SPECIAL COMMISSION OF INQUIRY INTO HEALTHCARE FUNDING

NSW HEALTH SUBMISSIONS

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INTRODUCTION

1.1 NSW Health welcomes the opportunity to respond to the Outline of Submissions by Counsel Assisting dated 20 December 2024 (referred to in these submissions as '**CA Submissions**' and assigned numbers).

1.2 NSW Health acknowledge Counsel Assisting's recognition (CA Submissions [12]) of its full cooperation in the important work of the Special Commission. That approach informs the content of these submissions too.

1.3 Sections 1 – 4 of CA Submissions variously describe some matters of background about the Special Commission, provide an Executive Summary, recite the Terms of Reference and explain the principal elements of the New South Wales public health system. NSW Health does not perceive that any further input is required from it in relation to those sections.

1.4 Accordingly, these submissions are directed to Sections 5 – 14 of CA Submissions, including the recommendations proposed. Matters of factual correction are contained in a table annexed to these submissions.

1.5 It is a matter for the NSW Government as to whether it supports any particular recommendation the Special Commission might make and this submission does not intend to address the detailed consideration that NSW Government would be required to give to the implementation of any particular recommendation. In recognition of that, NSW Health has used the opportunity of these submissions to identify issues with several of the proposed recommendations. In relation to the majority of the proposed recommendations, NSW Health provides comments as to matters it perceives might bear on, or flow from, the various recommendations, and also as to some of the analysis and conclusions posed by Counsel Assisting.

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

Counsel Assisting's recommendation 1 [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.

Counsel Assisting's recommendation 2 [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.

NSW Health response to Counsel Assisting's recommendations 1 and 2

5.1 **In response to recommendations 1 and 2, NSW Health makes a number of comments, set out below.**

Benefits of preventative care

5.2 The Special Commission received unchallenged evidence that health promotion and preventative care avoid disease and hospitalisation and promote the health and wellbeing of the community.[1]

5.3 The Special Commission also received unchallenged evidence that:

a. The trajectory for the costs of implementing business as usual in the public health system has been rising which, in the post-COVID-19 years

[1] See for example, Transcript of the Commission, 29 November 2023, T190.43-191.2 (Willcox); T200.2-41 (Chant and Lyons); T222.27-229.5 (Lyons); 16 April 2024, T2935.15-2938.36 (Spittal); 22 May 2024, T3106.9-26 (Nott); 18 September 2024, T5298.41-5301.10 (Wong).

of reduced funding growth, is placing increasing pressure on the health system;[2]

b. One potential solution is to increase investment in prevention.[3]

5.4 As the statement of Dr Fizzell, Acting Chief Health Officer, explained, "prevention" is any action taken to keep people well and prevent poor health and the risk of early death.[4] Prevention can be divided into primordial, primary, secondary and tertiary prevention activities, of which many programs are already in place at local and state levels.[5] When prevention was raised in evidence in the course of the Special Commission, it usually referred to primordial, primary and secondary prevention activities, although on many site visits existing examples of tertiary prevention activities, and recent innovations, were seen.

Current challenges

5.5 Considerable work will be required to facilitate implementation of a whole of government priority for preventative health, which would ordinarily be a matter for consideration for The Cabinet Office, which has a lead role in coordinating whole of government policy reform. This work would include the setting up of an effective and practical structure for the multiagency, multidisciplinary body. This body will need to interact not only with the health system (both public and private) but will also need to target the social determinants of health which

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2 See Exhibit M.6, Joint Statement of Alfa D'Amato, Steven Carr and Neville Onley (14 November 2024), [52]f [MOH.0011.0091.0001]; Exhibit A.1, *Joint Report of Nigel Lyons, Kerry Chant and Deborah Willcox* (17 November 2023) [133]-[134], [151] [MOH.9999.0001.0001]; Exhibit E.47, Statement of Mark Spittal (30 April 2024) [30]-[31], [56]-[59] [MOH.9999.1202.0001]; Exhibit K.34, Statement of Tracey Maisey (9 September 2024) [106] [MOH.0011.0064.0019]; Transcript of the Commission, 18 November 2024, T6258.8-28 (D'Amato); 21 November 2024, T6524.5-6529.46 (D'Amato, Carr, Portelli).

3 Exhibit A.1, *Joint Report of Nigel Lyons, Kerry Chant and Deborah Willcox* (17 November 2023) [128], [140]-[142], [173]-[176] [MOH.9999.0001.0001]; Transcript of the Commission, 28 November 2023, T166.27-T167.14 (Chant), T180.5-182.30 (Willcox and Chant); 29 November 2023, T192.22-34, 193.12-39; T195.22-196.17; 199.23-38 (Chant), T204.14-19; T226.8-38 (Lyons); Exhibit A.53, *Joint Report of Alfa D'Amato and Deborah Willcox* (27 November 2023) [82]-[84] [MOH.9999.0005.00001]; Transcript of the Commission, 22 May 2024, T3106.9-26, T3107.5-18 (Nott); 23 May 2024, T3326.8-31 (Astill); Exhibit E.47, Statement of Mark Spittal (30 April 2024) [18]-[19], [108]-[109] [MOH.0011.0064.0019]; Transcript of the Commission, 23 July 2024, T3887.38-46 (Nogajski); Statement of Jill Wong (6 September 2024) [14]-[15], [29]-[31] [MOH.0011.0061.0001]; Transcript of the Commission, 18 November 2024, T6291.19-43 (D'Amato).

4 Exhibit N.29, Statement of Jan Fizzell (9 December 2024) [5] [MOH.0011.0094.0001].

5 Exhibit N.29, Statement of Jan Fizzell (9 December 2024) [6]-[11] [MOH.0011.0094.0001].

include a person's employment, education, housing and social supports.[6] The First 2000 Days is an example of how this could be done. A whole of government priority for preventative health could build on the lessons learnt from that initiative.[7] It could also build on current NSW Health efforts to coordinate with other bodies such as Communities and Justice, and Education and Planning, as well as with primary care and non-government organisations, to act collectively on the social determinants of health and promote wellness.[8]

5.6 Prevention is recognised in the *Addendum to National Health Reform Agreement 2020-2025* as one of four strategic priorities[9] and as a "critical priority" for which the State and the Commonwealth agree on shared action for long-term health system reform.[10]

5.7 Both the Commonwealth Government and NSW Government have invested in measures to address the rising preventable chronic disease burden and improve poor health outcomes. This includes joint actions to improve the early detection and management of health conditions, achieve higher and equitable immunisation coverage, and targeted health promotion measures for vulnerable communities and priority cohorts including Aboriginal and Torres Strait Islander people.[11]

5.8 There is a need to support healthy living in those with chronic diseases – this includes initiatives such as health coaching, support for people with substance use disorders and providing services to prevent further ill-health in persons

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6 Exhibit A.1, *Joint Report of Nigel Lyons, Kerry Chant and Deborah Willcox* (17 November 2023) [86] [MOH.9999.0001.0001].

7 Exhibit D.10, Statement of Deborah Willcox (9 April 2024) [20(f) – (k)] [MOH.9999.0981.0001]; Exhibit G.105, Statement of Nigel Lyons (7 June 2024) [32] – [33] [MOH.9999.1870.0001].

8 Exhibit A.1, *Joint Report of Nigel Lyons, Kerry Chant and Deborah Willcox* (17 November 2023) [88] [MOH.9999.0001.0001]; Exhibit K.34, Statement of Tracey Maisey (9 September 2024) [99]-[103] [MOH.0011.0064.0001]; Exhibit N3.29, Statement of Jan Fizzell (9 December 2024) [32], [45]-[48] [MOH.0011.0094.0001]; Exhibit A.53, *Joint Report of Alfa D'Amato and Deborah Willcox AM* (27 November 2023), [112]-[115] [MOH.9999.0005.0001]; Exhibit D.10, Statement of Deborah Willcox (9 April 2024) [20](f)-[20](k) [MOH.9999.0981.0001];

9 Exhibit A.28, *Addendum to the National Health Reform Agreement (consolidated) 2020-2025* [2(c)] [SCI.0001.0024.0001].

10 Exhibit A.28, *Addendum to the National Health Reform Agreement (consolidated) 2020-2025* [C1(c)] [SCI.0001.0024.0001].

11 Exhibit A.1, *Joint Report of Nigel Lyons, Kerry Chant and Deborah Willcox* (17 November 2023) [82] [MOH.9999.0001.0001]; Exhibit N.1.2, Sax Institute, *Expert Report 2, Strengthening the focus on prevention of chronic disease through applying evidence-based insights* (29 November 2024) [116] [SCI.0011.0608.0001]; *Joint Report of Alfa D'Amato and Deborah Willcox* (27 November 2023) [112] – [115] [MOH.9999.0005.0001]; Exhibit M.2, Statement of Tracey O'Brien (12 November 2024), [60] – [65], [75] [MOH.0011.0087.0001]; Transcript of the Commission, 28 November 2023, T177.31-182.30 (Chant, Willcox & Lyons); 29 November 2023, T258.42-259.37 (Chant); 30 November 2023, T339.15-341.11 (Willcox).

with complex health needs – especially where there is an overlap in people living with a mental health condition, physical illness and social disadvantage. There are also evidence-based interventions such as changes to diet, medication management, and recommendations for exercise, immunisation and tobacco cessation.[12]

5.9 NSW Health also undertakes a range of initiatives to support the healthy ageing of the population. This includes falls prevention programs, physical activity, mental health support and ongoing age-specific health coaching which can all contribute to better health outcomes. Health programs can also be an important place for social connection for the ageing population. In addition, NSW is focused on prevention actions to keep all people healthy and well through healthy eating and active living, improving oral, mental and sexual health, and reducing tobacco and e-cigarette, drug and alcohol related harms.[13]

5.10 The *Addendum to National Health Reform Agreement 2020-2025* relevantly acknowledges that:

> "Despite consensus on the need to intervene earlier to prevent the onset of poor health and wellbeing, investment has historically been targeted towards treating ill health. Currently, there are few incentives for the health workforce to build prevention into practice, and there are ongoing difficulties measuring impacts, outcomes, and returns on investment for preventative health activities."[14]

5.11 The *Addendum to National Health Reform Agreement 2020-2025* refers to some of its key objectives as including to "increase investment in primary prevention", to "reduce the prevalence of chronic disease", to "address the underlying drivers of ill-health, including social, economic and environmental determinants", and to "improve the sustainability of the health system".[15]

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[12] Exhibit A.1, *Joint Report of Nigel Lyons, Kerry Chant and Deborah Willcox* (17 November 2023) [83] [MOH.9999.0001.0001].
[13] Exhibit A.1, *Joint Report of Nigel Lyons, Kerry Chant and Deborah Willcox* (17 November 2023) [84] [MOH.9999.0001.0001].
[14] Exhibit A.28, *Addendum to the National Health Reform Agreement (consolidated) 2020-2025* [C37] [SCI.0001.0024.0001].
[15] Exhibit A.28, *Addendum to the National Health Reform Agreement (consolidated) 2020-2025* [C39] [SCI.0001.0024.0001].

5.12 However, the *Addendum to National Health Reform Agreement 2020-2025* envisages that prevention activities are to be delivered within existing resources and programs, unless specific budget authority or agreement by jurisdictions has been sought and granted.[16] The document does not purport to identify new sources of funding or any new mechanism by which funding for prevention activities are to be prioritised within the existing funding envelope.

