentivises junior doctors to pursue training in rural general practice by offering an employment arrangement so they can maintain their employee entitlements.[1444] That model enables junior doctors to train as rural generalists in primary care and hospital settings while employed in a Local Health District for up to four years.[1445] The single employer model gives them certainty of location, income and working conditions, and they maintain employee entitlements while gaining a wide range of experience and early exposure to rural general practice.[1446] Based on a program piloted in the Murrumbidgee Local Health District, it has now been expanded to 80 training

[1437] Transcript of the Commission, 22 March 2024 T1712.16-37 (Ludford); Transcript of the Commission,16 May 2024 T2963.35-2964.7 (Spittal).
[1438] Exhibit B023.068, NSW Health New Health Technologies and Specialised Services, p 14 [MOH.9999.0888.0001 at 0017]; Exhibit B.10, Statement of Vanessa Janissen (8 February 2024) p 20 [MOH.9999.0008.0001 at 0020].
[1439] Exhibit H.002.036, NSW Health, NSW Health Workforce Plan 2022-2032: A supplementary guide, p 19 [MOH.0010.0275.0001 at 0019].
[1440] Exhibit H.002.036, NSW Health, NSW Health Workforce Plan 2022-2032: A supplementary guide, p 23 [MOH.0010.0275.0001 at 0023].
[1441] Exhibit H.005.021, Statement of Mr Richard Griffiths (16 July 2024) pp 24-27 [86]-[89] [MOH.0011.0022.0001 at 0024-0027].
[1442] Transcript of the Commission, 19 March 2024 T1361.39-1364.24 (Stephenson).
[1443] Exhibit B.023.024, NSW Regional Health Strategic Plan 2022-2032, p 25 [MOH.0001.0372.0001 at 0025].
[1444] Exhibit C.033.001, Statement of Jill Ludford (12 March 2024) [147]-[151] [MLH.0001.0016.0001 at 0030].
[1445] Exhibit M.008 Regional Health Strategic Plan 2022-2032 - Progress Snapshot 2022-23 p 25 [MOH.0100.0297.0001 at 0027].
[1446] Exhibit C.033.001 Statement of Jill Ludford (12 March 2024) [147]-[149] [MLH.0001.0016.0001 at 0030].

places per year in other rural and regional areas through collaborative trials and a memorandum of understanding with the Commonwealth.[1447]

998. In addition, ensuring that, where appropriate, clinicians operate at the optimal level of their scope of practice has been recognised as being useful in responding to the many workforce challenges across the state. The NSW Regional Health Strategic Plan 2022-2032 highlights the importance of maintaining quality and safety in the context of changing scopes of practice.[1448] There is also a recognised need to ensure that efforts are systematic and focus on changes that aim to address current or emerging workforce supply shortages.[1449]

13.1.3 Funding innovations

999. Examples of innovation in the funding of health services generally involves the identification of new funding models that better support and incentivise the delivery of care that meets the needs of the population and supports the sustainability of the system as a whole.

1000. One impetus for changing how health services are funded is to embed concepts of "value" across the sector (which have been explored above in the context of procurement).[1450]

1001. Some areas where scope for innovation in funding models has been identified include a shift from funding models that reward volume (outputs) to models that focus on outcomes that matter to patients and incentivise high value care, including bundled and blended models.[1451] There are example of moves toward such approaches in other jurisdictions, including:[1452]

    a. Denmark: Revised activity based funding model to remove unnecessary and low-value care based on Choosing Wisely resources from Canada;

[1447] Exhibit L.003 Statement of Luke Sloane (3 October 2024) [53]-[55] [MOH.0011.0079.0001 at 0009-0010].
[1448] Exhibit B.23.24, NSW Regional Health Strategic Plan 2022-2032, pp 18-19 [MOH.0001.0372.0001 at 0018-0019].
[1449] Exhibit H.2.36, NSW Health, NSW Health Workforce Plan 2022-2032: A supplementary guide, pp 20-21 [MOH.0010.0275.0001 at 0020-0021]; Exhibit N3.17, Rosemary Huxtable AO PSM, *Mid-Term Review of the National health Reform Agreement Addendum 2020-2025* (Final Report, 24 October 2023), p 113 [SCI.0011.0585.0001 at 0118].
[1450] See also, Exhibit M.21, PWC Funding for value, p 5 [SCI.0011.0588.0001 at 0005].
[1451] Exhibit M.21, PWC Funding for value, pp 5-8 [SCI.0011.0588.0001 at 0005].
[1452] Exhibit N.3.17, Rosemary Huxtable AO PSM, *Mid-Term Review of the National health Reform Agreement Addendum 2020-2025* (Final Report, 24 October 2023), p 144 [SCI.0011.0585.0001 at 0149].

b. United States: Some provider organisations have moved to having 40% of their revenue managed under value-based care contracts;

c. Norway: Mandatory bundled payments contracts have been introduced for dialysis, some high-cost treatment programs and hip replacement surgery; and

d. England: A "best practice tariffs" scheme rewards providers who deliver high quality care via pre-defined care pathways, with the aim of reducing unwarranted clinical variation for certain conditions.

1002. A funding innovation being used currently in New South Wales is collaborative commissioning. Collaborative commissioning involves pooling state, Commonwealth and other resources (as relevant), and allocating them in a coordinated way so that service delivery meets the specific needs of a given community.[1453]

13.2 Research

1003. Research is a key component of innovation in the wider health system. Reflective of its significance, "[r]esearch and innovation, and digital advances, inform service delivery" is one of the six strategic outcomes identified in the NSW Health Future Health Report and strategic framework.[1454]

1004. Research is also part of the core business of many NSW Health agencies. For example, Local Health Districts have a statutory function to undertake research that is relevant to health service provision.[1455] The Clinical Excellence Commission, Agency for Clinical Innovation and Bureau of Health Information also have research roles conferred in their respective determinations of functions.[1456] Similarly, the Cancer Institute NSW has specific functions concerning the conduct of cancer-related research.[1457]

[1453] Transcript of the Commission, 26 February 2024, T1102.37-1103.4 (Levesque); Transcript of the Commission, 19 March 2024, T1384.39-1386.43 (Mills/Neal); Transcript of the Commission, 22 April 2024 T2294.38-2296.35 (Schembri).
[1454] Exhibit B.23.23, Future Health: Guiding the next decade of care in NSW 2022-2032 Report, p 44 [SCI.0001.0010.0001 at 0044].
[1455] Health Services Act 1997 s 10(m).
[1456] Exhibit B.023.076, Clinical Excellence Commission Determination of Functions [SCI.0003.0001.0001 at 0385]; Exhibit B.023.048, Agency for Clinical Innovation Determination of Functions [MOH.0001.0345.0001]; Exhibit B.027, Bureau of Health Information Determination of Function [SCI.0001.0063.0001].
[1457] *Cancer Institute (NSW) Act 2003* (NSW) s 12.

1005. In the healthcare context, research occurs across a continuum spanning basic science, clinical, health services, policy and population health research.[1458] Core research activities include:

a. translational research, which relates to the transformation of the findings of biomedical research to clinical practice, and the translation of health services and population health research findings to clinical practice;[1459]

b. clinical trials, which, in addition to their role in developing innovations, also are an important avenue for offering patients access to new treatments, and for opportunities to upskill health practitioners and enhance their job satisfaction;[1460]

c. intervention research, which assesses methods to improve service delivery and health outcomes; and

d. implementation and evaluation research, which explore the qualitative and quantitative effects of health programs that have been introduced.[1461]

13.2.1 Oversight of research in New South Wales

1006. In February 2023 the Agency for Clinical Innovation and Office for Health and Medical Research were integrated to form the Division of Clinical Innovation and Research in the Ministry.[1462] The Division includes the Critical Intelligence Unit.[1463]

1007. The objective of establishing the Division of Clinical Innovation and Research was to enhance visibility of research and innovation as a key priority, and to better align work and investment across the continuum of research, discovery and implementation.[1464] The Division has responsibility for creating, fostering, disseminating, translating and using research.[1465]

[1458] Exhibit B.23.51, NSW Ministry of Health NSW Health and Medical Research Strategic Review 2012, p 64 [MOH.0001.0358.0001 at 0082].
[1459] Exhibit B.23.51, NSW Ministry of Health NSW Health and Medical Research Strategic Review 2012, p 4 [MOH.0001.0358.0001 at 0022].
[1460] Exhibit K.46, Statement of Dr Chris Levi (13 September 2024) [9] [MOH.0011.0070.0001 at 0002].
[1461] Exhibit B.23.51, NSW Ministry of Health NSW Health and Medical Research Strategic Review 2012, p 16 [MOH.0001.0358.0001 at 0034].
[1462] Exhibit B.3, Statement of Adjunct Professor Jean-Frederic Levesque (30 January 2024) [4] [MOH.0001.0435.0001 at 0001-0002].
[1463] Exhibit B.3, Statement of Adjunct Professor Jean-Frederic Levesque (30 January 2024) [6]-[8] [MOH.0001.0435.0001 at 0002]; Exhibit H.2.51, Corporate Governance & Accountability Compendium, [1.1.4] [MOH.0001.0297.0001 at 0011].
[1464] Transcript of the Commission, 26 February 2024 T1020.30-1021.3 (Levesque).
[1465] Exhibit B.3, Statement of Adjunct Professor Jean-Frederic Levesque (30 January 2024) [32] [MOH.0001.0435.0001 at 0008-0009].

1008. The Office of Health and Medical Research administers research grant programs, provides a policy framework to support research governance and infrastructure, and facilitates engagement with universities, research institutes, industry and government stakeholders.[1466]

13.2.2 Funding of research in New South Wales

1009. In 2023-2024 the Office for Health and Medical Research oversaw a budget of $104.7 million, which was allocated as grants for a range of types of research and innovation, as well as infrastructure support.[1467]

1010. The portion of this budget that funded the running costs of independent medical research institutes was $44.5 million. The impact of this spend is evaluated by reviewing performance indicators, academic achievements and through frameworks that assess effects on local policies and health care programs.[1468]

1011. The remainder of the Office for Health and Medical Research budget for 2023-2024 was allocated to the following initiatives:[1469]

a. cardiovascular Research Capacity Program to build capability in this field ($15 million);

b. the Medical Devices Fund, which gives competitive grants to promising proposals so they can be accelerated to a commercialisation stage. This is complemented by a commercialisation training program to help ensure success ($9.5 million);

c. the Translational Research Grants Scheme, which funds innovative health services research by Local Health Districts for initiatives with the potential to be translated quickly into benefits for patients and to be scaled up ($5 million);[1470]

[1466] Exhibit B.3, Statement of Adjunct Professor Jean-Frederic Levesque (30 January 2024) [9]-[14] [MOH.0001.0435.0001 at 0002-0003]; Transcript of the Commission, 26 February 2024 T1024.38-1025.18 (Levesque).
[1467] Exhibit B.3, Statement of Adjunct Professor Jean-Frederic Levesque (30 January 2024) [14] [MOH.0001.0435.0001 at 0003-0004].
[1468] Transcript of the Commission, 26 February 2024 T1025.39-1026.22 (Levesque).
[1469] Exhibit B.3, Statement of Adjunct Professor Jean-Frederic Levesque (30 January 2024) [14] [MOH.0001.0435.0001 at 0003-0004]; Transcript of the Commission, 26 February 2024 T1027.6-1028.47 (Levesque).
[1470] Transcript of the Commission, 28 November 2023 T112.10-32 (Chant).

d. research into cardiovascular disease, schizophrenia, Motor Neurone Disease, spinal cord injury and treatment, “omics” technologies, and paediatric precision medicine; and

e. early-mid career researcher grants and PhD scholarships.