5.13 The evidence showed that securing ongoing funding for a new program, including through the New Policy Proposal process, is enhanced if the program aligns with a whole of government priority as seen in the case of the First 2000 Days initiative.[17]

5.14 The evidence also showed that one of the best ways to overcome the challenge identified in CA Submissions [251] – the risk of shifting strategies – is to secure longer-term funding for a program or activity. Initial funding could be secured via the New Policy Proposal process which enables evidence to be developed to secure longer term funding. The mechanism by which funding is sought and obtained via the New Policy Proposal process was described in the evidence, both as to negotiations undertaken by Ministry with the Expenditure Review Committee[18], and as to the negotiation of services to be purchased by Ministry in the Service Agreements of each Local Health District or other agency.[19]

5.15 NSW Health notes the observation (CA Submissions [253]) that it is able to play a leadership role in the coordination and prioritisation of preventative

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16 Exhibit A.28, *Addendum to the National Health Reform Agreement (consolidated) 2020-2025* [C5] [SCI.0001.0024.0001].

17 Transcript of the Commission, 30 November 2023, T338.35-340.5, T353.3, T363.37 (D'Amato and Willcox); 16 May 2024, T2926.12 (Spittal); 18 November 2024, T6289.4-6296.24 (Finance Panel).

18 Exhibit A.53, *Joint Report of Alfa D'Amato and Deborah Willcox* (27 November 2023) [53]-[63] [MOH.9999.0005.0000]; Exhibit N.3.10, Statement of Olivia Hibbitt (18 June 2024) [35]-[39] [MOH.0006.0008.0001]; Exhibit M.6, Joint Statement of Alfa D'Amato, Steven Carr and Neville Onley (14 November 2024) [39]-[48] [MOH.0011.0091.0001]. See also Exhibit B.23.44, *NSW Business Case Guidelines* (August 2018) [MOH.0001.0351.0001], Exhibit M.6.3, *NSW Treasury Policy and Guidelines TPG 21-11: Parameter and Technical Adjustments and New Policy Proposals (Measures)* (December 2021) [SCI.0011.0579.0001] and Transcript of the Commission, 18 November 2024, T6257.11-20, T6270.44-6278.2, T6289.18-6291.11 (Treasury and Ministry Panel).

19 Exhibit M.4, Joint Statement of Matthew Daly, Joseph Portelli and Sharon Smith (14 November 2024), [17]-[18] [MOH.011.0089.0001]; Exhibit N.3.30, Joint Statement of Ashley Brown, Nathan Jones and Phillip Bannon (10 December 2024) [67], [81]-[82]) [MOH.0011.0096.0001], Transcript of the Commission 18 November 2024, T6274:31 – 36 (D'Amato); Transcript of the Commission 21 November 2024, T6513.10 - 25 (Portelli) and T6514.39 – 46 (Carr).

health activities, and that it is well placed to assess the array of potential prevention strategies available, but also notes that adequate funding would be required to support the "renewed focus" on preventative care underlying recommendations 4 and 5.[20]

5.16 Although the responsibility for social determinants of health extend beyond the provision of health services including prevention, NSW Health may be the appropriate agency to lead a multiagency, multidisciplinary body of the kind proposed and the Chief Health Officer/Population and Public Health Division may be an appropriate lead. Decisions as to such a body will, however, ultimately be one for the NSW Government after consultation with other relevant agencies.

[20] Exhibit N.3.29, Statement of Jan Fizzell (9 December 2024) [45]-49] [MOH.0011.0094.0001]; Exhibit N.1.2, *Sax Institute Report 2* (29 November 2024) [49]-[83] [SCI.0011.0608.0001]; Transcript of the Commission, 11 December 2024, T6924.28 (Wilson).

SECTION 6: FUNDING HEALTH SERVICES

Counsel Assisting's recommendation 3 [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.

Counsel Assisting's recommendation 4 [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 [Health] Networks are sufficiently resourced to deliver that system. That might include blended, bundled or other funding mechanisms to support that system.

Counsel Assisting's recommendation 5 [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.

NSW Health response to Counsel Assisting's recommendations 3-5

6.1 **In response to recommendations 3, 4 and 5, NSW Health makes a number of comments, set out below, and notes that the determination of the sufficiency of the funding envelope referred to in recommendation 5 is a matter for the NSW Government.**

6.2 **First**, any reformulation of the funding model is best done after completion of the system-wide services planning recommended in Section 7 of CA Submissions, so that it could be tailored to the optimal provision of the range

of healthcare services to be provided. Any such reformulation would likely utilise both internal and external expertise, as required.

6.3 However, contrary to the current wording of proposed recommendation 4, no funding model can ever "ensure" adequate resourcing for Local Health Districts and Specialty Health Networks to deliver a system.

6.4 Even if that system reflects the result of system-wide services planning that identifies, for a precise point in time, all the services which are to be prioritised and the locations where they are to be provided within the budget envelope available *at that time*[21], in a system as large and as complex as the NSW public health system these variables will constantly change.[22]

6.5 That is so even assuming the following three factors apply:

a. Workforce costs, comprising the largest component of NSW Health's budget[23], remain relatively stable – they have not been since COVID-19;[24]

b. Any disinvestment of services occurs strictly in accordance with the outcome of the services planning, notwithstanding countervailing community expectation and/or political pressure;[25] and

c. The government of the day makes no promise or announcement for the provision of healthcare services beyond the decisions made as a result of system-wide services planning.

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21 On the time that extensive services planning takes, on an LHD level, see Transcript of the Commission, 19 November 2024, T6325.24 (Hoey); 19 November 2024, T6346.39 (Wilson).

22 For examples of clinical service planning's alignment with funding commitment potentially becoming obsolete over time, see Transcript of the Commission, 18 March 2024, T1273.25-29 (Lindner); 24 April 2024, T2427.24-2428.23 (Middleton);16 August 2024, T5077.37-5078.13 (Bennett).

23 Transcript of the Commission, 28 November 2023, T145.32 (Lyons); Exhibit A.1, *Joint Report of Deborah Willcox, Kerry Chant and Nigel Lyons* (17 November 2023) [25] [MOH.9999.0001.0001]; Exhibit H5.23, Statement of Melissa Collins (17 July 2024) [61] [MOH.0011.0025.0001].

24 Exhibit N.3.17, Rosemary Huxtable AO PSM, *Mid-Term Review of the National Health Reform Agreement Addendum 2020-2025* (24 October 2023), [3.10] [SCI.0011.0585.0001]; Exhibit H.5.24, *Workforce Data Report of Rian Thompson* (17 July 2024), p 5 [MOH.0010.0377.0001]; Exhibit M.6, Statement of Alfa D'Amato (14 November 2024) [52a] & [57] [MOH.0011.0091.0001].

25 On the difficulties with withdrawing or disinvesting services, see Transcript of the Commission, 19 November 2024, T6348.39-6353.2 (Morgan, Wilson, Mains, Constable, Collins).

6.6 Further challenges in "ensuring" adequacy of funding are likely to arise given that:

a. Any substantial shift (as a result of services planning) towards provision of healthcare services in place of, or in priority to, the current suite of acute hospital services will likely require either a significant increase to NSW Health's funding envelope or a significant redirection of existing funding. Neither is likely to occur within a short timeframe.

b. As CA Submissions [398] correctly observes, any changes in service delivery will inevitably affect staff and job security, necessitating any change to occur progressively.

c. NSW Health is exploring a move towards service agreements focused on health outcomes to complement current one-year agreements, whereas NSW Health's budget envelope will continue to be determined by the NSW Government on an annual cycle[26] (although see discussion of the review process at [6.19]).

6.7 Although NSW Health would aspire to undertake the proposed system-wide services planning as thoroughly and as quickly as reasonably possible, the practical reality may be that even a carefully reformulated funding model devised to resource delivery of *that* system at *that* point in time rapidly faces resource constraints.

6.8 Accordingly, and recognising the imperfections in any services planning process and consequent funding model, NSW Health suggests a slight rewording of recommendations 4 and 5 as follows:

4. NSW Health should use health services planning informed by population health needs (conducted in accordance with recommendations 6-8 below) to guide discussions on resource allocation, to inform distribution of growth funding, including in relation to any increased funding for

[26] A point noted in Transcript of the Commission, 16 November 2024, T6292.5-14 (D'Amato), 21 November 2024, T6596.45-6597.22 (D'Amato).

preventative activities, and to determine the appropriate funding structure to support that resource allocation.

5. *Doing so will enable a considered assessment to be made of whether the present funding envelope available is "adequate" to sustain provision of the healthcare services needed, or whether it needs to be expanded and if so, by how much.*

6.9 **Second**, the inadequacy of the existing funding arrangements for funding the delivery of a public health system beyond acute care in public hospitals has been acknowledged in the *Addendum to National Health Reform Agreement 2020-2025* at C17-C18:

> "While Australia's health system performs comparatively well, current models for commissioning and funding health care are fragmented and do not reward providers for planning, coordination, and integration of care across a treatment journey. Policies and programs are designed in isolation from one another, even though patients access services across boundaries between programs. This has widespread impacts on people, providers and funders, and jeopardises the sustainability of the health system.
>
> Responding to the challenges the Australian health system will face in the future demands a financing system that is proactive, value-based and focused on individual and community needs. The current system does not afford the necessary funding flexibility and governance arrangements to address these challenges, provide best patient care and support contemporary models of care."

6.10 Schedule C to the *Addendum to National Health Reform Agreement 2020-2025* noted that the parties agreed that the Paying for Value and Outcomes reform will explore funding and payment mechanisms to create stronger incentives for providers, among other things, to focus on the entire patient journey; and that these mechanisms should aim to improve the extent to which funding is:

a. needs based, with funding distributed to patient and population need; and

b. flexible, with funding conditions giving providers the necessary discretion to provide care in the right place, at the right time, by the right workforce.

6.11 The parties further agreed that the reform plan for Paying for Value and Outcomes may include, but not be limited to, a number of activities and commitments including blended funding models, refinements to Activity Based Funding, capitation models, outcomes-based payments, and pooling of payment streams across programs and providers.

6.12 The foreshadowed reform plan under Schedule C to the *Addendum to National Health Reform Agreement 2020-2025* was therefore consistent with the evidence before the Special Commission as to the various ways in which the current funding model could be improved to promote delivery of a healthcare system beyond acute services in public hospitals.

6.13 This was not able to be explored in the evidence before the Special Commission, but NSW Health is currently in negotiations with the Commonwealth on the next addendum to the *National Health Reform Agreement*, which includes consideration of these alternative funding approaches.

6.14 In the meantime, some steps that NSW Health has undertaken to reform the funding model include a review of the funding methodology for small hospitals[27]; and to develop a longer-term service agreement to complement the existing one-year agreements.[28]

6.15 **Third**, against that background, there should be caution in accepting some of the opening comments made in CA Submissions [258]-[259].

6.16 The Special Commission might sympathise with patients, clinicians and the wider community who may well have little interest in arguments as to ultimate responsibility for funding and delivery of services within a fragmented health

[27] Exhibit M.9, *Small Hospitals Funding Model Review* (July 2024) [MOH.0100.0294.0001].

[28] Exhibit M.6, Joint Statement of Alfa D'Amato, Steven Carr and Neville Onley (14 November 2024) [79] [MOH.0011.0091.001 at 0024]; Transcript of the Commission, 21 November 2024, T6596.45-6597.28 (D'Amato).

system. But the practical reality is that, for so long as this fragmented health system exists, and with it the complicated mechanisms for allocating responsibility for funding, oversight and delivery, as observed in the *Addendum to National Health Reform Agreement 2020-2025* (and its predecessors), the challenges with allocating responsibility for funding will continue. No amount of collaborative planning and reformulation of funding approaches can be a complete panacea.

6.17 Nor, with respect, is there anything "surprising" about the fact that repeated commitment by all governments to deliver a quality and equitable healthcare system in Australia, as seen in the *Addendum to National Health Reform Agreement 2020-2025*, have not eliminated the challenges posed when a complex and fragmented funding model is applied in the real world delivery of a multitude of healthcare activities in different settings, for different populations, and by different health entities, only some of which are State public health agencies.

6.18 **Fourth**, the description in CA Submissions [296] oversimplifies the process of setting NSW Health's budget.

6.19 The suggestion that "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 reflect the somewhat arbitrary portion of the annual budget" does not reflect the evidence of the activity forecasting and modelling of health services undertaken by the System Information and Analytics Branch of Ministry[29] and NSW Health's interaction with NSW Treasury during the budget process, including review of the funding model, and consideration of the extent to which budgeted expenditure is sufficient to respond to price and activity growth in the coming year.[30] NSW Health's initial escalation is set at 4.0 per cent, which includes 2.5 per cent for cost growth and 1.5 per cent for service growth. The 1.5 per cent service growth assumption is unique to NSW Health and considers impacts of population growth, ageing, system efficiency

[29] Exhibit M.4, Joint Statement of Matthew Daly, Joseph Portelli and Sharon Smith (14 November 2024) [11] [MOH.011.0089.0001]
[30] Exhibit M.6, Joint Statement of Alfa D'Amato, Steven Carr and Neville Onley (14 November 2024) [49] [MOH.0011.0091.001]

and fiscal affordability. The amount of growth in any budget year is dynamic and can change based on circumstances[31] and is reviewed and adjusted to address emerging priorities or other decisions of Government.[32] Further, although NSW Health is expected to manage within its agreed budget, subject to agreement with Treasury, Ministry may seek additional funding during the year in accordance with TPG21-11.[33]

6.20 **Fifth**, as observed in CA Submissions [301]-[304], sections 127(1) and (2A) of the *Health Services Act 1997* mandate that 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, among other things, the National Health Reform Agreement. It follows that, in determining the extent to which funding is provided for the provision of healthcare services beyond acute services in public hospitals, the Minister has a statutory obligation to take into account the allocation of roles and responsibilities to the Commonwealth under the *Addendum to National Health Reform Agreement 2020-2025*.

6.21 The implications of s127 for NSW Health's ability to significantly increase its involvement in the delivery of primary care and aged care is explored in **Section 9 – Primary and Aged Care**. For present purposes, this statutory requirement serves as an important reminder that for so long as the National Health Reform Agreement and Commonwealth funding of public healthcare exists, reformulation of Ministry's approach to funding cannot be undertaken in isolation, but can only be done in conjunction with the Commonwealth and the other States and Territories.

6.22 **Sixth**, CA Submissions [309] refers to an "opaque" series of equity adjustors that are applied in the budget-building process, which are intended to account for particular demographic and socio-economic features of the relevant segment of the population. Whilst there was evidence from some executives and board members of some Local Health Districts that they did not

[31] Transcript of the Commission, 18 November 2024, T250.8 -9 (Katsounis)
[32] Exhibit M.1, *Submission of NSW Treasury (*11 November 2024) [2.2] – [2.6] [TRY.0001.0001.0001]
[33] Exhibit M.6, Joint Statement of Alfa D'Amato, Steven Carr and Neville Onley (14 November 2024) [47] [MOH.0011.0091.001]

understand the application of the equity adjustors, the notion that these equity adjustors are "opaque" was not explored in the evidence by reference to any specific adjustor, nor was it put to any of the relevant witnesses from Ministry. Such a conclusion cannot be drawn from the evidence and the Commissioner would accept that the adjustors have a rational basis. Nevertheless, NSW Health agrees with the principle that the funding model should be capable of being communicated and understood by Local Health Districts.

6.23 **Seventh**, CA Submissions [326] comments that "while the system should always aim for further improvement, there are arguably limited material gains in technical efficiency to be achieved into the future". The extent to which further technical efficiency could or could not be achieved in future was not explored in the evidence by reference to any specific measure or efficiency, or to any particular contributing factor, such as workforce productivity or technology. All that can be said is that, of the few witnesses who gave evidence on this issue, some commented that there may be limits in future to achieving any further technical efficiency out of the current funding model, and others commented that there is more to be done.[34] Those comments reflect a recognition that the system is already technically proficient.

6.24 In the circumstances, the evidence only permits a conclusion that the pursuit of technical efficiency through the current funding model has been successful in achieving material gains to date, but it cannot not be assumed that further material gains in technical efficiency would continue in future from the funding model alone.

[34] Transcript of the Commission, 30 November 2023, T279.8-18 (Willcox); 21 November 2024, T6523.15-35 (Daly); Exhibit K.54, Statement of Peter Treseder (13 September 2024) [46] [MOH.0011.0071.0001].

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

Counsel Assisting's recommendation 6 [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 greater level of engagement of community and other providers of health services at every stage in the planning process.

Counsel Assisting's recommendation 7 [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.

Counsel Assisting's recommendation 8 [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.

NSW Health response to Counsel Assisting's recommendations 6-8

7.1 **In response to recommendations 6-8, NSW Health makes a number of comments, set out below.**

Comments on recommendation 6

7.2 Consistently with the objective of **recommendation 6**, the need for better system-wide services planning, of the kind envisaged in recommendations 6-8, has been identified internally within NSW Health.[35]

7.3 This was discussed in the most recent statement of Mr McLachlan, Acting Deputy Secretary, Health System Strategy and Patient Experience:[36]

> "The [Strategy Reform and Planning Branch] has identified the need for [Ministry] to provide greater coordination of clinical service planning and clearer guidance on the clinical service planning of [Local Health District] and [Specialty Health Network] local planning teams.
>
> This stronger centralised co-ordination and guidance needs to be implemented in tandem with an uplift of statewide clinical service, workforce and financial planning capacity, to better support [Local Health District] and [Specialty Health Network] planning staff…
>
> Integration of each planning function is required to support the efficient delivery of outcomes and enable more accurate forecasting.
>
> Initial discussions with executives and planning teams across [Local Health Districts] and [Specialty Health Networks] about how to strengthen clinical services planning have taken place. Further work needs to be undertaken to understand the service planning capability across the system and strike an efficient balance between central and local resourcing. This will include consideration of clinical service planning functions that are best developed centrally to support efficient system-wide clinical service planning, such as planning analytics and horizon scanning. There is, however, an acknowledgement of the need to invest in this work to support NSW Health's Future Health Strategy.
>
> …"

7.4 The proposed recommendations will reinforce the work in this area that has already commenced. They also reflect generally, and build upon, the clinical services planning that each Local Health District is undertaking.[37]

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35 Exhibit D.10, Statement of Deborah Willcox (9 April 2024) [35]-[52], [98] [MOH.9999.0981.0001].

36 Exhibit N.3.28, Statement of Scott McLachlan (9 December 2024) [7]-[10] [MOH.0011.0095.0001].

37 See Exhibit D.3, Scott McLachlan (9 April 2024) [35] – [42] (Central Coast Local Health District's Clinical Services Planning process) [MOH.9999.0762.0001]; Exhibit N.3.9, Statement of Matthew Jennings (8 April 2024) [10] (South Western Sydney

Comments on recommendation 7

7.5 This characterisation of key components of this system-wide services planning was the subject of extensive and unchallenged evidence before the Special Commission.

7.6 As is discussed in greater detail in NSW Health's submissions on **Section 9 – Primary Care and Aged Care** (especially in relation to proposed recommendations 11, 12 and 14), the *Addendum to National Health Reform Agreement 2020-2025* allocates to the Commonwealth responsibility for:[38]

a. 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);

b. Maintaining Primary Health Networks to promote coordinated GP and primary health care service delivery, and service integration over time;

c. working with each State and with Primary Health Networks on system-wide policy and statewide planning for GP and primary health care; and

d. planning, funding, policy, management and delivery of the national aged care system.

Local Health District's new model of care identification and Clinical Services Planning process) [MOH.0006.0018.0001]; Exhibit D.78, Statement of Anthony Schembri (12 April 2024) [62] (Northern Sydney Local Health District's Clinical Services Planning process) [MOH.9999.1062.0001]; Transcript of the Commission, 15 April 2024, T1769.12-23 (Wilkinson) (work of CCLHD's planning team); Transcript of the Commission, 16 April 2024, T1900.37-1905.41 (Ministry system monitoring and insights team, including dynamic simulation modelling), T1920.46-1921.20 (planning based on long term projections and trends) (Smith); Transcript of the Commission, 19 April 2024, T2216.17-2217.2 (NSW Health Pathology planning) (Janissen); Transcript of the Commission, 22 April 2024, T2263.44-2267.18 (Northern Sydney Local Health District's Clinical Services Planning process) (Schembri); Transcript of the Commission, 23 April 2024 , T2356.36-2360.28 (CCLHD's CSP process) (MacLellan); Exhibit H.5.31, Statement of Steevie Chan (29 July 2024) [17] (Central Coast Local Health District's Clinical Services Planning process) [MOH.0011.0031.0001]; Exhibit H.5.2, Statement of Pamela Garrett (6 June 2024) [1] – [24] [MOH.9999.1291.0001] (Sydney Local Health District and Concord planning); Exhibit K.53B, Statement of Stewart Dowrick (12 Sep 2024) [27] (Mid-North Coast Local Health District Clinical Services Planning process and capital investment proposals) [MOH.0011.0069.0001].

[38] Exhibit A.28, A*ddendum to the National Health Reform Agreement 2020-2025*, [13b], [13c], [13d] and [13f] [SCI.0001.0024.0001].

7.7 The *Addendum to National Health Reform Agreement 2020-2025* goes on to state:[39]

> "The current health system in Australia is fragmented, making it difficult for people to get well-coordinated care. There is a complex split between the Commonwealth and State governments, and the not-for profit and private sectors, regarding who is responsible for planning, funding and delivering different services.
>
> While these mixed funding and accountability arrangements have benefits, they do not create strong incentives for providers to plan, work together and co-ordinate care for patients. Current models of commissioning and funding health care do not compensate or reward providers for planning, coordination, and integration of care across a treatment journey. Patients with chronic and complex conditions are particularly at risk of receiving fragmented and variable quality of care because they often use a wide range of health services.
>
> The Parties recognise that they need to work together to better plan and co-ordinate health services at the local level, and that this will benefit them both as population outcomes improve. This can only be achieved if there is greater collaboration across care settings, clinicians are engaged and supported to adopt new practices, accountabilities are clear, and there is a joint commitment across all agencies and governments that span the continuum of care."

7.8 The *Addendum to National Health Reform Agreement 2020-2025* then elaborates on this commitment, by noting that the Parties will, among other things, encourage local health organisations, such as Primary Health Networks, Local Hospital Networks and primary and community health services, to collaborate when planning health services and making investment decisions.[40]

7.9 The system-wide services planning described in recommendation 7 involves identification of the health needs of local communities. It also contemplates identification of the gaps or areas of unmet need. It further calls for collaboration with community and other providers of health services to determine how gaps are to be filled over the planning horizon. To the extent

[39] Exhibit A.28, *Addendum to the National Health Reform Agreement 2020-2025*, [C23]-[C25] [SCI.0001.0024.0001].
[40] Exhibit A.28, *Addendum to National Health Reform Agreement 2020-2025*, [C26] [SCI.0001.0024.0001].

that gaps in delivery of health needs are found in primary care and aged care (as was the import of some of the evidence before the Special Commission, particularly in rural and regional communities) system-wide services planning cannot occur without ongoing and genuine participation from Primary Health Networks and potentially other Commonwealth agencies, and primary and community health services, as envisaged in the *Addendum to National Health Reform Agreement 2020-2025*.

7.10 The interplay between recommendation 7 and the planning regime provided for under the *Addendum to National Health Reform Agreement 2020-2025* will need to be addressed in implementing the recommendation. That is especially so given the intent behind the system-wide services planning in recommendations 6-8 is to identify health needs of each community in a holistic way, not confined to acute health services or services that might historically have been the focus of the public health system. One idea as to how this might work is proffered in Section 9 of these submissions.