1012. The two primary sources of funding for medical research institutes are Commonwealth Government programs: the National Health and Medical Research Council and the Medical Research Future Fund.[1471] Researchers employed in Local Health Districts may obtain funding to support their research through the competitive grants processes administered by these bodies.[1472] The Pharmaceutical Benefits Scheme also funds some research.[1473]

1013. The Office for Health and Medical Research established the clinicaltrialsNSW initiative to build capacity, capability and collaboration across the state, and through this the Medical Research Future Fund has provided funding to enhance clinical trial access in rural, regional and remote areas.[1474] There are also opportunities to run clinical trials in New South Wales for therapies that have been developed overseas, with the costs being covered by the international sponsor.[1475]

1014. National Health and Medical Research Council and the Medical Research Future Fund grants are generally inadequate to cover the cost of taking advanced therapeutics to clinical trial, however, so researchers frequently engage with the commercial sector or seek venture capital for this.[1476] Some medical research institutes have established industry partnerships to support research.[1477] In addition to the life sciences industry (which includes biomedical, medical device and pharmaceutical companies), philanthropy is another source of investment in research.[1478]

[1471] Transcript of the Commission, 26 February 2024 T1030.31-39 (Levesque).
[1472] Exhibit K.46, Statement of Dr Chris Levi (13 September 2024) [7] [MOH.0011.0070.0001 at 0002]; Exhibit N3.8, Statement of Professor Ian Alexander (17 June 2024) [13] [MOH.0006.0024.0001 at 0004].
[1473] Exhibit N.3.8, Statement of Professor Ian Alexander (17 June 2024) [6] [MOH.0006.0024.0001 at 0002].
[1474] Exhibit K.46, Statement of Dr Chris Levi (13 September 2024) [10]-[15] [MOH.0011.0070.0001 at 0003].
[1475] Exhibit N.3.8, Statement of Professor Ian Alexander (17 June 2024) [14] [MOH.0006.0024.0001 at 0005].
[1476] Exhibit N.3.8, Statement of Professor Ian Alexander (17 June 2024) [13] [MOH.0006.0024.0001 at 0004].
[1477] Exhibit K.046, Statement of Dr Chris Levi (13 September 2024) [38]-[41] [MOH.0011.0070.0001 at 0001, 0010].
[1478] Exhibit B.23.51, NSW Ministry of Health NSW Health and Medical Research Strategic Review 2012, pp 48, 80 [MOH.0001.0358.0001 at 0066, 0098].

13.3 Current approaches to identifying and implementing innovation within the public health system

1015. Innovations are currently identified at a system level through the following structures:

a. The Critical Intelligence Unit in the Division of Clinical Innovation and Research identifies new models of care and initiatives through literature searches of key medical journals, and these are reviewed by a clinical panel to identify those with the potential for high system impact.[1479]

b. There are regular meetings of the Agency for Clinical Innovation International Expert Advisory Group, and the Office of Health and Medical Research engages with a network of research leaders who have strong national and international links for advice on emerging trends.[1480]

c. The Specialty Service and Technology Evaluation Unit in the Ministry of Health also undertakes some horizon scanning for emerging health technologies expected to reach the market within one to three years, as it is focused on improving health system readiness through planning.[1481]

d. Innovations are also identified to address specific health system issues through targeted searching and stakeholder engagement to develop solutions, for example, to tackle surgical wait times, manage end of life care, and deliver CAR-T cell therapies.[1482]

1016. Clinicians also inform the Ministry about emerging innovations in their respective fields of expertise,[1483] although the process is largely ad hoc. For example, this may be done through participation in the Agency for Clinical Innovation networks, the co-chairs of which are invited to events to hear about initiatives in other networks.[1484]

[1479] Exhibit B.3, Statement of Adjunct Professor Jean-Frederic Levesque (30 January 2024) [66] [MOH.0001.0435.0001 at 0021].
[1480] Exhibit B.3, Statement of Adjunct Professor Jean-Frederic Levesque (30 January 2024) [66] [MOH.0001.0435.0001 at 0022].
[1481] Exhibit N.3.10, Statement of Dr Olivia Hibbitt (18 June 2024) [5]-[10] [MOH.0006.0008.0001 at 0002-0003].
[1482] Exhibit B.3, Statement of Adjunct Professor Jean-Frederic Levesque (30 January 2024) [69] [MOH.0001.0435.0001 at 0023].
[1483] Exhibit N.3.10, Statement of Dr Olivia Hibbitt (18 June 2024) [11]-[12] [MOH.0006.0008.0001 at 0003].
[1484] Exhibit B.3, Statement of Adjunct Professor Jean-Frederic Levesque (30 January 2024) [70]-[71] [MOH.0001.0435.0001 at 0023-0026].

13.3.1 Prioritising innovations for implementation

1017. One of the stated functions of the Agency for Clinical Innovation is to support and promote innovations that are person-centred, clinically led, evidence-based and value driven, meaning that they aim to improve the effectiveness and efficiency of healthcare.[1485]

1018. The Division of Clinical Innovation and Research is aiming to develop a more rigorous process for assessing and prioritising innovations before significant investments are made, and to streamline transition to systemwide adoption.[1486] It will also establish a system for prioritising 'game-changer' innovations anticipated to have profound impacts and a way to determine the system changes necessary in order to realise the potential of the innovation.[1487]

1019. It is less clear that innovations will be prioritised based on the burden of disease or health issues that are of primary concern to the community. For example, dementia is currently the second most common cause of death nationally and expected to take over as the leading cause in the next few years. Dementia also creates a significant and escalating burden for the health system.[1488] Yet dementia is not identified as a focus for the Agency for Clinical Innovation, or the Office for Health and Medical Research, or in other evidence before the Special Commission concerning innovation priorities. The sole reference to dementia in the NSW Health Future Health Report is an example of specialist outreach for general practitioners who are managing cases of early onset dementia.[1489] Meanwhile, the Special Commission heard evidence that patients with dementia-related behavioural issues can be on acute hospital wards for months after they need acute care, blocking access for other people who require treatment.[1490]

1020. Ground-breaking innovations with the potential to benefit a small number of people appear to receive disproportionate attention relative to innovations like new models of care, even when the latter may result in greater net benefit

[1485] Exhibit B.23.50, Agency for Clinical Innovation Strategy 2023-2026, p 3 [MOH.0001.0350.0001 at 0003].
[1486] Exhibit B.3, Statement of Adjunct Professor Jean-Frederic Levesque (30 January 2024) [110] [MOH.0001.0435.0001 at 0038].
[1487] Exhibit B.3, Statement of Adjunct Professor Jean-Frederic Levesque (30 January 2024) [110] [MOH.0001.0435.0001 at 0039].
[1488] Exhibit A.22, Australian Government Intergenerational Report 2021: Australia over the next 40 years, p 27 [SCI.0001.0018.0001 at 0045].
[1489] Exhibit B.23.23, Future Health: Guiding the next decade of care in NSW 2022-2032 Report, p 28 [SCI.0001.0010.0001 at 0028].
[1490] Transcript of the Commission, 15 November 2024 T6154.19-27 (Potter), T6159.43-6160.10 (Okulicz).

economically and improve the health of many more people. In particular there is little emphasis on innovations aimed at prevention even though these may have significant downstream benefits, such as community paediatrics.

1021. There is also an apparent lack of coordination between the Agency for Clinical Innovation and Clinical Excellence Commission guiding where innovation is likely to have the greatest benefit in terms of risk reduction. For example, there is no specific focus on research or innovation relating to hospital acquired complications even though these are a significant cause of morbidity and can result in financial penalties.

13.3.2 Designing and implementing new models of care

1022. The Agency for Clinical Innovation has a framework to assist health services to understand the process of developing models of care, which covers identifying an issue or opportunity, defining what needs to change, designing a solution, implementing the new model and sustaining it.[1491] An updated version of this framework titled "Principles of developing models of care" is in development.[1492]

1023. This framework is supplemented by an implementation guide that outlines the steps involved in planning and assessing what is needed and operationalising the solutions developed.[1493]

1024. The Agency for Clinical Innovation Redesign School trains front line staff to develop innovative solutions and provides transferrable skills that can be used for future initiatives.[1494]

1025. In addition, the Agency for Clinical Innovation implementation team supports clinicians and managers at a local level to ensure solutions meet community needs and are appropriate for the relevant context so that they are effective and sustainable.[1495]

[1491] Exhibit B.23.167, Agency for Clinical Innovation, Understanding the process to develop a model of care [MOH.0001.0283.0001].
[1492] Exhibit B.3, Statement of Adjunct Professor Jean-Frederic Levesque (30 January 2024) [47] [MOH.0001.0435.0001 at 0013]; Exhibit N3.12, Supplementary Statement of Adjunct Professor Jean-Frederic Levesque (19 June 2024) [19] [MOH.0006.0038.0001 at 0004].
[1493] Exhibit B.23.58, Agency for Clinical Innovation Implementation Guide: Putting a model into practice [MOH.0001.0348.0001].
[1494] Exhibit B.3, Statement of Adjunct Professor Jean-Frederic Levesque (30 January 2024) [68] [MOH.0001.0435.0001 at 0022].
[1495] Exhibit B.3, Statement of Adjunct Professor Jean-Frederic Levesque (30 January 2024) [78] [MOH.0001.0435.0001 at 0030].

13.3.3 Scaling innovations across New South Wales

1026. The Innovation Executive Strategic Committee brings together executive leads of innovation from local health districts and specialty health networks to foster strategic collaborations that will drive innovation for the system reform agenda.[1496] The committee's roles are to identify priorities, address barriers, adapt and disseminate best practices, and undertake transformative initiatives.[1497]

1027. The Innovation Exchange is a website platform run by the Agency for Clinical Innovation to support collaboration and sharing of Local Health District innovations suitable for piloting at new sites or scaling.[1498] However, use of this platform is ad hoc, and few of the published initiatives have been adopted elsewhere, with health services tending to develop their own innovations rather than implementing an innovation shown to work elsewhere.

13.3.4 Managing the introduction of high cost innovations

1028. The New Health Technologies and Specialised Services guideline defines the processes for analysis of new health technologies and specialised services at a local level as well as those nominated for statewide adoption.[1499] Statewide adoption is only considered for innovations that are likely to be low volume with a volume/quality outcome relationship that will support concentration at a limited number of sites for safe, effective and efficient service delivery.[1500] Assessments are undertaken by the New Technology and Specialised Services Committee, an expert advisory group that facilitates planning and prioritisation of specialised services.[1501] An updated version of this guideline is currently pending approval.[1502] New South Wales has also led the development of a

[1496] Exhibit N3.12.3, Annexure C – Innovation Executive Strategic Committee Terms of Reference [MOH.0006.0041.0001].
[1497] Exhibit N.3.12.3, Annexure C – Innovation Executive Strategic Committee Terms of Reference [MOH.0006.0041.0001].
[1498] Exhibit B.3, Statement of Adjunct Professor Jean-Frederic Levesque (30 January 2024) [68] [MOH.0001.0435.0001 at 0022-0023].
[1499] Exhibit B.23.68, NSW Health GL2022_012 New Health Technologies and Specialised Services Guideline [MOH.9999.0888.0001].
[1500] Exhibit B.23.68, NSW Health GL2022_012 New Health Technologies and Specialised Services Guideline, pp 10-11 [MOH.9999.0888.0001 at 0013-0014]; Transcript of the Commission, 26 February 2024 T1080.11-1081.08 (Levesque).
[1501] Exhibit B.23.68, NSW Health GL2022_012 New Health Technologies and Specialised Services Guideline, p 12 [MOH.9999.0888.0001 at 0015].
[1502] Exhibit N.3.10, Statement of Dr Olivia Hibbitt (18 June 2024) [21] [MOH.0006.0008.0001 at 0005].

national framework for assessment, funding and implementation of high cost, highly specialised therapies and services.[1503]

1029. The Specialty Service and Technology Evaluation Unit provides a support and oversight role for new health technologies adopted at a statewide level as well as supra-local health district specialised services.[1504]

13.3.5 Evaluation of innovations after implementation

1030. The Agency for Clinical Innovation has a dedicated evaluation team and a framework that describes the health economics approach to evaluating innovations.[1505] The method of economic analysis used depends on the type of innovation being reviewed including whether it is low or high cost and the volume of patients for which it applies.[1506] The NSW Treasury guideline is also used for economic evaluation where projects involve significant investment.[1507]

1031. The Agency for Clinical Innovation aims to review models of care every five years to ensure they reflect the current evidence and new models are evaluated at around three years or perhaps earlier if a higher level of investment is involved.[1508] There is also follow up of projects undertaken through the redesign school to confirm that they have become embedded, and in some cases, these have of late been implemented statewide.[1509]

13.4 Some challenges in driving innovation

1032. There is a relatively uncoordinated approach to driving innovation across the State. For example, adoption and adaptation of models of care designed or endorsed by the Agency for Clinical Innovation is variable, with the result that there may be multiple models in use across the State based on clinician preferences and other factors.[1510]

[1503] Exhibit N.3.10.3, Annexure C – Framework for the assessment, funding and implementation of high cost, highly specialist therapies and services [MOH.0006.0007.0001].
[1504] Exhibit N.3.10, Statement of Dr Olivia Hibbitt (18 June 2024) [4]-[7] [MOH.0006.0008.0001 at 0001-0002].
[1505] Exhibit B.3, Statement of Adjunct Professor Jean-Frederic Levesque (30 January 2024) [99] [MOH.0001.0435.0001 at 0036]; Exhibit B.23.74, Agency for Clinical Innovation, Understanding the Use of Health Economics [MOH.0001.0349.0001].
[1506] Exhibit B.23.74, Agency for Clinical Innovation, Understanding the Use of Health Economics, p 10 [MOH.0001.0349.0001 at 0012].
[1507] Transcript of the Commission, 26 February 2024 T1053.13-22 (Levesque); Exhibit B.23.45, NSW Treasury TPG23-08 NSW Government Guide to Cost Benefit Analysis [MOH.0001.0325.0001].
[1508] Transcript of the Commission, 26 February 2024 T1052.43-1053.22 (Levesque).
[1509] Transcript of the Commission, 26 February 2024 T1082.12-25 (Levesque).
[1510] Exhibit B.3, Statement of Adjunct Professor Jean-Frederic Levesque (30 January 2024) [112] [MOH.0001.0435.0001 at 0039-0040]; Transcript of the Commission, 26 February 2024 T1118.26-1121.23 (Levesque).