Comments on recommendation 8

7.11 Although Ministry has identified the need for system-wide services planning, and transparent information will be required about that process, Ministry will need to consider which agency should undertake the reporting and the monitoring process. This consideration will include the possibility of an expanded reporting role for the Bureau of Health Information, and by what means it should occur. Input and expertise will likely be required from different groups inside NSW Health to determine appropriate objectives and consider how best they might be met.

Further considerations

7.12 There are two additional matters which the Special Commission might consider addressing more specifically if proposed recommendations 6-8 are adopted.

7.13 The **first** is that the extensive process envisaged in recommendations 6-8 will likely require dedicated funding for both Ministry and the Local Health Districts and Specialty Health Networks, beyond merely quarantining existing funding as considered in CA Submissions [476].[41] This is to enhance:

a. the clinical services planning capability within each Local Health District and Specialty Health Network, including (but not limited to) data collection and community engagement; and

b. the capability within Ministry, given the proposed shift towards more centralised system-wide clinical services planning led and coordinated by Ministry.

7.14 This is consistent with the evidence before the Special Commission as to the considerable magnitude of this undertaking.[42]

7.15 The **second** matter is the capacity to disinvest in services, if such a decision is reached as a result of system-wide clinical services planning. That decision may be reached either:

a. as part of the "difficult decisions about how to prioritise the distribution of a limited budgetary envelope" (see CA Submissions [480]); or

[41] Exhibit N.3.28, Statement of Scott McLachlan (9 December 2024) [18] [MOH.0011.0095.0001].

[42] See: Exhibit N.3.28, Statement of Scott McLachlan (9 December 2024) [7]-[14] [MOH.0011.0095.0001]; Exhibit L.7, Statement of Richard Griffiths (8 October 2024), [47], [112] [[MOH.0011.0083.0001]; Exhibit L.6, Statement of Philip Minns (8 October 2024) [14]-[16] [MOH.0011.0082.0001]; Transcript of the Commission, 19 November 2024, T6325.9-27 (Hoey), T6341.25-6342.26 (Mains), T6346.18-6347.11 (Wilson).

b. upon concluding that those services fall outside what could be met by the health services reasonably available within the immediate community and its surrounds (see CA Submissions [481]).

7.16 The objective of the proposed system-wide clinical services planning is to make both system-wide and local-level decisions about what services are to be provided. According to CA Submissions [367], the ultimate objective is to provide, within the confines of the finite NSW Health budget, services that best respond to local population need and community expectations regarding service availability.

7.17 Those objectives are often in tension.[43] Prioritisation or disinvestment decisions will be made as a result of balancing those competing factors, and after adopting a prediction as to the future needs of the community as well as the future availability and cost of workforce. This is not a process that will yield a single correct answer every time. Inevitably, reasonable minds would disagree as to the outcomes of the decision-making process. Whatever amount of community consultation might underlie the process, the extent to which the impact of "political considerations" (as described in CA Submissions [412]-[418]) can be reduced in a democracy is uncertain.

7.18 NSW Health acknowledges that transparency, accountability and meaningful community engagement should form part of system-wide services planning.

[43] Exhibit H.5.22, Statement of Philip Minns (17 July 2024) [20] [MOH.0011.0024.0001]; Exhibit L.6, Statement of Philip Minns (8 October 2024) [5]-[8] [MOH.0011.0082.0001]; Exhibit I.26, Statement of Elizabeth Hoskins (2 August 2024) [20] [MOH.0011.0035.0001]; Exhibit I.29, Statement of Terry Clout (6 August 2024) [20] [MOH.0011.0040.0001]; Exhibit K.52, Statement of Jill Wong (6 September 2024) [12], [23], [53], [MOH.0011.0061.0001]; Exhibit F.1, Statement of Brad Astill (8 May 2024) [53] [MOH.9999.1258.0001]; Exhibit M.3, Statement of Wendy Hoey (13 November 2024) [14] [MOH.0011.0086.0001]; Exhibit K.40, Statement of Tracey McCosker (13 September 2024) [22]-[24] [MOH.0011.0062.0001]; Exhibit K.54, Statement of Peter Treseder AO (13 September 2024) [36] [MOH.0011.0071.0001]; Transcript of the Commission, 28 November 2023, T108.34-109.15 (Willcox); Transcript of the Commission, 29 November 2023, T226.8-27 (Lyons),T255.4-256.9 (Willcox), T257.4-258.13 (Lyons); Transcript of the Commission, 30 November 2023 T370.41-372.14, 387.10-18 (Willcox); Transcript of the Commission, 22 March 2024, T1602.34-1603.28 (Yoosuff),T1648.15-23 (Bruce); Transcript of the Commission, 29 April 2024,T2565.3-2566.8 (Danos); Transcript of the Commission, 16 May 2024, T2975.16-38 (Spittal); Transcript of the Commission, 22 May 2024, T3110.4-14 (Nott); Transcript of the Commission, 16 August 2024, T5027.26-47 (Clout), T5040.2-5041.8 (Hoskins and Clout), T5064.12-5065.19 (Hoskins); Transcript of the Commission, 15 October 2024, T5702.35-5703.12 (Minns); Transcript of the Commission, 19 November 2024, T6381.8-15 (need to prioritise within budget), T6338.29-39, 6340.17-35 (community expectations) (Constable); Transcript of the Commission, 21 November 2024, T6560.45-6562.7(Daly).

Nevertheless, the challenge posed in making disinvestment decisions cannot be overstated.[44]

Other issues raised in Section 7 of Counsel Assisting's Submissions

7.19 The assessment in Section 7.1 generally accords with the current approach to service planning and its drivers, except for the following matters.

7.20 In relation to CA Submissions [335], it is unclear whether it is suggested that NSW Health agencies currently do not pursue development and implementation of innovative models of care in the absence of immediate funding contribution from the Commonwealth. There is no evidence of this, and substantial evidence to the contrary at least in relation to virtual care and urgent care services.[45]

7.21 In relation to CA Submissions [384], Ministry is presently working on strengthening service planning capability.[46]

7.22 In addition to the matters surveyed in CA Submissions [388]-[395], the evidence also referred to the significant differences in the budgetary environment in the years before and since COVID-19.

7.23 The relatively stable growth rate of 5 per cent per annum before COVID-19 combined with constrained wages growth enabled NSW Health's budget to address volume growth, equity and efficiency. In contrast, the post-COVID-19 fiscal environment has experienced multiple stressors, including cost escalation across the supply chain, accelerating demand growth from demographic changes, increased pressure on NSW Health as the healthcare

[44] See for example the ongoing community objection to the closure of the emergency department at Batemans Bay Hospital, despite more than a decade of community consultation over the decision: Exhibit I.58, Statement of Margaret Bennett (20 September 2024) [MOH.0011.0076.0001]; Transcript of the Commission, 16 August 2024, T5045.26-5047.41 (Hoskins and Clout), T5106.13-5107.46 (Bennett).

[45] Transcript of the Commission, 28 November 2023, T126.45-128.14 (Lyons), T133.11-28 (Willcox); Transcript of the Commission, 29 November 2023, T240.43-242.9 (Lyons and Willcox); Transcript of the Commission, 30 November 2023, T285.16-34 (Willcox), T285.47-286.18 (D'Amato);Transcript of the Commission, 29 April 2024, T2547.1-21 (Willcox); Transcript of the Commission, 16 November 2024 , T6253.33-40 (D'Amato).

[46] Exhibit N.3.28, Statement of Scott McLachlan (9 December 2024) [MOH.0011.0095.0001].

provider of last resort, and the need to commission an increased number of new facilities.[47]

7.24 Reflecting on the question of the adequacy of the budget envelope, Adjunct Professor D'Amato, Mr Onley and Mr Carr made the following observations:[48]

> "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 online of a large number of new facilities through the capital program.
>
> The limitations to the existing model have been recognised, and NSW Health has been looking at opportunities to shift the health system in line with the directions outlined in Future Health. This includes consideration of a longer term strategic four year service agreement focused on improving health outcomes to complement the existing one year agreements required by the current national arrangements.
>
> The implementation of the current funding model has seen considerable improvement in the quality and breadth of data NSW Health can now collect, report on and analyse. This should be further utilised to inform service and resourcing decisions.
>
> Given these ongoing challenges, the Commonwealth, states and territories will need to continue to review the operation of the current funding model to ensure it is able to respond to the changing health needs of the population.
>
> This may require consideration of a blended funding model that retains the benefits of [Activity Based Funding] but recognises the importance and role of population, equity and the need for greater investment in prevention, community and out of hospital care. This should be supported by additional funding for purchasing activity and investing in prevention. Internal consultation with Chief Executives of [Local Health Districts] has commenced to explore options in respect to a blended funding model that incorporates benefits from the [Activity Based Funding] funding (sic) model and provides certainty of funding for equity and population needs."

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[47] Exhibit M.6, Joint Statement of Alfa D'Amato, Neville Onley and Steven Carr (14 November 2024) [51]-[54] [MOH.0011.0091.0001].

[48] Exhibit M.6, Joint Statement of Alfa D'Amato, Neville Onley and Steven Carr (14 November 2024) [77]-[82] [MOH.0011.0091.0001].

7.25 In relation to CA Submissions [398]-[400], although by volume most of the services delivered in a given year by a Local Health District involve an adjusted continuation of the previous year's services (as would be expected given that a population's health needs do not rapidly change), the evidence does not support the contention that forward-looking planning processes (including in relation to the shifting burden of disease) play *no* role at all in determining service provision – as suggested in the first sentence of CA Submissions [400]. The evidence is to the contrary.[49]

7.26 The final sentence of CA Submissions [411] makes a broad statement as to what is "not acceptable" in the transportation of patients over long distances to obtain health services. This statement overlooks the complexity of this issue. In particular:

a. Non-emergency transport services differ in each regional area of the State, and even within Local Health Districts. The HealthShare NSW Patient Transport Service manages non-emergency patient transport (road) in greater metropolitan Sydney, including in the Hunter New England and Illawarra Shoalhaven Local Health Districts. In rural and regional NSW, Local Health Districts currently manage their own non-emergency patient transport services, supported by NSW Ambulance in some areas.[50]

[49] See Exhibit D.3, Statement of Scott McLachlan (9 April 2024) [35] – [42] (Central Coast Local Health District's Clinical Services Planning process) [MOH.9999.0762.0001]; Exhibit N.3.9, Statement of Matthew Jennings, (8 April 2024) [MOH.0006.0018.0001] [10] (South Western Sydney Local Health District's new model of care identification and Clinical Services Planning process) [MOH.0006.0018.0001]; Exhibit D.78, Statement of Anthony Schembri (12 April 2024) [62] (Northern Sydney Local Health District's Clinical Services Planning process) [MOH.9999.1062.0001]; Transcript of the Commission, 15 April 2024, T1769.9 (work of Central Coast Local Health District's planning team) (Wilkinson); Transcript of the Commission, 16 April 2024, T1900.37-1905.26 (Ministry system monitoring and insights team, including dynamic simulation modelling), T1920.46 – 1921.20 (planning based on long term projections and trends), (Smith); Transcript of the Commission, 19 April 2024, T2216.17 – T2217.2 (Janissen) (use of Local Health District interactions in Clinical Services Planning process); Transcript of the Commission, 22 April 2024, T2263.40 (Northern Sydney Local Health District's Clinical Services Planning process) (Schembri); Transcript of the Commission, 22 April 2024, T2356.37 (Central Coast Local Health District's Clinical Services Planning process) (MacLellan); Exhibit H.5.31, Statement of Steevie Chan (29 July 2024) [17] (Central Coast Local Health District's Clinical Services Planning process) [MOH.0011.0031.0001]; Exhibit H.5.2, Statement of Pamela Garrett (6 June 2024) [MOH.9999.1291.0001], [1] – [24] (SLHD and Concord planning) [MOH.9999.1291.0001]; Exhibit K.53B, Statement of Stewart Dowrick (12 Sep 2024), [27] (Mid-North Coast Local Health District Clinical Services Planning process and capital investment proposals) [MOH.0011.0069.0001].