1033. The Agency for Clinical Innovation has identified, based on feedback from stakeholders, the following priority challenges for 2023 to 2026:[1511]

a. Integrating patient care at the interfaces between different types of care providers with innovations that streamline patient journeys and promote connectivity between providers;

b. Reducing unwarranted clinical variation and promoting high-value care, through data analytics that identify variations in care delivery and innovations to address variation;

c. Redesigning healthcare to facilitate uptake of new technologies, therapies and clinical processes, by ensuring systems are prepared for emerging technologies and there are pathways for rapid assessment, adoption and implementation of innovations;

d. Implementing virtual care and digitally-enabled models to enhance care delivery;

e. Supporting equity by identifying unmet need and disparities in access and outcomes across vulnerable groups and areas that innovative models of care can address;

f. Delivering person-centred and culturally appropriate care; and

g. Fostering financial and environmental sustainability in the identification, design and implementation of clinical innovations.

1034. As noted above – there are various barriers that sit within the funding model in driving and implementing innovations across the system. In this respect, the activity based funding model has been said to limit the capacity for local innovation in ways that could improve technical and/or allocative efficiency, or increase activity and consequently enable the State to secure more funding from the Commonwealth, for example through the classification of outpatient clinics. There may be concerns that adopting a new model will have a negative financial impact in an activity based funding context because it will result in reduced activity (even though it may be better for patients).[1512]

[1511] Exhibit B.23.50, Agency for Clinical Innovation Strategy 2023-2026, p 6 [MOH.0001.0350.0001 at 0003].
[1512] Transcript of the Commission, 26 February 2024 T1106.32-1107.6 (Levesque).

1035. In contrast to some other jurisdictions there is no innovation fund in New South Wales to scale and embed innovations, even when they have been proven to represent good value.[1513] For example, a $2 billion fund has been established by the Victorian Government to stimulate industry investment in life sciences.[1514]

1036. The literature indicates that unless enough resources are committed for a sufficient period to embed implementation, it is unlikely the benefits will be sustained because it takes time for true change in clinician behaviour and for the relevant processes to be integrated and become business as usual.[1515] Mindful of this the Agency for Clinical Innovation is cautious about the number of initiatives it rolls out statewide.[1516] Some promising programs are not scaled up due to the time that it will take to implement them, particularly in circumstances where a Local Health District does not see a particular innovation as a priority for their population.[1517]

1037. Culture may influence how receptive a group is to a new technology or other innovation. This includes organisational and clinical cultures, and there may be cultural considerations for groups in the community such as First Nations people and people from culturally and linguistically diverse backgrounds.[1518]

1038. Positions for practitioners to undertake training to extend or expand their scope of practice are limited and uncoordinated, and as a result training opportunities are sporadic and driven by areas of interest and willingness to provide training and supervision rather than clinical or geographical areas of need. At the same time, communities and clinical groups may resist new models of care involving roles being transferred away from traditional care providers. Stakeholder engagement is essential to provide reassurance that the process is safe and may improve access to care and the quality of care they can receive.[1519]

[1513] Transcript of the Commission, 26 February 2024 T1105.32-1106.27 (Levesque).
[1514] Exhibit B.3, Statement of Adjunct Professor Jean-Frederic Levesque (30 January 2024) [112] [MOH.0001.0435.0001 at 0041].
[1515] Transcript of the Commission, 26 February 2024 T1108.47-1109.8 (Levesque).
[1516] Transcript of the Commission, 26 February 2024 T1109.10-38 (Levesque).
[1517] Exhibit B.003, Statement of Adjunct Professor Jean-Frederic Levesque (30 January 2024) p 34 [87]-[95] [MOH.0001.0435.0001 at 0034]; Transcript of the Commission, 26 February 2024 T1104.32-1105.26 (Levesque).
[1518] Transcript of the Commission, 26 February 2024 T1115.4-14 (Levesque); Exhibit EB.001, Murdi Paaki Regional Assembly and University of Sydney Engagement Model [SCI.0009.0050.0001]; Exhibit B.023.167, Agency for Clinical Innovation Understanding the process to develop a model of care, p 9 [MOH.0001.0283.0001].
[1519] Exhibit B.003, Statement of Adjunct Professor Jean-Frederic Levesque (30 January 2024) p 40 [112] [MOH.0001.0435.0001 at 0040]; Transcript of the Commission, 26 February 2024 T1059.17-39 (Levesque).

1039. It may be difficult to balance conflicting system performance objectives relating to an innovation, for example a tension between equity and efficiency, and similarly challenges managing long term expected gains in the context of short term objectives.[1520] Further, rapidly evolving technologies rely on large language models and artificial intelligence, and there are concerns that lack of data integration and modelling capacity will be an impediment to the introduction of programs that kind.[1521]

1040. The implementation of new diagnostic and therapeutic innovations may also be associated with over-investigation, over-diagnosis, over-treatment and over-monitoring, a situation which tends to be exacerbated in specialties and geographical locations where there is an oversupply of practitioners.[1522] At present there seems to be no central guidance about the extent to which this should be permitted at public expense, despite the fact that it is known to result in inequity such as access to specialist care.

1041. Without appropriate controls innovations that are adopted based on evidence of net benefit for one cohort may be used for a broader group of patients for whom there may no additional benefit relative to the previous therapeutic option, yet a significant increase in cost. This can occur with both procedures and medications. Unwarranted clinical variation may also be associated with "indication creep" of this nature.[1523] Reducing unwarranted clinical variation is complex and multifaceted, requiring robust measurement of variation, consideration of available evidence, identification of levers for change and effective change management.[1524]

1042. A Positive Cost Effectiveness Analysis/Cost Utility Analysis for an innovation may be predicated on a corresponding reduction in the use of a pre-existing therapeutic option, but unless adequate controls are put in place to ensure those reductions are realised, there may simply be a shift in the case-mix to

[1520] Exhibit B.003, Statement of Adjunct Professor Jean-Frederic Levesque (30 January 2024) p 40 [112] [MOH.0001.0435.0001 at 0040].
[1521] Exhibit B.003, Statement of Adjunct Professor Jean-Frederic Levesque (30 January 2024) p 40 [112] [MOH.0001.0435.0001 at 0040].
[1522] Exhibit A.31, National Preventive Health Strategy 2021-2030, p 20 [SCI.0001.0027.0001 at 0020]; Exhibit H002.026, Australian Government Department of Health, National Medical Workforce Strategy 2021-2031, p 33 [SCI.0011.0388.0001 at 0043].
[1523] Exhibit B.23.168, Sutherland Kim and Adjunct Professor Jean-Frederic Levesque 'Unwarranted clinical variation in health care: Definitions and proposal of an analytic framework' (2020) 26 *Journal of Evaluation in Clinical Practice* 687, p 692 [MOH.0001.0273.0001 at 0006].
[1524] Exhibit B.3, Statement of Adjunct Professor Jean-Frederic Levesque (30 January 2024) p 42 [113] [MOH.0001.0435.0001 at 0042].

include new patients, or an increase in other procedures to fill the gap created. The benefits anticipated from an innovation may be based in part on it replacing an outdated technology or practice, but this needs to be managed to ensure it occurs. A far greater focus is needed on disinvesting in low value care and reducing futile care.[1525]

1043. Although reducing unwarranted clinical variation and disinvesting in low value care are described as priorities, there appears to be little central guidance or support for managing resistance to changes of this nature. The Special Commission heard of procedures where there was a clear safety reason for ceasing procedures at a particular site and yet it took years to convince medical practitioners of the merits of this being done. At the same time, it is evident some clinicians agree that low value care should not be offered but do not feel empowered to refuse demands for it to be provided by patients and families.

1044. Similarly, there may be insufficient appreciation of the increased costs that will result from introduction of an innovation. For example, it may be recognised that a new screening program will result in more procedures for people picked up through screening, but a failure to account for the increased burden on anatomical pathology when those procedures result in many more biopsies being taken. There may also be a need for staff to be upskilled to use a new technology but also maintain their skills in the pre-existing treatment modalities – such as being able to perform operations robotically, laparoscopically and as open surgery according to a patient's needs.

1045. The Commission heard evidence that a significant proportion of health expenditure occurs close to the end a person's life, often in the context of high levels of co-morbidity such that it is death rather than life that is being prolonged, and often at great expense.[1526] However clinicians experience pressure from families and other staff to provide every possible intervention for patients, and it is confronting to have conversations that question the appropriateness of this.[1527]

[1525] Exhibit A.1, Joint Report of Dr Nigel Lyons Dr Kerry Chant AO PSM and Deb Willcox AM, [152]-[154] [MOH.9999.0001.0001 at 0023].
[1526] Transcript of the Commission, 14 November 2024 T6024.16-36 (Hislop).
[1527] Transcript of the Commission, 14 November 2024 T6024.16-46 (Hislop).

1046. Strategies are also needed to manage the response to the makers and early adopters of innovative technologies, who may stimulate media and community interest with a view to influencing decision making. There need to be robust mechanisms in place to identify and manage conflicts of interest that may arise.

13.5 National Health Reform Agreement Addendum 2020-2025 Mid-Term Review

1047. The mid-term review of the National Health Reform Agreement Addendum 2020-2025 found there was a generally held view that the National Health Reform Agreement had not realised its aspiration to take a system wide approach and drive innovation and integration.[1528] In fact, the activity based funding model was seen as discouraging innovation, by financially penalising initiatives like new models of care deemed out of scope for the Commonwealth funding contribution, even if they reduce in-scope activity.[1529]

1048. The Commonwealth established a $100 million Health Innovation Fund for states and territories to trial innovative initiatives that support health prevention and better use of health data.[1530] However it is one off funding that does not support full implementation of programs, and as a result investment in innovations is often tactical and not maintained after the pilot project.[1531]

1049. The mid-term review recommended a standalone agency to drive innovation and reform based on system performance data indicating where there are innovation opportunities.[1532] The National Innovation and Reform Agency would be responsible for identifying emerging system pressures, and would be authorised to develop and advise on long-term system reforms and innovation.[1533] It would work with all jurisdictions and the national bodies to

[1528] Exhibit N.3.17, Rosemary Huxtable AO PSM, *Mid-Term Review of the National health Reform Agreement Addendum 2020-2025* (Final Report, 24 October 2023), p 1 [SCI.0011.0585.0001 at 0006].
[1529] Exhibit N.3.17, Rosemary Huxtable AO PSM, *Mid-Term Review of the National health Reform Agreement Addendum 2020-2025* (Final Report, 24 October 2023), pp 29, 75 [SCI.0011.0585.0001 at 0034, 0080].
[1530] Exhibit N.3.17, Rosemary Huxtable AO PSM, *Mid-Term Review of the National health Reform Agreement Addendum 2020-2025* (Final Report, 24 October 2023), p 99 [SCI.0011.0585.0001 at 0104].
[1531] Exhibit N.3.17, Rosemary Huxtable AO PSM, *Mid-Term Review of the National health Reform Agreement Addendum 2020-2025* (Final Report, 24 October 2023), p 36 [SCI.0011.0585.0001 at 0041].
[1532] Exhibit N.3.17, Rosemary Huxtable AO PSM, *Mid-Term Review of the National health Reform Agreement Addendum 2020-2025* (Final Report, 24 October 2023), pp 3, 100 [SCI.0011.0585.0001 at 0008, 0105].
[1533] Exhibit N.3.17, Rosemary Huxtable AO PSM, *Mid-Term Review of the National health Reform Agreement Addendum 2020-2025* (Final Report, 24 October 2023), pp 6, 11 [SCI.0011.0585.0001 at 0011, 0016].

ensure national buy-in and priority setting, and have strong reporting lines through the Health Chief Executives Forum to Health Ministers.[1534]

1050. The National Innovation and Reform Agency would have skills and experience in system policy and financing, and expertise in developing models of care, change management and research and data analysis. [1535] It would develop innovations to be trialled, be a knowledge exchange hub to facilitate uptake of proven ideas and advise on whole of system ambitious outcomes and benchmarks to advance reform objectives.[1536]

1051. To support the National Innovation and Reform Agency a dedicated fund was identified as critical. The new Innovation Fund would comprise new and freed up monies for short term activities while work is undertaken with jurisdictions and national bodies to develop options for implementing successful innovations and reforms at scale.[1537] This would include a "Funding Innovation Pathway" that identifies at the outset how initiatives like optimal models of care with innovative funding mechanisms will be scaled up if they meet evaluation milestones.[1538]

1052. The mid-term review also emphasised the need for funding reform, with a new National Health Reform Agreement that includes financing mechanisms to drive innovation and focus on value-based care, payment for outcomes and enabling digital and data enabled delivery models.[1539]

1053. If the next iteration of the National Health Reform Agreement were to adopt the recommendations relating to innovation identified in the mid-term review, the role of the Agency for Clinical Innovation will likely need to be adapted to align with those initiatives.

[1534] Exhibit N.3.17, Rosemary Huxtable AO PSM, *Mid-Term Review of the National health Reform Agreement Addendum 2020-2025* (Final Report, 24 October 2023), pp 11,101 [SCI.0011.0585.0001 at 0016, 0106].
[1535] Exhibit N.3.17, Rosemary Huxtable AO PSM, *Mid-Term Review of the National health Reform Agreement Addendum 2020-2025* (Final Report, 24 October 2023), p 101 [SCI.0011.0585.0001 at 0106].
[1536] Exhibit N.3.17, Rosemary Huxtable AO PSM, *Mid-Term Review of the National health Reform Agreement Addendum 2020-2025* (Final Report, 24 October 2023), p 101 [SCI.0011.0585.0001 at 0106].
[1537] Exhibit N.3.17, Rosemary Huxtable AO PSM, *Mid-Term Review of the National health Reform Agreement Addendum 2020-2025* (Final Report, 24 October 2023), p 11 [SCI.0011.0585.0001 at 0016].
[1538] Exhibit N.3.17, Rosemary Huxtable AO PSM, *Mid-Term Review of the National health Reform Agreement Addendum 2020-2025* (Final Report, 24 October 2023), pp 7-8, 11 [SCI.0011.0585.0001 at 0012-0013, 0016].
[1539] Exhibit N.3.17, Rosemary Huxtable AO PSM, *Mid-Term Review of the National health Reform Agreement Addendum 2020-2025* (Final Report, 24 October 2023), p 79 [SCI.0011.0585.0001 at 0084].

13.6 The horizon

1054. Rapidly advancing clinical and technological innovations have the potential to absorb an enormous volume of resources. Innovations in workforce, scope of practice, funding and models of care receive less attention, even though they may be less costly and could bring benefit to far more people.

1055. As any avid consumer of health system commentary will readily appreciate,[1540] advances in artificial intelligence are already enhancing many health related modalities such as:[1541]

    a. Diagnostic platforms (pathology and radiology);

    b. Programs that predict patient deterioration and clinical risks; and

    c. Research and development including drug discoveries.

1056. Massive disruptions will occur with personalised medicine as people are required to think differently and the way care is provided will be challenged.[1542]

1057. Whilst it may be accepted for the purposes of the analysis that many of the innovations being made have the capacity to support better patient outcomes, the reality is that it is unlikely (even with significant further funding) that the public health system will be able to support the adoption of all innovations that might become available for those who want or might benefit from them. Unless there is a coordinated approach to innovation based on agreed principles and priorities, there is a risk that even those that can and should be pursued within the public health system in New South Wales will not be harnessed to their full extent.

1058. That is not to say that New South Wales has not achieved success in developing and implementing innovations. As noted above, New South Wales has taken a proactive role in the advancement of clinical technologies such as bacteriophage and viral vector delivery for management of genetic diseases. However, it remains unclear how the State proposes to identify, assess, and then fund the future innovations (which are likely to come with significant costs)

[1540] Including the many podcasts that explore those topics: see, for example, Transcript of the Commission, 26 February 2024, T1055-1057.
[1541] Transcript of the Commission, 26 February 2024 T1123.14-1129.46 (Levesque).
[1542] Transcript of the Commission, 26 February 2024 T1136.1-33 (Levesque).

that have the potential to change the way healthcare is delivered. Having regard to the evidence before the Special Commission, those innovations are fast approaching.

13.7 Conclusion and key recommendations

1059. As part of a system-wide approach to service planning and design, the Agency for Clinical Innovation must play a clearer role in coordinating the identification and development of innovations, facilitating their implementation statewide and continuing to support them until they are embedded. To do this effectively, the Agency for Clinical Innovation should clearly identify research priorities, including necessary translational research. That must be accompanied by strong leadership that empowers clinical and non-clinical staff at all levels of the health system to reduce unwarranted clinical practice variation, withhold low value care, and prevent over-investigation, over-diagnosis and over-treatment.

1060. In setting these research priorities, the Agency for Clinical Innovation should ensure that:

a. Funding of research should be driven by community needs and priorities.

b. Investment in innovation and research aligns with capacity to improve health outcomes and include innovations that support prevention and/or are likely to have system management benefits.

c. Investment in innovation should be evidence based with controlled introduction and ongoing monitoring to prevent indication creep or indiscriminate use, and to ensure costs are properly reflected and anticipated savings are realised.

14 FIRST NATIONS HEALTHCARE

1061. More than 200,000 First Nations people live in New South Wales, comprising 3.4 per cent of the state's population and 33 per cent of all First Nations people nationally.[1543] About 80 per cent of First Nations people in New South Wales live in cities or inner regional areas, but those living in outer regional and remote areas comprise a higher proportion of the population in those regions.[1544]

1062. Although there have been some improvements in limited categories of health measures in recent years,[1545] the First Nations population continue to have an average life expectancy eight to 10 years less than non-Indigenous people, and a higher rate of potentially avoidable deaths.[1546] In one survey, fewer than three in 10 First Nations adults aged 18-64 were considered to be in good health compared to more than half of non-Indigenous people in the same age group.[1547]

1063. First Nations people have higher hospitalisation rates and a greater burden of disease, but often less equitable access to medical services and procedures, and a lack of access to culturally appropriate care.[1548] Cardiovascular diseases, mental and substance use disorders, cancers, respiratory diseases and injuries are the leading causes of disease burden.[1549]

1064. First Nations people are also over-represented in suicide statistics, with twice the rate of suicide per 100,000 people in regional areas.[1550] The incarceration rates are also much greater, at 2,500 per 100,000 compared to a rate of 160 per 100,000 for non-Indigenous people.[1551]

[1543] Exhibit E.1, Mid-Term Evaluation of the NSW Aboriginal Health Plan 2013-2023, Centre for Epidemiology and Evidence and Centre for Aboriginal Health (May 2019) p 15 [SCI.0009.0020.0001 at 0022]; Exhibit A.1, Joint Report of Dr Nigel Lyons, Dr Kerry Chant AO PSM and Ms Deb Willcox AM, [60] [MOH.9999.0001.0001 at 0009].
[1544] Exhibit E.1, Mid-Term Evaluation of the NSW Aboriginal Health Plan 2013-2023, Centre for Epidemiology and Evidence and Centre for Aboriginal Health (May 2019) p 15 [SCI.0009.0020.0001 at 0022].
[1545] Exhibit B.36, NSW Health Annual Report 2022-2023, NSW Ministry of Health (November 2023) pp 311-312 [SCI.0001.0059.0001 at 0320-0322].
[1546] Exhibit E.1, Mid-Term Evaluation of the NSW Aboriginal Health Plan 2013-2023, Centre for Epidemiology and Evidence and Centre for Aboriginal Health (May 2019) p 15 [SCI.0009.0020.0001 at 0022]; Exhibit A.1, Joint Report of Dr Nigel Lyons, Dr Kerry Chant AO PSM and Deb Willcox AM, [107] [MOH.9999.0001.0001 at 0016].
[1547] Exhibit M.16, Australia's Health 2024: Data Insights, Australian Institute of Health and Welfare (10 June 2024) p 164 [SCI.0011.0499.0001 at 0176].
[1548] Exhibit B.23.23, Future Health: Guiding the next decade of health care in NSW 2022-2032, NSW Ministry of Health, p 19 [MOH.0001.0320.0001 at 0037].
[1549] Exhibit E.1, Mid-Term Evaluation of the NSW Aboriginal Health Plan 2013-2023, Centre for Epidemiology and Evidence and Centre for Aboriginal Health (May 2019) p 15 [SCI.0009.0020.0001 at 0022].
[1550] Transcript of Commission, 19 March 2024 T1289.12-42 (Manzie); Transcript of Commission, 15 May 2024 T2807.29-35 (Kealy-Bateman).
[1551] Transcript of Commission, 15 May 2024 T2807.29-35 (Kealy-Bateman).

1065. An Australian Institute of Health and Welfare analysis of survey data identified five social determinants that explain 35% of the health gap for First Nations people, and six health risk factors responsible for another 30% of the gap.[1552] Of the five social determinants, those with the greatest impact are employment status (and hours worked), followed closely by household income, then schooling level, highest non-school qualification, and housing quality.[1553] The six risk factors identified were (in order of impact) smoking followed by overweight/obesity, then fruit and vegetable consumption, physical exercise level, binge drinking and high blood pressure.[1554] Based on this analysis, the authors nominated the areas that would contribute most to closing the health gap as: boosting year 12 school completion rates; increasing employment and weekly hours of work; and reducing smoking prevalence and obesity rates.[1555]

1066. There is some overlap between social determinants and health risk factors, and First Nations people also have higher rates of chronic stress and intergenerational trauma due to inequities that stem from colonisation.[1556] Nevertheless, it is estimated that 49% of the disease burden experienced by First Nations people could be prevented by a reduction in modifiable risk factors.[1557]

1067. Notwithstanding their significantly higher burden of disease, First Nations people only use health services slightly more frequently than the wider population, which has been attributed to barriers such as racism and discrimination, cultural insensitivity of health services, long distances needed to travel, and out of pocket costs.[1558] The Australian Institute of Health and Welfare has reported that a third of the gap is unexplained by survey data, and as well as access and discrimination, the cumulative effects of life events, social

[1552] Exhibit M.16, Australia's Health 2024: Data Insights, Australian Institute of Health and Welfare (10 June 2024) p 161 [SCI.0011.0499.0001 at 0173].
[1553] Exhibit M.16, Australia's Health 2024: Data Insights, Australian Institute of Health and Welfare (10 June 2024) pp 161, 171 [SCI.0011.0499.0001 at 0173, 0183].
[1554] Exhibit M.16, Australia's Health 2024: Data Insights, Australian Institute of Health and Welfare (10 June 2024) pp 161, 171 [SCI.0011.0499.0001 at 0173, 0183].
[1555] Exhibit M.16, Australia's Health 2024: Data Insights, Australian Institute of Health and Welfare (10 June 2024) p 178 [SCI.0011.0499.0001 at 0190].
[1556] Exhibit M.16, Australia's Health 2024: Data Insights, Australian Institute of Health and Welfare (10 June 2024) pp 168-169 [SCI.0011.0499.0001 at 0180-0181]; Exhibit E.1, Mid-Term Evaluation of the NSW Aboriginal Health Plan 2013-2023, NSW Ministry of Health (May 2019) p 15 [SCI.0009.0020.0001 at 0022].
[1557] Exhibit A.31, National Preventive Health Strategy 2021-2030, Australian Government Department of Health, p 5 [SCI.0001.0027.0001 at 0005].
[1558] Exhibit E.1, Mid-Term Evaluation of the NSW Aboriginal Health Plan 2013-2023, Centre for Epidemiology and Evidence and Centre for Aboriginal Health (May 2019) p 15 [SCI.0009.0020.0001 at 0022].

determinants and risk factors may play a role.[1559] In contrast, demographic and geographic factors contributed to a limited degree.[1560]

14.1 The experiences of First Nations people in accessing care

1068. The Special Commission has heard evidence that many First Nations people will not access mainstream health services, or will avoid particular facilities in their regions, as the care delivered is not culturally safe.[1561] Due to a lack of trust in the system, many First Nations people, no matter how sick they are, are more likely to present to the Aboriginal Medical Service rather than calling 000 or going to hospital.[1562] As a result, some First Nations people are missing out on vital care they need.[1563]

1069. The reasons why individuals make decisions around whether and where to access care are varied. However, the Special Commission has heard that racism remains a pervasive issue impacting the experiences of First Nations people in their interactions with public services, including health services. In this respect, First Nations people describe their experiences of racism in those public health settings as being sometimes passive and at other times it is "in your face" and "nasty."[1564] They observe that racism may be intentional or unintentional.[1565]

1070. "Unconscious bias" is a term used to describe attitudes and stereotypes which change a person's perceptions and affect their decisions or actions without them realising this.[1566] An unconscious bias is often subtle, but it leads to discrimination if the bias results in a person being treated differently or not receiving treatment they need.[1567] Views may differ as to whether it amounts