[50] Exhibit B.11, Statement of Carmen Rechbauer (12 February 2024) [77]-[80] [MOH.9999.0009.0001].

b. It is appropriate for ambulant patients to travel by a range of means including private vehicle, public transport, community transport and ride share services. Patients may be reimbursed some of the cost of travel through the Isolated Patients Travel and Accommodation Assistance Scheme which supports patients in the community requiring transport for specialised health treatment that is not available locally. [51]

c. Patient Transport Services' core functions are to provide transport for people who require stretcher transport and are assessed by a medical practitioner or registered nurse as medically unsuitable for community, public or private transport.

[51] Exhibit M.8, *Regional Health Strategic Plan 2022-2032 – Progress Snapshot 2022-23 (*1 November 2023), p. 13 [MOH.0100.0297.0001].

SECTION 8: STATEWIDE SERVICES

Counsel Assisting's recommendation 9 [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.

NSW Health response to Counsel Assisting's recommendation 9

8.1 **In response to recommendation 9, NSW Health makes a number of comments, set out below.**

8.2 The wording of the proposed recommendation might imply that Ministry presently undertakes none of the roles itemised in it, whereas more accurately, Ministry shares those roles with the relevant Local Health District. Nevertheless there is a role for Ministry to provide enhanced governance and accountability for supra-LHD services, albeit that, the planning and delivery of these services requires integration with Local Health Districts.

8.3 The term 'supra-LHD services' should be understood to include those 'statewide services' and 'specialised services' variously cited in service agreements.

Work underway

8.4 Counsel Assisting principally rely on the oral evidence of Dr Browne (in respect of the NSW Brain Injury Rehabilitation Program) and Prof Middleton (in respect of the NSW Spinal Cord Injury Service) to support recommendation 9. The work of the Specialty Service and Technology Evaluation Unit and the role of the New Technology and Specialised Services Committee in the management and oversight of supra-LHD services is not considered. Nor are the criteria for

a service to be considered a supra-LHD service noted: these are found in the *New Technologies and Specialised Services Guideline*.[52]

8.5 Ms Willcox, then Deputy Secretary, Health System Strategy and Patient Experience, described how the Specialty Services and Technology Evaluation Unit provides oversight of supra-LHD services and the NSW Nationally Funded Centres, and maintains and updates the NSW Health Guide to Role Delineation of Clinical Services.[53] The New Technology and Specialised Services Committee within the Specialty Service and Technology Evaluation Unit presently provides oversight and governance of supra-LHD services, including monitoring implementation and outcomes and providing advice to inform service agreements. This Committee is chaired by the Deputy Secretary, Health System Strategy and Patient Experience, and has representation from across Ministry and the Agency for Clinical Innovation, the Cancer Institute NSW and the Clinical Excellence Commission.[54]

8.6 The Specialty Service and Technology Evaluation Unit works closely with Ministry's System Purchasing Branch and other branches and pillars to determine advice regarding changes and enhancements to supra-LHD services. There is an open expression of interest process conducted to determine the location of supra-LHD services, following determination of the requirements for each service by the New Technology and Specialised Services Committee.[55] Ministry involvement in supra-LHD services is generally most intense at the implementation phase. Once a supra-LHD service is established, Local Health Districts are responsible for ongoing service delivery including purchasing negotiations, clinical governance and monitoring in accordance with local policies and procedures.

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[52] Exhibit B.23.068, NSW Health, *New Health Technologies and Specialised Services Framework*, NSW Health Guideline GL2022_012 [MOH.0001.0343.0001]; See Exhibit N4.7, NSW Health, *New Health Technologies and Specialised Services,* NSW Health Guideline GL2024_008 (24 June 2024) [MOH.0100.0022.0001].

[53] Exhibit D.10, Statement of Deborah Willcox (9 April 2024) [37] [MOH.9999.0981.0001 at 0017-18].

[54] Exhibit D.10, Statement of Deborah Willcox (9 April 2024) [37] [MOH.9999.0981.0001 at 0017-18]; Exhibit N.3.10, Statement of Olivia Hibbitt (18 June 2024) [8] [MOH.0006.0008.0001 at 0002].

[55] Exhibit D.10, Statement of Deborah Willcox (9 April 2024) [37] [MOH.9999.0981.0001 at 0017-18].

8.7 Mr McLachlan, Acting Deputy Secretary, Health System Strategy and Patient Experience, described some aspects of the work of the Strategic Reform and Planning Branch in strengthening clinical services planning and explained that as a result of initial discussions with executives and planning teams across Local Health Districts about how to do this, there is currently an increased focus on population level planning in a consistent and co-ordinated way across the NSW Health system, through an increased role for Ministry. His evidence was that it is intended this will occur by Ministry having an increased role in (amongst other things) co-ordination of networked and supra-LHD services, although he stated that there is existing central co-ordination of supra-LHD services.[56] Ms Willcox's evidence was that the aim of the planning work done annually for purchasing and the role of the Agency for Clinical Innovation in relation to supra-LHD services is to provide effective co-ordination, because Ministry has a good idea of "where our patients are coming from, the demand and what the need is in the system".[57]

8.8 Dr Hibbitt, Director of the Specialty Services and Technology Evaluation Unit within Ministry, provided an example of how a supra-LHD service is established, by reference to the NSW transcatheter aortic valve implantation supra-LHD service that was established in 2020.[58] Transcatheter aortic valve implantation is used to replace aortic valves in patients who have severe, symptomatic aortic stenosis. The New Technology and Specialised Services Committee recommended that transcatheter aortic valve implantation be established as a supra-LHD service following analysis by the Strategic Investment and Analysis Unit within Ministry's Strategic Reform and Planning Branch, which showed that a significant proportion of procedures were performed at three sites, with most patients drawn from Local Health Districts in which those sites were located.[59]

[56] Exhibit N.28, Statement of Scott McLachlan (9 December 2024) [11] - [12] [MOH.0011.0095.0001 at 0002-0003].
[57] Transcript of the Commission, 29 April 2024, T2555.44-2556.2 (Willcox).
[58] Exhibit N.3.10, Statement of Olivia Hibbitt (18 June 2024) [19]-[20] [MOH.0006.0008.0001 at 0004-5].
[59] Exhibit N.3.10, Statement of Olivia Hibbitt (18 June 2024) [19]-[20] [MOH.0006.0008.0001 at 0004-5].

8.9 Establishing transcatheter aortic valve implantation as a supra-LHD service supported equity of access for patients living in regional and remote Local Health Districts and provision of the service to high-risk patients who would not otherwise be treated in this way.[60] The transcatheter aortic valve implantation service continues to operate as a supra-LHD service at eight sites, and has seen an increasing volume of procedures performed.[61] The establishment of this service was initially overseen by an Expert Advisory Group made up of representatives from all eight sites, who were nominated by their respective Local Health Districts, but the group has now transitioned to the Agency for Clinical Innovation as a clinical practice group, which is tasked with identifying opportunities for service improvement.[62]

8.10 The transcatheter aortic valve implantation service provides an example of a system-led approach to obtaining additional funding for supra-LHD services: it received $21.6 million in additional funding over four years from the NSW Government, which was announced in the 2021 state budget.[63] It is now funded via additional activity purchasing during the annual service agreement negotiations.[64] Supra-LHD services are listed separately in Local Health District service agreements and in some cases are funded through separate arrangements such as block funding.

Potential challenges

8.11 A challenge that the proposed recommendation must confront is the need to ensure that centralisation of governance at Ministry level does not diminish the capacity of the supra-LHD services to harness local expertise.[65]

[60] Exhibit N.3.10, Statement of Olivia Hibbitt (18 June 2024) [19] [MOH.0006.0008.0001 at 0004-5].
[61] Exhibit N.3.10, Statement of Olivia Hibbitt (18 June 2024) [20] [MOH.0006.0008.0001 at 0005].
[62] Exhibit N.3.10, Statement of Olivia Hibbitt (18 June 2024) [20] [MOH.0006.0008.0001 at 0005].
[63] Exhibit N.3.10, Statement of Olivia Hibbitt (18 June 2024) [38] [MOH.0006.0008.0001 at 0010].
[64] Exhibit N.3.10, Statement of Olivia Hibbitt (18 June 2024) [38] [MOH.0006.0008.0001 at 0010].
[65] See eg Exhibit N.3.10, Statement of Olivia Hibbitt (18 June 2024) [26] [MOH.0006.0008.0001 at 0006-0007].

Counsel Assisting's recommendation 10 [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 Childrens Hospital[s] Network, John Hunter Childrens 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.

NSW Health response to Counsel Assisting's recommendation 10

8.12 **In response to recommendation 10, NSW Health makes a number of comments, as set out below.**

8.13 As Counsel Assisting have identified in CA Submissions [533], there was a consensus in the evidence that paediatric services would benefit from a statewide plan clearly identifying how paediatric services in Local Health Districts and the specialist children's hospitals interact with and support each other. Thus, for example, the evidence of Ms Cox, Chief Executive of Sydney Children's Hospitals Network, was that the delivery of care for children and young people would be strengthened by the creation of a statewide plan and that a process of role delineation as part of a statewide plan, setting out what could be expected to be provided, would be very helpful.[66] The creation of a statewide plan is also consistent with recommendations in the *Review of Governance for the Sydney Children's Hospitals Network*[67] noting that the evidence of Dr Lyons, then Specialist Advisor to NSW Health, was that the advice sought in that review was directed to the role of the Sydney Children's Hospitals Network[68] and that further review of broader recommendations in the *Alexander Repor*t was undertaken in the *Henry Review*.[69]

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66 Transcript of the Commission, 11 June 2024, T3435.19-26, T3442.45-3444.9 (Cox); see also Transcript of the Commission, 14 June 2024, T3653.22-3564.3 (Preddy).

67 Exhibit G.17, *Review of Governance for the Sydney Children's Hospitals Network, Final Report of the Expert Panel* (June 2019) [SCI.0010.0004.0001 at 0004].

68 Transcript of the Commission, 14 June 2024, T3695.15-44 (Lyons).

69 Transcript of the Commission, 14 June 2024, T3696.17-25 (Lyons); Exhibit G.18, *Review of health services for children, young people and families within the NSW Health system* (December 2019) [SCI.0010.0001.0001).

8.14 The development of a statewide plan for paediatric services is a complex process, because a significant component of those services is, and will continue to be, provided by Local Health Districts (CA Submissions [533]). Any such statewide plan will need to accommodate differences in each Local Health District.

Work underway

8.15 Ministry is currently examining the structure of statewide paediatric services with engagement through the Children Young People and Families Executive Steering Committee (a peak committee with a variety of committees sitting underneath it)[70] as required.