[1559] Exhibit M.16, Australia's Health 2024: Data Insights, Australian Institute of Health and Welfare (10 June 2024) pp 169-170 [SCI.0011.0499.0001 at 0181-0182].
[1560] Exhibit M.16, Australia's Health 2024: Data Insights, Australian Institute of Health and Welfare (10 June 2024) p 168 [SCI.0011.0499.0001 at 0180].
[1561] Transcript of the Commission, 14 May 2024 T2750.15-22 (Knight); Transcript of the Commission, 28 November 2024 T6730.23-32 (L Bellear).
[1562] Transcript of the Commission, 27 November 2024 T6629.8-18 (Burling).
[1563] Transcript of the Commission, 28 November 2024 T6737.41-6738.2 (Newman).
[1564] Transcript of the Commission, 14 May 2024 T2750.27-41 (Knight/McHughes); Transcript of the Commission, 27 November 2024 T6625.28-34 (Tongs), T6628.1-3 (Peckham).
[1565] Transcript of the Commission, 14 May 2024 T2753.27-2754.33 (Gordon).
[1566] Exhibit H.1.95.2, Prevention of Bullying, Discrimination and Harassment in the Workplace, College of Intensive Care Medicine, p 11 [SCI.0011.0284.0001 at 0011].
[1567] Exhibit H.1.95.2, Prevention of Bullying, Discrimination and Harassment in the Workplace, College of Intensive Care Medicine, pp 11-12 [SCI.0011.0284.0001 at 0011-0012].

to racism per se, however some believe that using the term “unconscious bias” provides an excuse to be racist.[1568]

1071. However, described, race-based decisions (conscious or otherwise) create the potential for serious misdiagnoses in First Nations people;[1569] an example of which can be observed in a recent Coronial Inquest.[1570]

1072. The Special Commission was told that despite years of training, promotions and policies aimed at preventing it, culturally unsafe practices and behaviours persist, and will likely continue to do so unless those who display such behaviours are held to account on a consistent basis.[1571]

1073. In some locations, the engagement of Aboriginal Liaison Officers has not necessarily reduced the incidence of such behaviours, partly because they have no authority to challenge the attitudes and behaviours of others, and in part because they are expected to be everywhere in the hospital at once as there are so few of them.[1572] It is said that First Nations people are fearful of making complaints about the behaviours of health staff because they experience repercussions, and there is a perception that there are never any consequences for the staff member about whom they complained.[1573]

1074. The experiences of First Nations people in accessing care have also resulted in high rates of patients being recorded as “did not wait” or “discharged against medical advice”.[1574] This has led to the term “take own leave” being coined to refer to situations when a person does not wait for care or leaves before their treatment has been completed, and the need to investigate the reasons why this occurs and find solutions.[1575]

[1568] Transcript of the Commission, 28 November 2024 T6736.45-6737.11 (Newman).
[1569] Transcript of the Commission, 14 May 2024 T2753.27-2754.33 (Gordon), T2759.22-2760.20 (McHughes); Transcript of the Commission, 27 November 2024 T6641.23-42 (Rose)
[1570] Inquest into the death of Ricky Hampson, Coroners Court of NSW, Lidcombe, Deputy State Coroner Magistrate Erin Kennedy, 20 August 2024.
[1571] Transcript of the Commission, 28 November 2024 T6736.40-6737.6 (Newman).
[1572] Transcript of the Commission, 27 November 2024 T6644.8-9 (Rose); Transcript of the Commission, 28 November 2024 T6736.7-38 (Newman).
[1573] Transcript of the Commission, 14 May 2024 T2764.38-2765.45 (Gordon/Knight/Shillingsworth).
[1574] Transcript of the Commission, 27 November 2024 T6630.4-8 (Samuelsson); Transcript of the Commission, 28 November 2024 6737.10-19 (Newman).
[1575] Exhibit F.26, Safety and Quality Account: 2022-23 Report and 2023-24 Future Priorities, Far West Local Health District, p 67 [MOH.9999.1282.0001 at 0067].

1075. The NSW Aboriginal Health Plan 2024-2034 describes the elimination of racism as being pivotal to success of the plan.[1576] For example, identifying and eliminating racism is a key focus for priority reform area 3 (Transforming government organisations), and it is said there is "an urgent need to address the devastating consequences of racism".[1577] However, other than a plan to establish "clear, consistent and easily accessible anti-racism policies and procedures", the actions do not identify what responses are to be taken if substantiated instances of racism occur within the system.[1578]

1076. Racism was also highlighted as an issue in the NSW Aboriginal Health Plan 2013-2023, as was the need to develop policies and processes for "culturally safe work environments and culturally respectful and secure health service provision".[1579] In the mid-term review of that plan it was reported that some Local Health Districts were focused on preventing it through cultural training and needed to do more work on systems for identifying and responding to incidents of racism.[1580] The mid-term review made recommendations about further actions that were required to address racism;[1581] although it is somewhat unclear to what extent these were implemented.

14.2 Initiatives to enhance cultural safety

1077. Clinical safety is inextricably linked with cultural safety, and optimising cultural safety involves dedicated, planned actions to effect institutional change.[1582] The NSW Aboriginal Health Plan 2024-2034 identifies embedding cultural safety and addressing racism at all levels of the health system as core to the third reform priority and one of five commitments to ways of working.[1583]

[1576] Exhibit N.3.31, NSW Aboriginal Health Plan 2024-2034: Sharing power in system reform, NSW Ministry of Health (October 2024) pp 2-3, 9 [SCI.0011.0744.0001 at 0006-0007, 0013].
[1577] Exhibit N.3.31, NSW Aboriginal Health Plan 2024-2034: Sharing power in system reform, NSW Ministry of Health (October 2024) pp 19, 21 [SCI.0011.0744.0001 at 0023, 0025].
[1578] Exhibit N.3.31, NSW Aboriginal Health Plan 2024-2034: Sharing power in system reform, NSW Ministry of Health (October 2024) p 21 [SCI.0011.0744.0001 at 0025].
[1579] Exhibit D.1.125, NSW Aboriginal Health Plan 2013-2023, NSW Ministry of Health (December 2012) p 15 [MOH.9999.0881.0001 at 0017].
[1580] Exhibit E.1, Mid-Term Evaluation of the NSW Aboriginal Health Plan 2013-2023, Centre for Epidemiology and Evidence and Centre for Aboriginal Health (May 2019) p 7 [SCI.0009.0020.0001 at 0011].
[1581] Exhibit E.1, Mid-Term Evaluation of the NSW Aboriginal Health Plan 2013-2023, Centre for Epidemiology and Evidence and Centre for Aboriginal Health (May 2019) p 13 [SCI.0009.0020.0001 at 0017].
[1582] Exhibit N.3.31, NSW Aboriginal Health Plan 2024-2034: Sharing power in system reform, NSW Ministry of Health (October 2024) p 21 [SCI.0011.0744.0001 at 0025].
[1583] Exhibit N.3.31, NSW Aboriginal Health Plan 2024-2034: Sharing power in system reform, NSW Ministry of Health (October 2024) pp 6, 9 [SCI.0011.0744.0001 at 0010, 0013].

1078. NSW Health organisations must include an Aboriginal Health Impact Statement when they develop or revise a policy, initiative or program.[1584] The intent is to ensure that Aboriginal health needs are considered at an early stage, barriers and enablers are assessed and managed, there is a focus on equity and monitoring and evaluating outcomes, and effective partnerships are supported.[1585] Key principles relating to cultural safety underpin the Aboriginal Health Impact Statement, including trust and cultural respect, and recognition of cultural values, traditions and a holistic approach to Aboriginal health.[1586]

1079. The key to cultural competency is listening to First Nations people and developing genuine cultural awareness. This allows for creation of appropriate policies and guidelines.[1587] For example, Broken Hill health service partnered with the community to understand its high rate of 'did not waits' then worked with the emergency department to improve cultural safety and communication, and this led to a dramatic improvement.[1588] However it is difficult to sustain such improvements if there is a lack of stability in staffing, so improvements tend to slip backwards.[1589]

1080. NSW Health describes cultural safety as a priority and states its focus is to address racism and unconscious bias through delivery of "Respecting the Difference" training.[1590] One might question whether this is really a sufficient response to what is a real barrier to First Nations people accessing health care.

1081. All NSW Health staff must complete eLearning and face to face "Respecting the Difference" training which includes consideration of cultural safety and identifying opportunities to implement learnings.[1591] Participants are required to reflect on "racism, unconscious bias, white privilege, the dominance of non-Aboriginal cultures as "the norm", and how to counteract these ingrained power

[1584] Exhibit K.56, Aboriginal Health Impact Statement, NSW Health (Policy Directive No PD2017_034) [MOH.0010.0646.0001].
[1585] Exhibit K.56, Aboriginal Health Impact Statement, NSW Health (Policy Directive No PD2017_034) p 6 [MOH.0010.0646.0001 at 0006].
[1586] Exhibit K.56, Aboriginal Health Impact Statement, NSW Health (Policy Directive No PD2017_034) p 6 [MOH.0010.0646.0001 at 0006].
[1587] Transcript of the Commission, 14 May 2024 T2735.41-2736.16 (McHughes).
[1588] Transcript of the Commission, 14 May 2024 T2736.45-2737.43 (Hampton).
[1589] Transcript of the Commission, 14 May 2024 T2737.34-42 (Hampton).
[1590] Exhibit B.36, NSW Health Annual Report 2022-2023, NSW Ministry of Health (November 2023) p 86 [SCI.0001.0059.0001 at 0095].
[1591] Exhibit E.4, Aboriginal Cultural Training – Respecting the Difference, NSW Health (Policy Directive No PD2022_028) p i [SCI.0009.0017.0001 at 0002].

structures through practising anti-racism".[1592] Importantly, staff must acknowledge and analyse their own individual cultural biases.[1593] However, it is not clear whether there is any monitoring of the effectiveness of this training in ensuring that culturally safe care is available to First Nations people in every NSW Health facility across the State.

1082. That is not to downplay the significance of this type of training. First Nations cultural awareness training is important for staff from non-Indigenous backgrounds; particularly if working with First Nations patients for short rotations. First Nations communities (rightly and understandably) tire of having to resolve issues created by clinicians who lack cultural awareness.[1594]

1083. "Respecting the Difference" training may be beneficial in reducing unintentional racism, but other strategies are needed to address intentionally racist behaviour, and evidence provided by First Nations people strongly suggests that this remains a significant issue.

1084. Cultural safety is also an important consideration in the context of health system innovation. Consultation to explore how best to foster cultural acceptance of an innovation is critical, and uptake should not be assumed simply because it will enhance service access or outcomes. Socio-economic factors and remoteness may affect access to technology, but cultural appropriateness is also important, and this is said to have been a specific consideration in the rollout of virtual care modalities.[1595] Innovative models of care also need to reflect a First Nations community's priorities, expectations and cultural context, which will vary from place to place.

1085. The Agency for Clinical Innovation has a Director of Aboriginal Health and clinical networks to manage the Aboriginal Health program and to assist other networks across the Agency to consider First Nations health issues in an appropriate way.[1596] Shared decision making tools have been developed to engage First Nations patients in reducing unwarranted clinical variation, and the

[1592] Exhibit N.3.31, NSW Aboriginal Health Plan 2024-2034: Sharing power in system reform, NSW Ministry of Health (October 2024) p 21 [SCI.0011.0744.0001 at 0025].
[1593] Exhibit E.32, Cultural Respect Framework 2016-2026 for Aboriginal and Torres Strait Islander Health, Australian Health Ministers' Advisory Council National Aboriginal and Torres Strait Islander Health Standing Committee, p 9 [SCI.0009.0008.0001 at 0011].
[1594] Transcript of the Commission, 14 May 2024 T2742.16-23 (Gordon), 2766.10-27 (Hampton).
[1595] Exhibit B.23.67, NSW Virtual Care Strategy 2021-2026: Connecting patients to care, NSW Ministry of Health (February 2022) p 12 [MOH.0001.0371.0001 at 0014].
[1596] Transcript of the Commission, 26 February 2024, T1088.16-34 (Levesque).

Alcohol and Drug Cognitive Enhancement program has been adapted under the name Yellow Gum Healing.[1597]

1086. Local innovations are somewhat ad hoc, with no shortage of solutions but difficulty obtaining resources to deliver them.[1598]

14.3 Planning services for First Nations people

1087. The importance of meaningful consultation and collaboration between NSW Health agencies and First Nations communities and care providers cannot be overstated. It is critical to ensuring that health services and research are culturally appropriate and has the added benefit of promoting efficient use of available resources. Effective collaboration can also help to prevent waste, avoid service gaps that exacerbate unmet need, and facilitate coordinated planning focused on optimising outcomes.

1088. Although there are some examples within the system of approaches to support meaningful consultation and collaboration between NSW Health agencies and First Nations healthcare providers when planning services,[1599] the Special Commission has heard that there is often little or no effective consultation with Aboriginal Community Controlled Health Organisations in the planning of health services and facilities locally. Some initiatives that are taken are seen as tokenistic, rather than substantive collaboration.[1600]

1089. In this context, meaningful consultation does not mean telling the community what is planned, it means identifying a specific community's needs and priorities in collaboration with that community, and co-designing solutions.[1601] Needs may differ between communities but systemic change is about policies and practice, and these must recognise the barriers experienced, including in rural and remote areas, through local consultation with First Nations people.[1602]

1090. The Aboriginal Community Controlled Health Organisations expressed frustration about what they see as missed opportunities to collaborate in the

[1597] Exhibit B.3, Statement of Adjunct Professor Jean-Frederic Levesque (30 January 2024) [59(d)], [85(e)] [MOH.0001.0435.0001 at 0018, 0033].
[1598] Transcript of the Commission, 14 May 2024 T2746.42-2749.22 (Mason/Gordon); Transcript of the Commission, 28 November 2024, T6800.16-21 (Newman).
[1599] See, for example, Transcript of the Commission, 27 November 2024, T6679.14-24, 6684.25-6685.10 (Falzon).
[1600] Transcript of the Commission, 27 November 2024 T6629.23-30 (Burling); Transcript of the Commission, 28 November 2024 T6738.6-36 (Raudino), 6739.34-6740.8 (C Layer), 6774.9-10 (L Bellear).
[1601] Transcript of the Commission, 14 May 2024, T2740.4-34 (Hampton)
[1602] Transcript of the Commission, 14 May 2024, T2738.18-2739.4 (Hampton).

delivery of health services to First Nations people. An example was given of hospital Aboriginal liaison officers duplicating part of the assessments being done by the local Aboriginal Medical Service, and leaving it to fill the gap.[1603] Aboriginal Community Controlled Health Organisations have been told no additional funding is available for the services they provide only to hear of requests for tender having been issued to provide health care services they are already providing.[1604] It was also noted that Local Health Districts are funded to employ Aboriginal cancer navigators, but turn to Aboriginal Community Controlled Health Organisations when they cannot recruit to the positions.[1605] Some collaboration occurs at a clinical service level, but it is uncoordinated and tends to be based on the willingness of individuals to work together.[1606]

1091. Local Health Districts develop Aboriginal Health Plans to address the needs of First Nations people in their population.[1607] Aboriginal Community Controlled Health Organisations are consulted in the development of these plans but can find the level of participation challenging as they are not resourced to perform this role.[1608]

1092. It was suggested that joint clinical service planning between Aboriginal Medical Services and Local Health Districts would address a lot of concerns. This would reduce duplication and allow them to work together to address workforce shortages and resource limitations.[1609] It would enable coordination of patient journeys in the community and in hospital, and collaboration to address issues earlier, rather than relying on siloed, output-driven funding agreements.[1610] Joint clinical services planning would mean each group can optimise the value of their contribution and facilitate sharing of resources, communication and effective referral pathways in both directions.[1611]

[1603] Transcript of the Commission, 28 November 2024, T6738.45-6739.25 (T Layer).
[1604] Transcript of the Commission, 28 November 2024, T6745.8-32 (Newman).
[1605] Transcript of the Commission, 27 November 2024, T6697.40-6699.14 (Wheeler/Falzon).
[1606] Transcript of the Commission, 27 November 2024, T6683.39-6685.7 (Wheeler/Falzon).
[1607] For example: Exhibit D.1.40, District Aboriginal Health Plan 2021-2026, Nepean Blue Mountains Local Health [MOH.9999.0808.0001]; Exhibit E.13, Improving Aboriginal Health Strategy 2018-2023, Western New South Wales Local Health District [SCI.0009.0037.0001]; Exhibit E.31, Aboriginal Health Framework 2021, Far West Local Health District [SCI.0009.0011.0001]; Exhibit I.30.5, Aboriginal Mental Health and Wellbeing Strategy 2020-2025 Implementation Plan, Southern New South Wales Local Health District [MOH.0010.0426.0001].
[1608] Transcript of the Commission, 27 November 2024 T6635.37-6636.15 (Samuelsson).
[1609] Transcript of the Commission, 28 November 2024 T6768.6-15 (Newman).
[1610] Transcript of the Commission, 28 November 2024 T6769.2-6770.12 (Newman), T6770.30-6771.42 (L Bellear)
[1611] Transcript of the Commission, 28 November 2024 T6776.45-6778.42 (T Layer/Newman); T6782.29-46 (Newman).

1093. It is clear that Aboriginal Community Controlled Health Organisations want input in the design and planning of new health services and facilities and believe (with good reason) that their knowledge of what works best for their community will make the final result more efficient and effective.[1612] Such an approach aligns with the National Safety and Quality Health Service Standards, which require health services to:[1613]

a. demonstrate a welcoming environment that recognises the importance of the cultural beliefs and practices of First Nations people; and

b. work in partnership with First Nations communities to meet their healthcare needs.

1094. There is significant scope to enhance and embed those processes within both system wide planning and at the local level for the benefit of the system and First Nations communities. In this respect, NSW Aboriginal Health Plan 2024-2034 expressly recognises the benefits in doing so.[1614]

1095. However, in pursuing those objectives it must be recognised that there is an important difference between "doing things with people" and "doing things to people"; the latter is in no sense a collaboration. An example was given of a town with more than 48 non-government service providers, as well as lead agencies, each working in their own silos, while around them the town was experiencing some of the worst rates of social disadvantage, unemployment, incarceration and mortality.[1615]

14.4 Funding services for First Nations people

1096. Local Health Districts and Specialty Health Networks are funded in their total budget allocation (not as a separate line item) to provide health services for First Nations people. Some key performance indicators for health promotion and health services for First Nations people are contained in Service Agreements,[1616] but like most others – they warrant reconsideration to ensure that they are measuring those things that are likely to result in improved health

[1612] Transcript of the Commission, 28 November 2024 T6738.13-43 (Raudino), 6740.10-12 (C Layer).
[1613] Exhibit D.1.22, National Safety and Quality Health Service Standards, Australian Commission on Safety and Quality in Health Care, pp 12, 15 [MOH.9999.0795.0001 at 0016, 0019].
[1614] See, for example, Exhibit N.3.31, NSW Aboriginal Health Plan 2024-2034: Sharing power in system reform, NSW Ministry of Health (October 2024) p 4, 16, 18 [SCI.0011.0744.0001 at 0008, 0020, 0022].
[1615] Transcript of the Commission 14 May 2024 T2740.36-2741.39 (Gordon), T2770.24-30 (Mason).
[1616] Exhibit B.23.27, Service Agreement 2023-24, NSW Health, pp 22-25, 29, 31 [MOH.0001.0288.0001 at 0023-0026, 0030, 0032].

outcomes, rather than measuring the things that are easily measurable or in respect of which current data sets are available.

1097. The Ministry also gives grants to a range of non-government organisations to provide general and specialised health services to First Nations people and/or to conduct indigenous health research. In 2022-23 these grants totalled in excess of $20 million.[1617]

1098. Some Aboriginal Community Controlled Health Organisations receive funding from NSW Health though those grants in addition to the funding they receive from other sources – such as the Commonwealth Department of Health and Aged Care, Primary Health Networks, and NSW Rural Doctors Network.[1618] In addition they bill Medicare to fund general practitioners and may pursue business opportunities to generate income they can use to bolster services.[1619]

1099. A broad consensus that emerged in the evidence was that Aboriginal Community Controlled Health Organisations regard funding they receive as being inadequate given the magnitude of the health gap First Nations people face and the range of services required for their complex health care needs.[1620] For example, Aboriginal Community Controlled Health Organisations identified patient transport as an issue, but there is no provision for it in the funding for health programs.[1621] Patient transport is a necessary service particularly in rural areas because without it people cannot travel to receive medical care they need, so innovative solutions are sought such as trying to negotiate with Transport for NSW to fund bus trips.[1622]

1100. However, the Special Commission has heard that the quantum of funding is only one of their concerns, with a number of other related challenges being identified that could be addressed without needing to increase the overall funding envelope.

[1617] Exhibit B.36, NSW Health Annual Report 2022-2023, NSW Ministry of Health (November 2023) pp 105-123 [SCI.0001.0059.0001 at 0114-0132.
[1618] Transcript of the Commission, 27 November 2024 T6682.41-45, T6691.26 (McCowen); Transcript of the Commission, 28 November 2024 T6728.31-6729.1 (Lester), T6756.35-38 (T Layer).
[1619] Transcript of the Commission, 27 November 2024 T6631.4-6 (Samuelsson); Transcript of the Commission, 28 November 2024 T6723.33-35 (MacQueen), T6727.8-35 (C Layer), T6762.23, T6796.40-47 (Raudino).
[1620] Transcript of the Commission, 27 November 2024 T6629.32-35 (Burling), T6633.30-38 (Samuelsson), T6682.39-6683.18 (McCowen).
[1621] Transcript of the Commission, 28 November 2024 T6722.42-6723.14 (Duroux/Bellear/Roxburgh), T6728.9-11 (C Layer) [SCI.0011.0637.0001 at 0009, 0015].
[1622] Transcript of the Commission, 14 May 2024 T2747.25-38 (Mason).

1101. First, Aboriginal Community Controlled Health Organisations have little if any autonomy in terms of how they are permitted to use the funding they receive, with the result that they cannot pool resources and allocate them in line with priorities in their communities.[1623] They receive several tied funding allocations from different sources, and are often prevented from using funds in ways they believe would be of more value for patients.[1624] They receive little funding for health promotion and preventive care, even though they see these as priorities to reduce the incidence of chronic disease.[1625]

1102. Tying funds to the delivery of particular programs sits uncomfortably with principles of self-determination and sacrifices the benefits of devolution, which have been referred to above in the context of Local Health Districts

1103. There is a strongly held view that the funds could be used more effectively if Aboriginal Community Controlled Health Organisations had more control over how they could be used, as this would enable them to allocate funding to reflect the needs and priorities of their communities.[1626] This is consistent with the Strengthening Medicare Taskforce recommendation to invest in Aboriginal Community Controlled Health Organisations to commission primary care services for their communities.[1627] It is also consistent with the current NSW Health Aboriginal Health Plan.[1628]

1104. Secondly, funding tends to be provided on a short term basis, yet it frequently takes longer than the period in respect funding is provided to establish and implement programs, and ongoing resources are needed to sustain them.[1629] As observed elsewhere in this outline, similar issues have been raised by other non-government organisations, and even within NSW Health more broadly. There are also inconsistencies between the length of existing plans for First Nations health (10 years), and funding duration for programs such as palliative

[1623] Transcript of the Commission, 28 November 2024 T6773.22-6774.33 (Bellear/Raudino/C Layer).
[1624] Transcript of the Commission, 28 November 2024 T6782.29-35 (Duroux).
[1625] Transcript of the Commission, 28 November 2024 T6749.38-6752.17 (Bellear/C Layer).
[1626] Transcript of the Commission, 27 November 2024 T6708.3-4 (Falzon), T6709.4-24 (Falzon/Longbottom); Transcript of the Commission, 28 November 2024 T6727.37-40 (C Layer).
[1627] Exhibit A.61, Strengthening Medicare Taskforce Report, Australian Government (December 2022) p 5 [SCI.0001.0053.0001 at 0005].
[1628] Exhibit N.3.31, NSW Aboriginal Health Plan 2024-2034: Sharing power in system reform, NSW Ministry of Health (October 2024) pp 9, 17-18 [SCI.0011.0744.0001 at 0013, 0021-0022].
[1629] Transcript of the Commission, 27 November 2024 T6695.7-42 (Falzon/Longbottom), T6672.6-17 (Edwards); Transcript of the Commission, 28 November 2024, T6757.43-6758.8 (Raudino), T6760.6-42 (Binge).

care, which will always be needed.[1630] There is a perception that government is not realistic about trusting Aboriginal Community Controlled Health Organisations with longer term funding streams.[1631]

1105. The short term nature of the funding has significant workforce disadvantages. It makes it hard to attract good staff, particularly if they have to relocate, because only short term contracts can be offered when ongoing funding is uncertain.[1632] Alternatively, staff may have to be let go when the funding for a program ceases, and this can have a negative effect on the community.[1633] It was also noted that when a program is working well then suddenly ends because no further funding has been obtained, people who work in the Aboriginal Medical Service sometimes find themselves the target of the community's frustration.[1634]

1106. Access to specialist services is an ongoing challenge, in part because specialists will not relocate to areas of need because programs only have short-term funding.[1635] Although some Aboriginal Community Controlled Health Organisations have outreach services from visiting specialists, others have none and must transport patients further afield.[1636] Some specialists accept just the Medicare payment but in other cases the cost may be prohibitive, and some Aboriginal Community Controlled Health Organisations fundraise to offset costs so people receive investigations and care they need.[1637]

1107. Aboriginal Community Controlled Health Organisations also find that the short term funding for delivery of programs does not fully cover the associated costs of management, administration, transport and overheads.[1638]