8.16 Dr Lyons agreed that it is now an appropriate time to put some more structure and clarity around existing paediatric networks and to give more clarity as to how they operate, without interfering with clinical decision-making, so that the system supports appropriate networking arrangements and enables clinicians to get support more readily. [71] His evidence was that having established better governance of paediatric services across the state, the Children Young People and Families Executive Steering Committee will begin work on how statewide planning could be applied to clinical care and service delivery.[72]

8.17 He further noted that, as recognised by CA Submissions [532], the Sydney Children's Hospitals Network is negotiating heads of agreement with Local Health Districts, which he recognised was good practice for providing clarity as to how the relationship between the various services (including tertiary and quaternary services) would operate.[73]

Potential challenges

8.18 A challenge in the statewide planning process contemplated by the recommendation is thrown up by the variable levels of service capability within

[70] Transcript of the Commission, 11 June 2024, T3439.7-32 (Cox).
[71] Transcript of the Commission, 14 June 2024, T3691.30-35 (Lyons).
[72] Transcript of the Commission, 14 June 2024, T3704.35-42 (Lyons).
[73] Transcript of the Commission, 14 June 2024, T3703.7-15 (Lyons).

different Local Health Districts. The variation reflects workforce availability, in particular constraints arising from difficulties in attracting general paediatricians and in attracting paediatricians into rural and regional environments.[74] Some of those challenges may be best addressed by bespoke arrangements between Local Health Districts and the Sydney Children's Hospitals Network.[75] Dr Lyons identified a risk that a broad statewide plan could be "so high level that it actually won't deliver the solutions to the issues that people have been raising", even where applicable principles are agreed.[76]

Other issues raised in Section 8 of Counsel Assisting's Submissions

8.19 CA Submissions [498] state that "[a]s a matter of practice, the Ministry's oversight role does not extend to the planning or governance of statewide services", overstates the position. Dr Hibbitt and Mr McLachlan explained Ministry's role in relation to supra-LHD services, including its planning and funding function.[77] The issue is to what extent Ministry's existing role should be enhanced.

8.20 Counsel Assisting submit (CA Submissions [504]) that a large number of people with a spinal cord injury are not receiving care in a timely way, or at all, and who are not visible to the NSW Spinal Cord Injury Service. It is not the case that patients are receiving no care; there are some who receive such care locally, rather than from the NSW Spinal Cord Injury Service.[78] NSW Health accepts that further work is needed to understand the current state of spinal cord injury care and to support planning and governance that is coordinated across Local Health Districts to enable a state-based approach to managing these small patient cohorts.

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74 Transcript of the Commission, 14 June 2024, T3703.17-28 (Lyons).
75 Transcript of the Commission, 14 June 2024, T3706.12-39 (Lyons).
76 Transcript of the Commission, 14 June 2024, T3704.3-4 (Lyons).
77 Exhibit N.3.10, Statement of Olivia Hibbitt (18 June 2024) [36] [MOH.0006.0008.0001 at 0009].
78 Exhibit N.12.3, *Evidence and utilisation of spinal cord injury services in NSW (August 2020)* [MOH.0006.0042.0001 at 0014].

8.21 Ministry has been active in this regard. Prof Middleton gave evidence of the development of the spinal model of care and work he had done with the Agency for Clinical Innovation on the development of that model.[79] He explained that his current work with Ms Marley at Ministry had identified the need to develop a New Policy Proposal to put forward in order to seek additional funding for the spinal model of care.[80] The spinal model of care would provide an opportunity to increase access to specialist care for spinal cord injury, enabling the most complex cases to receive specialist care, as well as supporting efficient care by reducing length of stay and building the capacity of non-specialist services.

8.22 CA Submissions [505] submit that there are insufficient specialist rehabilitation beds at Royal Rehab and Prince of Wales Hospital to enable patient flow. All Local Health Districts and Specialty Health Networks can submit funding requests to Ministry for new services or expansion of existing services requiring funding beyond the base, for consideration as part of the purchasing process.[81] In recent years, Ministry has purchased additional spinal cord injury rehabilitation service capacity for the system, subsequent to a funding request from Royal Rehab through the Northern Sydney Local Health District. In 2022-2023, recurrent activity and block funding totalling $4.5 million was allocated to Northern Sydney Local Health District for additional spinal cord injury rehabilitation beds at Royal Rehab.[82]

8.23 CA Submissions [507] submit that the lack of overarching co-ordination with respect to patient flow between Local Health Districts for statewide services "prevented" any "systematic prioritisation of which patients should attend which service". The import of Prof Middleton's evidence in the passage cited in support was simply that there was not currently any systematic way of prioritising which patients should attend which service across Local Health

79 Transcript of the Commission, 24 April 2024, T2425.18-47; 2428.28-45; 2436.20-38 (Middleton).
80 Transcript of the Commission, 24 April 2024, T2428.28-45 (Middleton).
81 Exhibit M.4, Statement of Matthew Daly, Joseph Portelli and Sharon Smith (14 November 2024) [36] –[40] [MOH.0011.0089.0009].
82 Exhibit A.47, *2022-2023 Northern Sydney Local Health District Service Agreement*, [SCI.0002.0013.0001]. 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] .

Districts,[83] not that systematic prioritisation was currently prevented or impeded in some way.

8.24 CA Submissions [510] note Prof Middleton's evidence that the supra-LHD designation for the NSW Spinal Cord Injury Service did not make any practical difference to the operation of the service and did not "really mean anything" beyond a line in service agreements. As set out in the *New Technologies and Specialised Services Guideline*,[84] supra-LHD services are those services which have been assessed to have a level of impact on the system that requires specialised service planning, governance, oversight, evaluation and/or monitoring by Ministry. The level of oversight from Ministry is generally most intense in the implementation phase of a new service, or when there are identified service gaps that require addressing, or a new technology has significantly altered the way the service is provided. In contrast, once a service is well-established (as is the case with the NSW Spinal Cord Injury Service), Ministry expects that ongoing management will be driven by Local Health Districts in conjunction with the Agency for Clinical Innovation as the clinical lead. Issues may be escalated to Ministry at any time via the New Technologies and Specialised Services Committee.[85]

8.25 At CA Submissions [515], Counsel Assisting also cites Dr Browne's evidence concerning inadequate beds for traumatic brain injury rehabilitation. NSW Health accept that further work is needed at Ministry level to strengthen planning across Local Health Districts and Specialty Health Networks, to enable a state-based approach to managing this small patient cohort.

8.26 At CA Submissions [528], Counsel Assisting submit that the current structure for supra-LHD services "is neither an appropriate nor a transparent mechanism for providing such services in an optimal and equitable manner". There is a role for Ministry to provide enhanced governance and accountability for supra-

[83] Transcript of the Commission, 24 April 2024, T2423.25-34 (Middleton).
[84] See Exhibit N4.7, NSW Health, *New Health Technologies and Specialised Services,* NSW Health Guideline GL2024_008 (24 June 2024) [MOH.0100.0022.0001].
[85] Exhibit N.3.10, Statement of Olivia Hibbitt (18 June 2024) [22]-[23] [MOH.0006.0008.0001].

LHD services, but planning and delivery of those services requires integration with Local Health Districts. As to the matters identified by Counsel Assisting concerning the current structure, Local Health Districts are presently able to raise centrally with Ministry both service needs and funding requirements for supra-LHD services, through the purchasing and service agreement processes.

SECTION 9: PRIMARY CARE AND AGED CARE

Counsel Assisting's recommendation 11 [604]

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

Counsel Assisting's recommendation 12 [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.

Counsel Assisting's recommendation 14 [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.

NSW Health response to Counsel Assisting's recommendations 11, 12 and 14

9.1 **NSW Health identifies issues with recommendations 11, 12 and 14, as set out below.**

9.2 NSW Health proposes the following alternative recommendation that, it submits, retains the spirit of recommendation 12:

> *NSW Health in undertaking its system-wide clinical services planning pursuant to recommendations 6-8 works together with the Commonwealth and Primary Health Networks who are responsible for the planning of primary health care, to ensure overall integrated health service planning. In appropriate cases, this may include an assessment of the feasibility and cost of NSW Health delivering some of that care. If that process determines that NSW Health is the most appropriate provider of that care, intergovernmental discussions (including under the National Health Reform Agreement) should occur to secure access to Commonwealth funding streams sufficient to fund the delivery of this care by NSW Health prior to the delivery of any services.*

9.3 Sections 9.1 - 9.4 of CA Submissions are generally accurate as to the importance of adequate primary care, the current state of the primary care sector, the impact of inadequate access to primary care, and the findings in the *Mid-Term Review of National Health Reform Agreement 2020-2025*.

9.4 However, for the reasons discussed below, NSW Health submits that its alternative formulation of the recommendation is more consistent with:

a. the regime for intergovernmental sharing of healthcare responsibilities currently set out in the *Addendum to National Health Reform Agreement 2020-2025*; and

b. the system-wide services planning process proposed in Sections 6-8 of CA Submissions.

9.5 Section 9.5 of CA Submissions ("The role of NSW Health in relation to primary care") at [567]-[568] refers to a single passage in paragraph 13 of the *Addendum to National Health Reform Agreement 2020-2025* as demonstrating that the responsibility of the Commonwealth government is in "system management, support, policy and funding" of primary care, but not in service delivery. With respect, this somewhat simplifies the regime agreed under the *Addendum to National Health Reform Agreement 2020-2025*, as is clear when the *Addendum* is examined in its entirety.

9.6 The initial sections entitled "Preliminaries" and "Objectives" recognise that responsibility for health is shared between the Commonwealth and the States, and that all governments have a responsibility to ensure that systems work together effectively and efficiently to produce the best outcomes for people, including interfaces between health, aged care and disability services.[86] However, the *Addendum to National Health Reform Agreement 2020-2025* records as one of its agreed objectives that the Commonwealth and the States "work together" to ensure the best possible outcomes for the Australian people through the "collective investments" governments make in health.[87]

9.7 The way this is to occur is then described as a "partnership to implement arrangements for a nationally unified and locally controlled health system"[88] which will, among other things:

a. improve the provision of GP and primary care services, including Aboriginal and Torres Strait Islander community controlled health organisations, and the effective integration of health services at a local and national level[89]; and

[86] Exhibit A.28, *Addendum to the National Health Reform Agreement (consolidated) 2020-2025* [1c] [SCI.0001.0024.0001].
[87] Exhibit A.28, *Addendum to the National Health Reform Agreement (consolidated) 2020-2025* [5] [SCI.0001.0024.0001].
[88] Exhibit A.28, *Addendum to the National Health Reform Agreement (consolidated) 2020-2025* [7] [SCI.0001.0024.0001].
[89] Exhibit A.28, *Addendum to the National Health Reform Agreement (consolidated) 2020-2025* [7b] [SCI.0001.0024.0001].

b. work effectively with the aged care and disability support systems to deliver better outcomes.[90]

9.8 The section of the *Addendum to National Health Reform Agreement 2020-2025* entitled "Roles and Responsibilities" does not limit the Commonwealth's responsibilities to system management, support, policy and funding of primary care, leaving all service delivery responsibility to the States.

9.9 Instead, the individual responsibilities of the States and the Commonwealth are specified:

a. in the case of the States, to provide health and emergency services through the public hospital system, including equitable access to such services[91]; system management of public hospitals; taking a lead role in managing public health activities; and sole management of the relationship with Local Hospital Networks to ensure a single point of accountability in each State for public hospital performance, performance management and planning.[92]

b. In the case of the Commonwealth, its particular responsibilities regarding primary care and aged care include [emphasis added]:

i. "maintaining Primary Health Networks to promote coordinated GP and primary health care services delivery, and service integration over time";[93]

ii. "working with each State and **with PHNs** on system-wide policy and statewide planning for GP and primary health care"[94];

iii. "supporting and regulating private health insurance to enable an effective private health sector and patient choice"[95];

[90] Exhibit A.28, *Addendum to the National Health Reform Agreement (consolidated) 2020-2025* [7h] [SCI.0001.0024.0001].
[91] Exhibit A.28, *Addendum to the National Health Reform Agreement (consolidated) 2020-2025* [8] [SCI.0001.0024.0001].
[92] Exhibit A.28, *Addendum to the National Health Reform Agreement (consolidated) 2020-2025* [10] [SCI.0001.0024.0001].
[93] Exhibit A.28, *Addendum to the National Health Reform Agreement (consolidated) 2020-2025* [13c] [SCI.0001.0024.0001].
[94] Exhibit A.28, *Addendum to the National Health Reform Agreement (consolidated) 2020-2025* [13d] [SCI.0001.0024.0001].
[95] Exhibit A.28, *Addendum to the National Health Reform Agreement (consolidated) 2020-2025* [13e] [SCI.0001.0024.0001].

iv. "planning, funding, policy, management and **delivery** of the national aged care system"[96];

v. "continuing to focus on reforms in primary care that are designed to improve patient outcomes and reduce avoidable hospital admissions".[97]

9.10 The *Addendum to National Health Reform Agreement 2020-2025* does not envisage that the Commonwealth government would *itself* deliver primary care.[98] Rather, it envisages that the Commonwealth government would maintain and fund Primary Health Networks to do so. This may be contrasted with its treatment of aged care: the *Addendum to National Health Reform Agreement 2020-2025* provides for the Commonwealth government to plan, fund, set policy, manage, **and deliver** aged care.

9.11 The *Addendum to National Health Reform Agreement 2020-2025* also identifies certain matters as joint Commonwealth-State responsibilities, including:

a. "collecting and providing patient-level data to support the objectives of this Addendum"[99];

b. "working together on policy decisions or areas of the system that impact on each other's responsibilities"[100];

c. ensuring that the commitments in the *Addendum to National Health Reform Agreement 2020-2025* contribute to closing the gap in Aboriginal and Torres Strait Islander disadvantage and life expectancy[101]; and

[96] Exhibit A.28, *Addendum to the National Health Reform Agreement (consolidated) 2020-2025* [13f] [SCI.0001.0024.0001].
[97] Exhibit A.28, *Addendum to the National Health Reform Agreement (consolidated) 2020-2025* [13d] [SCI.0001.0024.0001].
[98] On this at least, the second sentence in CA Submissions [568] is correct.
[99] Exhibit A.28, *Addendum to the National Health Reform Agreement (consolidated) 2020-2025* [9e] [SCI.0001.0024.0001].
[100] Exhibit A.28, *Addendum to the National Health Reform Agreement (consolidated) 2020-2025* [9f] [SCI.0001.0024.0001].
[101] Exhibit A.28, *Addendum to the National Health Reform Agreement (consolidated) 2020-2025* [9g] [SCI.0001.0024.0001].

d. identifying rural and regional areas where there is limited access to health and related services with a view to developing new models of care to address equity of access and improve outcomes[102]; and

9.12 In this way, the *Addendum to National Health Reform Agreement 2020-2025 does* provide for the States to have a supporting role in the planning of primary care to the extent it impacts on their responsibilities. However, the States are required to do so not in isolation but by "working together" with the Commonwealth and its Primary Health Networks.

9.13 This regime is reinforced throughout the schedules to the *Addendum to National Health Reform Agreement 2020-2025*.

9.14 For instance, Schedule C describes the shared action on long-term health system reform to achieve agreed critical priorities which include delivery of safe, high-quality care in the right place at the right time through, among other things, "joint planning and funding at a local level". [103] It then explains that as part of the parties' shared commitment to this joint planning and funding at a local level, they will [emphasis added]:

> "a. encourage local health organisations, **such as Primary Health Networks**, Local Hospital Networks, as well as primary and community health services, to collaborate when planning health services and making investment decisions;
>
> b. develop commissioning arrangements that provide stronger incentives for local health organisations to co-ordinate care, pool funding and integrate health services; and
>
> c. establish shared reporting and accountability arrangements to effectively measure the impact on population health outcomes, quality of health services and value at the local level."[104]

[102] Exhibit A.28, *Addendum to the National Health Reform Agreement (consolidated) 2020-2025* [9h] [SCI.0001.0024.0001].
[103] Exhibit A.28, *Addendum to the National Health Reform Agreement (consolidated) 2020-2025* [C1] [SCI.0001.0024.0001].
[104] Exhibit A.28, *Addendum to the National Health Reform Agreement (consolidated) 2020-2025* [C26] [SCI.0001.0024.0001].

9.15 The reform plan for "Joint Planning and Funding at a Local Level" includes local-level commissioning, identifying and supporting removal of barriers to joint governance, needs assessment, service integration, evaluation and funding, addressing workforce matters including capability gaps, and ongoing monitoring and evaluation.[105]

9.16 Schedule E elaborates as to the way in which the Commonwealth and States are to engage to support local care delivery, but makes it plain that the Commonwealth is to have lead responsibility for GP services and primary health care [emphasis added]:

> "E37. GP and primary health care services are integral to an effective and efficient Australian health system. The Commonwealth will renew its efforts to improve GP and primary health care services in the community to improve care for patients. **The Commonwealth will take lead responsibility for the system management, funding and policy development of GP and primary health care with the objective of delivering a GP and primary health care system that meets the health care needs of Australians, keeps people healthy, prevents disease and reduces demand for hospital services**.
>
> E38. The Commonwealth and the States will work together on system-wide policy and local, regional and State level planning and funding for GP and primary health care given the impact on the efficient use of hospitals and other State funded services, and because of the need for effective integration across Commonwealth and State-funded health care services at the local level to improve patients' outcomes through early intervention and better coordination of care.
>
> E39. Commonwealth and States will work together to trial and test better approaches to accountability and funding that supports more integrated service delivery for communities. States will work cooperatively with the

[105] Exhibit A.28, *Addendum to the National Health Reform Agreement (consolidated) 2020-2025* [C28] [SCI.0001.0024.0001].

Commonwealth **in the implementation and ongoing operation of the Commonwealth's primary health initiatives**."[106]

9.17 Schedule E reinforces the notion that the Commonwealth is to deliver primary care through Primary Health Networks. Under the heading "Reforms to primary care to reduce potentially avoidable hospital admissions", Schedule E states: [emphasis added]

> "E40. The Commonwealth will continue to invest in programs designed to minimise the impact of potentially preventable hospital admissions arising from shortcomings in areas **within its own direct policy control** including:
>
> a. Integrating the planning, co-ordination and commissioning of services at a regional level **through Primary Health Networks**, with a specific focus on the interface between primary health care, and hospital services;"[107]

9.18 There are also several other provisions which set out the respective roles and responsibilities of Primary Health Networks and Local Health Districts:

a. Paragraph E27 sets out the list of "objectives" of Primary Health Networks, which relevantly include: "*identifying the health needs of their local areas and development of relevant focused and responsive services*".

b. This is further reflected in paragraph E30, the effect of which is that Primary Health Networks' plans need to take into account State-wide plans, and vice versa.

c. Paragraph E33 provides that States "will not establish duplicate GP or primary health care planning and integration", in effect prohibiting Local Health Districts and the Ministry from duplicating the service planning functions of Primary Health Networks.

[106] Exhibit A.28, *Addendum to the National Health Reform Agreement (consolidated) 2020-2025* [E37]-[E39] [SCI.0001.0024.0001].

[107] Exhibit A.28, *Addendum to the National Health Reform Agreement (consolidated) 2020-2025* [E40] [SCI.0001.0024.0001].

d. Paragraphs E6(b) and E36(b) require Primary Health Networks and Local Health Districts to engage with each other when undertaking their respective service planning activities.

Aged Care

9.19 It will be recalled that the *Addendum to National Health Reform Agreement 2020-2025* allocates to the Commonwealth the "planning, funding, policy, management and delivery" of the national aged care system.[108] It does so under Commonwealth legislation including the *Aged Care Act 1997* (Cth) and the *Aged Care Safety and Quality Commission Act 2018* (Cth).

9.20 Schedule F to the *Addendum to National Health Reform Agreement 2020-2025* addresses interfaces between health, disability and aged care services. In doing so it recognises that healthcare outcomes comprise only one component of aged care and disability care, and it is improvement of those healthcare outcomes for which the Commonwealth and the States have shared responsibility.[109]

9.21 Schedule F allocates to the States responsibility for, among other things, disability supports for people aged under 65 years who are not eligible for the National Disability Insurance Scheme, and funding of Commonwealth residential aged care or Home Care Packages for people aged under 65 years.[110]

9.22 The regime under Schedule F presupposes that, except in providing access to mainstream public hospital and State owned and run community services[111], the Commonwealth is responsible for aged care even if it is expected that delivery of the care would usually be done by the private sector through Commonwealth-funded aged care programs.

[108] Exhibit A.28, *Addendum to the National Health Reform Agreement (consolidated) 2020-2025* [13f] [SCI.0001.0024.0001].
[109] Exhibit A.28, *Addendum to the National Health Reform Agreement (consolidated) 2020-2025* [F3], [F8] [SCI.0001.0024.0001].
[110] Exhibit A.28, *Addendum to the National Health Reform Agreement (consolidated) 2020-2025* [F7] [SCI.0001.0024.0001]
[111] Exhibit A.28, *Addendum to the National Health Reform Agreement (consolidated) 2020-2025* [F7b] [SCI.0001.0024.0001].

9.23 The *Addendum to National Health Reform Agreement 2020-2025* is signed by all Australian governments. The CA Submissions do not seek an abandonment of New South Wales' commitment to the *Addendum to National Health Reform Agreement 2020-2025*, or a unilateral departure by New South Wales from the regime agreed to therein.

9.24 New South Wales' commitment to that national agreement, and its responsibilities thereunder, ought not be seen as mere inconveniences that can be rescinded or abrogated in pursuit of NSW Health's decision to go its own way on primary care and aged care. Nothing in the broad definitions of 'primary purposes' and the statutory functions of Local Health Districts provided in sections 9-10 of the *Health Services Act 1997* warrants such an approach. Given the broad range of healthcare activities that a Local Health District undertakes, when acting consistently with the responsibilities allocated to States under the *Addendum to National Health Reform Agreement 2020-2025*, it is understandable that the *Health Services Act 1997* defines their purposes and functions broadly.

9.25 Indeed, as observed in CA Submissions [301]-[304], sections 127(1) and (2A) of the *Health Services Act 1997* mandate that 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, among other things, the National Health Reform Agreement. It follows that, in determining the extent to which funding is provided for healthcare services beyond acute services in public hospitals, the Minister has a statutory obligation to take into account the allocation of roles and responsibilities to the Commonwealth under the *Addendum to National Health Reform Agreement 2020-2025*.

9.26 The practical reality is that the responsibility for adequate delivery of primary care *is* being exercised by the Commonwealth, which it achieves either directly

through system management, policy and funding of services (including through the Medicare Benefits Scheme), or indirectly through the role of Primary Health Networks in supporting, commissioning and planning of services. This is expressly acknowledged in section 5.2.2 of the *Final Report of the Mid-Term Review of the National Health Reform Agreement 2020-2025*, albeit while identifying some variable capacity among Primary Care Networks to deliver on the ground.[112]

9.27 Many witnesses from Primary Health Networks provided an overview of the role and function of Primary Health Networks, including the assessment of primary care needs of their communities.[113]

9.28 There was also extensive evidence as to the collaboration that occurs between Primary Health Networks and Local Health Districts for provision of primary care across a range of localities and programs.[114]

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[112] Exhibit N.3.17, *Mid-Term Review of the National Health Reform Agreement Addendum 2020-25 Final Report* (24 October 2024) [SCI.0011.0585.0001 at 0073, see also 0032 and 0041].

[113] Transcript of the Commission, 19 March 2024, T1378.46, T1380.5, T1384.33 – T1387.18, T1390.23, T1396.8 – T1399.26 (Neal & Mills); 15 August 2024, T4873.1 (Buist & Gow); 19 March 2024, T1282.18 (Manzie); 17 May 2024, T3080.21 (Williams); 19 September 2024, T5458.31-5466.29, T5473.8-19, T5489.13 – T5491.6 (Nankervis & Koschel); Exhibit I.42, Statement of Prudence Buist (14 August 2024) [SCI.0011.0351.0001]; Exhibit E.86, Statement of Robin Williams (16 May 2024) [17]-[19] [SCI.0009.0106.0001]; Exhibit K.105, Statement of Richard Nankervis and Alison Koschel (16 September 2024) [13], [20]-[22] [SCI.0011.0433.0001]. See also Transcript of the Commission, (19 September 2024), T5387.31 – T5388.21 (Grotowski – University of Newcastle).