1108. Thirdly, reporting requirements were consistently described as onerous, with a high administrative burden associated with reporting and acquittals across multiple different programs, taking up resources that could be put to better

[1630] Transcript of the Commission, 27 November 2024 T6695.35-39 (Longbottom); Transcript of the Commission, 28 November 2024 T6768.23-34 (Newman).
[1631] Transcript of the Commission, 28 November 2024 T6760.6-42 (Binge).
[1632] Transcript of the Commission, 28 November 2024 T6768.29-34 (Newman).
[1633] Transcript of the Commission, 27 November 2024 T6695.27-31 (Longbottom).
[1634] Transcript of the Commission, 28 November 2024 T6762.25-43 (C Layer).
[1635] Transcript of the Commission, 27 November 2024 T6688.19-24 (McCowen); Transcript of the Commission, 28 November 2024 T6768.29-34 (Newman), T6777.9-18 (Newman).
[1636] Transcript of the Commission, 27 November 2024 T6617.40-47 (Simon), T6627.8-12 (Peckham), T6629.39-43 (Burling).
[1637] Transcript of the Commission, 27 November 2024 T6642.2-33 (Rose), T6706.9-22 (Falzon).
[1638] Transcript of the Commission, 27 November 2024 T6686.37-44 (Falzon), T6695.21-25 (Longbottom); Transcript of the Commission, 28 November 2024 T6796.43-6797.18 (Raudino).

use.[1639] Some Aboriginal Community Controlled Health Organisations are required to prepare around 100 reports per year for various government agencies.[1640] In some instances, the reporting burden may outweigh the benefit of the funding stream. [1641] As a consequence, some Aboriginal Community Controlled Health Organisations are reluctant to apply for funding, or decline funding that is offered, because the amount in question does not justify assuming the additional reporting obligations.[1642] The burden of those onerous reporting obligations is amplified by the fact that funding towards administration costs incurred by those organisations is limited.[1643]

1109. It is also said that the targets and performance indicators against which they must report always focus on outputs, there is no reporting on outcomes.[1644] There is a strong focus on quantitative data and no apparent interest in qualitative information – for example, they may have to report how many kidney health checks were done, but not what the results were, whether people received appropriate referrals, how long they had to wait for specialist care, and so on.[1645] Organisations feel the need to balance demonstrating outputs (which is required to obtain more funding) with ensuring people are seen for as long as it takes, as this is what will help to achieve better outcomes for them.[1646]

1110. Finally, it was noted that there are inefficiencies in the funding mechanisms for First Nations health services, including multiple layers between the funding source and the service provider, adding administrative costs and diverting funding streams away from clinical services.[1647]

1111. Some of those challenges are recognised in NSW Aboriginal Health Plan 2024-2034.[1648]

[1639] Transcript of the Commission, 27 November 2024 T6691.26-34 (McCowen), T6695.44-46 (Longbottom); Transcript of the Commission, 28 November 2024 T6761.29-33 (Binge); T6772.22-31 (Raudino), T6780.30-36 (Layer).
[1640] Transcript of the Commission, 27 November 2024 T6645.9-41 (Tongs).
[1641] Transcript of the Commission, 27 November 2024 T6660.33-42 (Samuelsson).
[1642] Transcript of the Commission, 27 November 2024 T6690.40-47 (McCowen); Transcript of the Commission, 28 November 2024 T6773.2-9 (L Bellear).
[1643] Transcript of the Commission, 27 November 2024 T6660.44-6661.5 (Samuelsson).
[1644] Transcript of the Commission, 27 November 2024 T6696.1-21 (Falzon); Transcript of the Commission, 28 November 2024 T6767.40-6768.4 (Newman).
[1645] Transcript of the Commission, 28 November 2024 T6766.1-38 (L Bellear).
[1646] Transcript of the Commission, 27 November 2024 T6661.7-38 (Samuelsson); Transcript of the Commission, 28 November 2024 T6725.25-47 (T Layer), 6763.10-27 (T Layer).
[1647] Transcript of the Commission, 27 November 2024 T6710.24-45 (Falzon/Longbottom).
[1648] Exhibit N.3.31, NSW Aboriginal Health Plan 2024-2034: Sharing power in system reform, NSW Ministry of Health (October 2024) p 4, 16, 18 [SCI.0011.0744.0001 at 0008, 0020, 0022].

14.5 Current NSW Health initiatives

1112. It is uncontroversial that NSW Health is aware of the importance of closing the gap and has taken action over a number of years in an attempt to improve services for, and health outcomes of, First Nations people.

1113. Several NSW Health plans and policies outline such objectives. They include:

a. Future Health Strategy, which has a specific objective to "Close the gap by prioritising care and programs for Aboriginal people", by addressing racism, embedding cultural safety, delivering services in partnership, and improving engagement with Aboriginal people.[1649] Significantly to the issues outlined above, it highlights the value of learning from Aboriginal people, and emphasises the need to focus on equitable outcomes and strengthen the Aboriginal health workforce.[1650]

b. The NSW Regional Health Strategic Plan 2022-2032, which includes a number of objectives specifically intended to support Aboriginal people. They include career pathways for Aboriginal health staff, improved access and equity to health services, investment in prevention and early intervention, building engagement, and expanding integrated care.[1651]

c. Brighter Beginnings, a whole of government initiative that aims to give children the best start in life from conception to the age of five has a particular focus on Aboriginal children and is supported by the NSW Health First 2,000 Days Framework.[1652]

d. The Aboriginal Procurement Policy, which is intended to support Aboriginal employment opportunities and business growth by setting targets for government clusters to procure goods and services from Aboriginal businesses.[1653] NSW Health has published the Aboriginal Procurement Participation Strategy which confirms its commitment to the whole of

[1649] Exhibit B.23.23, Future Health: Guiding the next decade of health care in NSW 2022-2032, NSW Ministry of Health, p 35 [MOH.0001.0320.0001 at 0053].
[1650] Exhibit B.23.23, Future Health: Guiding the next decade of health care in NSW 2022-2032, NSW Ministry of Health, pp 29, 35, 40 [MOH.0001.0320.0001 at 0047, 0053, 0058].
[1651] Exhibit B.23.24, NSW Regional Health Strategic Plan 2022-2032, NSW Ministry of Health, pp 29, 36-38, 44-45, 51-53, 59-60 [MOH.0001.0372.0001 at 0029, 0036-0038, 0044-0045, 0051-0052, 0059-0060].
[1652] Exhibit B.23.24, NSW Regional Health Strategic Plan 2022-2032, NSW Ministry of Health, pp 44-45 [MOH.0001.0372.0001 at 0044-0045].
[1653] Exhibit B.23.21, Aboriginal Procurement Policy, NSW Treasury (January 2021) p 1 [MOH.0001.0277.0001 at 0003].

government policy.[1654] The Participation Strategy identifies priorities to help NSW Health reach its targets, which for 2022 were $19.6 million spend and 66 contracts.[1655]

1114. The NSW Aboriginal Health Plan 2013-2023 defined the following six strategic directions and identified the actions required and the entity responsible for them:[1656]

    a. Building trust through partnerships;

    b. Implementing what works and building the evidence;

    c. Ensuring integrated planning and service delivery;

    d. Strengthening the Aboriginal workforce;

    e. Providing culturally safe work environments and health services; and

    f. Strengthening performance monitoring, management and accountability.

1115. The mid-term evaluation of the NSW Aboriginal Health Plan 2013-2023 found there had been "moderate" progress against these six strategic directions, noting some successes and identifying areas that needed improvement.[1657] Successes included an increase in staff who identify as Aboriginal, a reduction in incomplete emergency department visits, and lower rates of unplanned hospital readmissions in some Local Health Districts.[1658]

1116. The mid-term evaluation report made a number of recommendations to address the deficits identified in the review, which broadly covered the following areas:[1659]

    a. Build and maintain meaningful partnerships between Local Health Districts and Aboriginal Community Controlled Health Services to drive strategic planning, shared priorities, and accountability to First Nations

[1654] Exhibit B.23.115, Aboriginal Procurement and Participation Strategy, NSW Ministry of Health (March 2022) p 4 [MOH.0001.0276.0001 at 0006].
[1655] Exhibit B.23.115, Aboriginal Procurement and Participation Strategy, NSW Ministry of Health (March 2022) pp 3, 5-6 [MOH.0001.0276.0001 at 0005, 0007-0008].
[1656] Exhibit D.1.125, NSW Aboriginal Health Plan 2013-2023, NSW Ministry of Health (December 2012) pp 10-16 [MOH.9999.0881.0001 at 0012-0018].
[1657] Exhibit E.1, Mid-Term Evaluation of the NSW Aboriginal Health Plan 2013-2023, Centre for Epidemiology and Evidence and Centre for Aboriginal Health (May 2019) p 5 [SCI.0009.0020.0001 at 0012].
[1658] Exhibit E.1, Mid-Term Evaluation of the NSW Aboriginal Health Plan 2013-2023, Centre for Epidemiology and Evidence and Centre for Aboriginal Health (May 2019) pp 3-4 [SCI.0009.0020.0001 at 0010-0011].
[1659] Exhibit E.1, Mid-Term Evaluation of the NSW Aboriginal Health Plan 2013-2023, Centre for Epidemiology and Evidence and Centre for Aboriginal Health (May 2019) pp 6-12 [SCI.0009.0020.0001 at 0013-0019].

communities. Additionally, establish tools and mechanisms to evaluate the quality of those partnerships;

b. Enhance whole of government activities to address the social determinants of health through education, housing, aged care and the National Disability Insurance Scheme;

c. Invest in Aboriginal Community Controlled Health Service-led research, elevate the focus on First Nations health in mainstream research, prioritise studies of what works in First Nations health for NSW Health grant schemes, explore ways to ensure engagement in research design and foster knowledge translation;

d. Increase the focus on improving access to care, patient experiences and health outcomes of First Nations people in whole-of-health system integrated care initiatives, investigate integrated care issues and implement solutions, and collaborate to define and implement holistic models of health and wellbeing;

e. Strengthen intersectoral work through data sharing and joint planning between state and federal governments and between New South Wales Government departments to leverage the potential for data linkage and improve service delivery and health outcomes;

f. Build the First Nations health workforce, have a targeted strategy to increase those in leadership positions, support Aboriginal Health Workers to transition to clinical roles, review and develop strategies for enablers and barriers to employment and career progression for First Nations people;

g. Promote and strengthen implementation of the Aboriginal Health Impact Statement, and drive an increase in completion rates of Respecting the Difference training to 80 per cent;

h. Manage episodes of "take own leave"[1660] as clinical incidents to identify triggers like racism, support health organisations to deliver services free

[1660] "Take own leave" refers to when a person did not wait for care or left before their treatment was completed – see Exhibit F.26, Safety and Quality Account: 2022-23 Report and 2023-24 Future Priorities, Far West Local Health District, p 67 [MOH.9999.1282.0001 at 0067].

from racism with stronger policies and procedures to address instances of racism, and develop strategies and resources to build cultural safety;

i. Develop and implement an Aboriginal governance and accountability framework, have Directors / Managers of Aboriginal Health report to Local Health District Chief Executives, build ways for the NSW Aboriginal Strategic Leadership Group to inform Local Health District planning, and enhance First Nations health capacity, focus and expertise on the boards of Local Health Districts and Specialty Health Networks; and

j. Monitor progress towards culturally safe health services through improved information in patient experience surveys, enhance and use dashboards to prioritise action and accountability for First Nations health, and continue to build clinical safety and quality of the health system for First Nations people.

1117. The NSW Aboriginal Health Plan 2024-2034 is more comprehensive than its predecessor. It starts by defining commitments to the ways of working with culture at the centre surrounded by self-determination, cultural safety, equity, and truth telling and healing,[1661] and adopts the four interconnected national "Closing the Gap Priority Reforms". It adds a fifth priority reform specifically for New South Wales, as follows:[1662]

a. Formal Partnerships and shared decision making;

b. Building the community-controlled sector;

c. Transforming government organisations;

d. Shared access to data and information at a regional level; and

e. Employment, business growth and economic prosperity (New South Wales addition).

1118. The priority reform areas are described as "cross-cutting enablers of change for structural and systemic transformation across the health system".[1663]

[1661] Exhibit N.3.31, NSW Aboriginal Health Plan 2024-2034: Sharing power in system reform, NSW Ministry of Health (October 2024) p 6 [SCI.0011.0744.0001 at 0010].
[1662] Exhibit N.3.31, NSW Aboriginal Health Plan 2024-2034: Sharing power in system reform, NSW Ministry of Health (October 2024) pp 8-9 [SCI.0011.0744.0001 at 0012-0013].
[1663] Exhibit N.3.31, NSW Aboriginal Health Plan 2024-2034: Sharing power in system reform, NSW Ministry of Health (October 2024) p 8 [SCI.0011.0744.0001 at 0012].

Underpinning all of the priority reform areas are five strategic directions for strategic focus and tactical action:[1664]

a. Growing and supporting the Aboriginal Workforce;

b. Providing holistic, integrated person-centred care;

c. Enhancing health promotion, prevention and early intervention;

d. Addressing the social, cultural, economic, political, commercial and planetary determinants of health; and

e. Strengthening monitoring, evaluation, research and knowledge translation.

1119. Each reform priority and strategic direction identifies one or more focus areas to indicate what the plan "aspires to change in that area".[1665] These are accompanied by high-level strategies outlining how success will be achieved and what success will look like.[1666]

1120. The NSW Aboriginal Health Plan 2024-2034 is evidently the product of a consultation process. It is endorsed by an Advisory Committee co-chaired by the Executive Director for the Centre for Aboriginal Health and interim Chief Executive Officer of the Aboriginal Health and Medical Research Council, who say it is aspirational and will foster optimism for the achievement of real outcomes.[1667]

1121. However, many of the issues identified as warranting attention in the previous plan, and also in the mid-term evaluation, have carried over to the 2024-2034 plan, suggesting that progress has been well short of what was anticipated or required. In effect, none of the actions identified as necessary more than a decade ago has been completed to a point where it can be closed and the focus shifted to new concerns. The range and scope of priorities has simply been expanded.

[1664] Exhibit N.3.31, NSW Aboriginal Health Plan 2024-2034: Sharing power in system reform, NSW Ministry of Health (October 2024) p 10 [SCI.0011.0744.0001 at 0014].
[1665] Exhibit N.3.31, NSW Aboriginal Health Plan 2024-2034: Sharing power in system reform, NSW Ministry of Health (October 2024) p 8 [SCI.0011.0744.0001 at 0012].
[1666] Exhibit N.3.31, NSW Aboriginal Health Plan 2024-2034: Sharing power in system reform, NSW Ministry of Health (October 2024) p 8 [SCI.0011.0744.0001 at 0012].
[1667] Exhibit N.3.31, NSW Aboriginal Health Plan 2024-2034: Sharing power in system reform, NSW Ministry of Health (October 2024) p 2 [SCI.0011.0744.0001 at 0006].

1122. Moreover, and unlike the previous plan and the mid-term evaluation, the NSW Aboriginal Health Plan 2024-2034 does not allocate responsibility to any entity for achieving identified strategies. It does not articulate specific actions, or discuss accountability, or refer to any consequences for failing to act. Instead, the intention is to develop, through a collaborative process, a statewide implementation plan (aligned with the Future Health and Regional Health Strategic Plan) with detailed information about actions, timeframes, and which part of the health system is to take the lead.[1668]

1123. With only high-level strategies and an implementation plan yet to be developed, it is not possible to be confident that the plan will effectively address the range of issues that emerged in the evidence. In this respect, it is not known what resources (including funding) will be provided to support implementation; without adequate funding, there is little prospect that it will achieve its aims.

1124. In addition to those system-wide plans and policies, local initiatives have also been developed using a whole of government approaches. For example, the Coonamble Together Project, involved a facilitator engaging representatives from health, police, education and other agencies facilitate solutions and co-ordinate efforts across relevant agencies. However, the project ceased when funding for the facilitator was discontinued.[1669]

14.6 First Nations health workforce

1125. First Nations people are under-represented in the medical, nursing and allied health professions in New South Wales.[1670] A strong First Nations health workforce is rightly seen as critical to ensuring cultural safety in the health system.[1671]

1126. Aboriginal Peer Workers and Care Navigators are employed by all Local Health Districts and Specialty Health Networks in an attempt to foster a culturally safe workplace for Aboriginal staff and patients.[1672] However Aboriginal Community Controlled Health Organisations also find themselves having to provide support

[1668] Exhibit N.3.31, NSW Aboriginal Health Plan 2024-2034: Sharing power in system reform, NSW Ministry of Health (October 2024) p 4 [SCI.0011.0744.0001 at 0008].
[1669] Transcript of the Commission, 16 May 2024 T2918.30-2920.6 (Spittal).
[1670] Exhibit E.1, Mid-Term Evaluation of the NSW Aboriginal Health Plan 2013-2023, Centre for Epidemiology and Evidence and Centre for Aboriginal Health (May 2019) p 4 [SCI.0009.0020.0001 at 0011].
[1671] Exhibit B.23.23, Future Health: Guiding the next decade of health care in NSW 2022-2032, NSW Ministry of Health, p 40 [MOH.0001.0320.0001 at 0058].
[1672] Exhibit B.23.24, NSW Regional Health Strategic Plan 2022-2032, NSW Ministry of Health, p 25 [MOH.0001.0372.0001 at 0025].

for First Nations people within NSW Health facilities because cultural safety has not yet been realised for them.[1673]

1127. The mid-term evaluation of the NSW Aboriginal Health Plan 2013-2023 recommended building the First Nations health workforce with all organisations having a target of 2.6% or more, and targeted strategies to increase First Nations people in leadership positions.[1674] Since then, NSW Health organisations have been set a target of 3.43% by 2031 based on the "National Aboriginal and Torres Strait Islander Health Workforce Strategic Framework and Implementation Plan 2021-2031", and must report annually on progress.[1675] Six key priority areas have been identified to facilitate meeting that target, namely:[1676]

    a. Lead and plan Aboriginal workforce development;

    b. Build cultural understanding and respect;

    c. Attract, recruit and retain Aboriginal staff;

    d. Develop and strengthen the capabilities of Aboriginal staff;

    e. Collaboration to achieve workforce priorities; and

    f. Track our achievements and improve results.

1128. Each of the six key priority areas includes a range of required actions and identifies where the core responsibility lies for achieving them.[1677] Responsibility for most actions is allocated to Local Health Districts[1678] to identify local opportunities and strategies with limited central co-ordination.[1679]

1129. Whilst there are undeniably benefits, there are also unintended negative consequences of setting targets that NSW Health organisations must meet for their First Nations health workforce. Aboriginal Community Controlled Health Organisations expressed frustration that they recruit and train staff only to lose

[1673] Transcript of the Commission, 27 November 2024 T6699.7-22 (Falzon).
[1674] Exhibit E.1 NSW Health, Mid-Term Evaluation of the NSW Aboriginal Health Plan 2013-2023 p 9 [SCI.0009.0020.0001 at 0016].
[1675] Exhibit H.3.60, Aboriginal Workforce Composition, NSW Health (Policy Directive No PD2023_046) p 2 [MOH.0010.0313.0001 at 0005].
[1676] Exhibit H.3.60, Aboriginal Workforce Composition, NSW Health (Policy Directive No PD2023_046) p 4 [MOH.0010.0313.0001 at 0007].
[1677] Exhibit H.3.60, Aboriginal Workforce Composition, NSW Health (Policy Directive No PD2023_046) pp 5-20 [MOH.0010.0313.0001 at 0008 – 0023].
[1678] For example: Exhibit E.14, Aboriginal Workforce Affirmative Action Framework 2019-2023, Western New South Wales Local Health District [SCI.0009.0031.0001]; Exhibit F.22, Outline of Evidence of Justin Files (7 May 2024) [7]-[12] [MOH.9999.1262.0001 at 0002-0003].
[1679] Exhibit H.3.60, Aboriginal Workforce Composition, NSW Health (Policy Directive No PD2023_046) [MOH.0010.0313.0001].

them to jobs with higher salaries in Local Health Districts or non-government organisations that have been given funding and do not have staff to provide the service.[1680] As a consequence, Aboriginal Community Controlled Health Organisations would like to explore opportunities such as sharing of staff rather than having to compete for those that are in short supply.[1681]

14.6.1 Aboriginal Health Workers / Aboriginal Health Practitioners

1130. There are four categories of Aboriginal Health Worker recognised in the NSW Health Service Aboriginal Health Workers' (State) Award:[1682]

a. Aboriginal Health Workers, who have non-clinical roles that provide advocacy, support, liaison and health promotion in hospital and settings;

b. Principal Aboriginal Health Workers, that are degree qualified and may develop, implement and review primary health care strategy and policies and be responsible for supervising and training Aboriginal Health Workers; and

c. Senior Aboriginal Health Workers, that are chosen based on cultural knowledge, understanding, skills and roles in a community and function as cultural navigators for delivery of individual health services or health programs, and may be responsible for supervising and training.

1131. Aboriginal Health Practitioner is a protected title for people with a Certificate IV in Aboriginal Primary Health Care Practice and registered with the national board. They provide a range of clinical services to local Aboriginal communities.

1132. Aboriginal Health Workers and Aboriginal Health Practitioners are specifically identified as groups that should be developed and supported to take a greater role in NSW Health facilities, in areas such as emergency departments and multidisciplinary teams.[1683]

[1680] Transcript of the Commission, 28 November 2024 T6734.18-21 (L Bellear), 6740.38-6741.33 (Roxburgh), 6746.6-13 (Newman).
[1681] Transcript of the Commission, 28 November 2024 T6777.35-6778.2 (Newman).
[1682] Exhibit H.3.25, NSW Health Information Bulletin Definition of an Aboriginal Health Worker p 4 [MOH.0010.0308.0001 at 0004].
[1683] Exhibit H.3.60, Aboriginal Workforce Composition, NSW Health (Policy Directive No PD2023_046) pp 6, 11-12 [MOH.0010.0313.0001 at 0009, 0014-0015].

14.6.2 Supporting First Nations students to train in other health professions

1133. There are some initiatives that support students from First Nations backgrounds to train in what might be termed traditional health professions – medicine, nursing, midwifery and allied health.

1134. At a state level there is an Aboriginal Allied Health Cadetship Program as well as an Aboriginal Allied Health Network that brings together allied health professionals, assistants, technicians, cadets and trainees.[1684] There is also an Aboriginal Medical Workforce Pathway that facilitates the recruitment allocation of Aboriginal medical graduates to prevocational training positions.[1685]

1135. Examples of local initiatives include:

    a. Western New South Wales Local Health District funds trainees to complete the Charles Sturt University's Djirruwang Aboriginal training program, which provides them with a degree as a mental health clinician.[1686]

    b. The Murrumbidgee Local Health District 'Growing Our Own' initiative provides vocational training (with pay) to year 11 and 12 students who graduate as an Assistant in Nursing or Allied Health Assistant, with First Nations students making up more than half the graduates to date.[1687]

1136. However, if there is no consensus as to the benefit, efforts to establish a new program may not be successful. For example, a proposal to train local First Nations people as Assistants in Nursing was identified as having the associated benefit of reducing spending on agency staff whilst boosting the First Nations workforce, however funding could not be secured to implement it.[1688]

14.7 Conclusion and key recommendations

1137. A co-ordinated, whole of government approach is required to improve the health outcomes of First Nations people.

1138. Meaningful collaboration and consultation must be embedded at an organisational level and should include joint clinical service planning,

[1684] Exhibit B.23.24, NSW Regional Health Strategic Plan 2022-2032, NSW Ministry of Health, p 25 [MOH.0001.0372.0001 at 0025].
[1685] Exhibit B.23.24, NSW Regional Health Strategic Plan 2022-2032, NSW Ministry of Health, p 25 [MOH.0001.0372.0001 at 0025].
[1686] Transcript of the Commission, 15 May 2024, T2810.29-41 (McFarlane).
[1687] Transcript of the Commission, 22 March 2024, T1721.41-1722.33 (Ludford).
[1688] Transcript of the Commission, 14 May 2024, T2742.1-34 (Gordon).

undertaken with the involvement of all relevant stakeholders and with a focus on reducing duplication, addressing service gaps and improving patient journeys.

1139. Wherever possible:

a. yearly and other short term funding cycles for programs to be delivered by Aboriginal Community Controlled Health Organisations (particularly in relation to core, ongoing services) should be avoided;

b. funds devoted to First Nations healthcare should be pooled and allocated to Aboriginal Community Controlled Health Organisations; and

c. Aboriginal Community Controlled Health Organisations should be given flexibility, within the collaborative clinical service planning process referred to above, to use funding allocated to them to design and deliver the services that are required to meet the needs of the communities they service.

1140. Reporting requirements that attach to funding allocated to Aboriginal Community Controlled Health Organisations must be rationalised and simplified so as to ensure that they do not impose an unnecessary burden on the already strained resources of those organisations or unnecessarily divert those resources away from the delivery of front-line care to First Nations people.

1141. There should be greater collaboration and co-ordination with First Nations organisations across the State with a view to building a strong First Nations health workforce, and to optimise training pathways and workplace opportunities including in roles that are shared between, for examples, Aboriginal Community Controlled Health Organisations and NSW Health agencies or facilities.

E C Muston SC

R D Glover

I Fraser

D Fuller

T Waterhouse

Counsel Assisting the Special Commission of Inquiry into Healthcare Funding

20 December 2024