[114] Exhibit B.36, NSW Health, *Annual Report 2022-2023* (November 2023) [SCI.0001.0059.0001 at 0068]; Exhibit N.3.9.6, South Western Sydney Local Health District, *Advance Care Planning, End of Life and Palliative Care Strategic Plan 2016-2021* (January 2016) [MOH.0006.0014.0001 at 0055]; Exhibit K.61.1, Johnstaff, *Service Planning: Bellinger River District Hospital* (November 2020) [MOH.0010.0602.0001 at 0016]; Exhibit L.3.4, Primary Health Network Cooperative, *Response to Consultation on Thin Markets in regional and remote Australia* (20 October 2023), p 3, section 2, p 12-13, section 3.3-3.4 [MOH.0010.0689.0001] [Query re collaboration with LHDs in NSW and refers more generally to 'local stakeholders']; Exhibit I.30.4, NSW Health, *NSW Aboriginal Mental Health and Wellbeing Strategy 2020-2025* (December 2020) [MOH.0014.0243.0001 at 0016]; Exhibit A.50, NSW Health and NSW Primary Health Networks, *Working together to deliver person-centred healthcare – joint statement* [SCI.0001.0045.0001], Exhibit A.51 NSW Health and NSW Primary Health Networks, *Working together to deliver person-centred healthcare – joint statement* [SCI.0001.0046.0001]; Exhibit A.30, Bilateral Agreement between the Commonwealth and New South Wales (2022) [SCI.0001.0026.0001 at 0015, 0019, 0022, 0024]; Exhibit C.1, Murrumbidgee Local Health District, *Quality and Safety Account 2022-2023* (November 2023) [SCI.0004.0034.0001 at 0045, 0048, 0054-55; Exhibit D.12, Nepean Blue Mountains Local Health District, *Strategic Plan 2023-2028*, p 10-11 [SCI.0007.0037.0001 at 0010-0011]; Exhibit E.27, Australian Healthcare and Hospitals Association, *Sustainability of primary care in small towns and communities initiative: models and strategies for general practice in rural and remote communities* (23 January 2020) [SCI.0009.0042.0001 at 0029]; Exhibit F.18, Western Health Alliance Limited t/as Western NSW Primary Health Network, *Securing the future of Primary Health Care in small towns in Western NSW* (March 2019) [SCI.0009.0111.0001 at 0005]; Exhibit I.42.2, South Eastern NSW Primary Health Network, Southern NSW Local Health District, Illawarra Shoalhaven Local Health District, *South Eastern NSW Regional Mental Health and Suicide Prevention Plan* 2018-2023 (February 2021) [SCI.0011.0327.0001 at 0007-0020]; Exhibit K.9, Mid North Coast Local Health District, *Clinical Services Plan 2018-2022* (April 2018) [SCI.0011.0402.0001 at 0014]; Exhibit K.113, Hunter New England and Central Coast Primary Health Network, *Needs Assessment and Planning* [SCI.0011.0445.0001]; Exhibit K.114, Hunter New England and Central Coast Primary Health Network, *Core Needs Assessment 2022-25* [SCI.0011.0446.0001 at 0007]; Exhibit N.3.27, NSW

9.29 This evidence bears out the importance of the Primary Health Networks' role in the planning process for the delivery of primary care, even where some of that care is provided by Local Health Districts in coordination with Primary Health Networks as envisaged in the *Addendum to National Health Reform Agreement 2020-2025*.

Unfunded expansion into primary care and aged care

9.30 As CA Submissions [587]-[588] observe, the evidence included several examples where Local Health Districts have stepped in to provide or support primary care services where they are not otherwise available.[115] However, these are isolated instances. They do not demonstrate that as a general proposition Local Health Districts are "best placed" to identify and address gaps in primary care services. Nor do they demonstrate that Local Health Districts would generally be best placed to attract a primary care workforce to address these gaps, let alone be able to utilise that workforce "synergistically" to address workforce challenges in other areas of the public health system within the regions.

9.31 There was evidence from several witnesses that the opportunity to deliver primary care through a salaried position could enhance the prospect of professionals opting to commit to the delivery of primary care in rural and remote areas.[116] Nevertheless, in circumstances where there is a nationwide

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Health, *Annual Report 2023-24* (October 2024) [SCI.0011.0717.0001 at 0038]; Exhibit E.6, Western NSW Primary Health Network, *Strategic Plan Overview 2023* [SCI.0009.0029.0001].

[115] Transcript of the Commission, 22 April 2024, T2315.34-2316.3 (McLachlan); 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].

[116] Exhibit A.49, NSW Health, *Regional Health Strategic Plan 2022-2032* (February 2023) [MOH.0001.0372.0001 at 0060]; Exhibit C.33.1, Statement of Jill Ludford (12 March 2024) [148]-[151] [MLH.0001.0016.0001]; Exhibit H.2.26, Australian Government Department of Health, *National Medical Workforce Strategy 2021-2031* (15 March 2022) [MOH.0010.0056.0001 at 0080], Exhibit H.5.21, Statement of Richard Griffiths (16 July 2024) [93] [MOH.0011.0022.0001]; Exhibit H.5.23, Statement of Melissa Collins (17 July 2024) [119] [MOH.0011.0025.0001]; Exhibit K.42, Statement of David Quirk (4 September 2024) [16(e)] [MOH.0011.0053.0001]; Exhibit K.48, Statement of Martin Cohen (16 September 2024) [43] [MOH.0011.0073.0001]; Exhibit A.33, Royal Australian College of General Practitioners, *General Practice Health of the Nation 2023* (November 2023) [SCI.0001.0029.0001 at 0058); Exhibit E.37, Legislative Council, *Health outcomes and access to health and hospital services in rural, regional and remote New South Wales* (May 2022) [SCI.0009.0077.0001 at 0018, 0079, 0088, 0089, 0092, 0095, 0100, 0101], Exhibit N.3.2, *NSW Government Response to the inquiry into health outcomes and access to health and hospital services in rural, regional and remote New South Wales* (1 September 2022), [SCI.0011.0516.0001 at 0011]; Exhibit N.3.13, NSW Health, *Progress Report - Parliamentary Inquiry into Health Outcomes and Access to Health and Hospital Services in Rural, Regional and Remote New South Wales* (30 June 2024) [SCI.0011.0517.0001 at 0028]; Exhibit L.3, Statement of Luke

shortage of general practitioners set to become worse[117], there is doubt whether this would supply a solution across the State. In particular, there is a risk of Local Health Districts 'cannibalising' the existing primary care workforce including in fragile private markets in those very rural and remote communities.[118]

9.32 Similarly, the evidence did not grapple in any substantive way with the source of long-term funding for Local Health Districts to sustain any significant increased involvement in primary care or aged care, as per the proposed recommendations. Section 9 of CA Submissions does not mention funding other than to observe at the very end (at [605]) that access to Commonwealth funding streams for the delivery of this care should "clearly be pursued" by Ministry, but so the submission has it, increased involvement should not await the outcome of such pursuit.

9.33 NSW Health submits there are at least the following problems with this proposition.

9.34 **First**, whether New South Wales is to bear the significant financial risk from increased NSW Health involvement in primary care and aged care, without first securing Commonwealth funding, is a matter for the NSW Government. NSW Health does not determine its own budget. It cannot speak for Government's willingness to bear this risk.

Sloane (3 October 2024) [55]-[57] [MOH.0011.0079.0001]; Exhibit L.16, Statement of Andrew Holland (30 September 2024) [27] [SCI.0011.0469.0001]; Exhibit N.3.17, Rosemary Huxtable AO PSM, *Mid-Term Review of the National Health Reform Agreement Addendum 2020-2024 Final Report* (24 October 2024), [5.8.1.2] [SCI.0011.0585.0001]; Transcript of the Commission, 29 November 2023, T273.8-274.15 (Lyons), 18 March 2024, T1174.30-1176.18 (Christmas), 1218.3-1221.3 (Shenouda), 21 March 2024, 1625.45-1626.16 (Yoosuff), 22 March 2024, T1697.43-1699.9 (Ludford), 29 April 2024, T2544.13-36 (Willcox), 14 May 2024, T2698.43-2699.16 (Chua), 15 May 2024, T2789.40-2790.32 (Hua), 16 April 2024, 2945.16-6946.27 (Spittal), 15 August 2024, T4902.28-40, 19 September 2024, T5382.39-5383.28 (Grotowski), 16 October 2024, T10-43 (General Practice Panel); Exhibit E.42, Outline of Evidence of Josh Carey (30 April 2024) [27]-[28] [MOH.9999.1195.0001]; Exhibit E.44, Outline of Evidence of Mark Arnold (30 April 2024) [27] [MOH.9999.1199.0001]; Exhibit E.47, Statement of Mark Spittal (30 April 2024) [161]-[164] [MOH.9999.1202.0001]; Exhibit B.36, NSW Health, *Annual Report 2022-2023* (November 2023) [SCI.0001.0059.0001 at 0009]; Exhibit K.105, Statement of Richard Nankervis and Alison Kaschel (16 September 2024) [24] [SCI.0011.0433.0001]; Exhibit N.3.27, NSW Health, *Annual Report 2023-2024* (October 2024) [SCI.0011.0717.0001 at 0054].

[117] Exhibit J.2, *Supply and Demand Study, General Practitioners in Australia* (August 2024), pp 8 – 9, 11 [SCI.0011.0392.0010 at 0009 – 0010, 0012].

[118] Transcript of the Commission, 18 March 2024, T1163.20- 43, T1164.44 - T1165.07, (Christmas); 16 October 2024 T5837.20 – T5838.05 (Sloane).

9.35 **Second**, a significant increased involvement in primary care and aged care is a long-term commitment. It requires capital works, including repurposing of existing, and developing new, infrastructure and workforce. It requires extensive clinical services planning. It requires careful coordination and planning with existing primary and aged care markets, clinicians, and Primary Health Networks to determine if NSW Health intervention is needed, desirable, feasible and/or the most efficient use of resources. As discussed in Section 6 of these submissions above, in circumstances where there was extensive evidence that the current funding envelope already imposes significant challenges on NSW Health to deliver existing services, a significantly increased involvement in primary care and aged care cannot occur without a source of long-term funding, whether from the NSW Government, or from the Commonwealth, or both. It would be irresponsible of NSW Health to assume the burden that arises from Counsel Assisting's proposed course, without first securing the requisite long term-funding. Indeed, to do so may be in contravention of one of the statutory functions of Local Health Districts, under s 10(e) of the *Health Services Act* 1997, "to ensure the efficient and economic operation of its health services and health support services and use of its resources."

9.36 **Third**, were NSW Health to act on proposed recommendations 11, 12 and 14 within its current funding envelope, that could only result in either a thinning in the delivery of healthcare services, because existing resources are diverted to provision of that significantly increased primary care and aged care, or disinvestment of existing healthcare services in favour of significantly increased primary care and aged care. Either outcome would constitute a departure by NSW Health from the State's clear responsibilities for public hospitals under the *Addendum to National Health Reform Agreement 2020-2025*. In effect, without securing a source of long-term funding first, implementation of the recommendations would require the State unilaterally deprioritising something that forms part of its *Addendum to National Health*

Reform Agreement 2020-2025 responsibilities, to try to solve a problem that forms part of the Commonwealth's responsibilities.

9.37 **Fourth**, given the regime agreed by all governments under the *Addendum to National Health Reform Agreement 2020-2025* (as discussed above), acting on proposed recommendations 11, 12 and 14 would require reform of the *Addendum to National Health Reform Agreement 2020-2025*.

9.38 At the least, it would require adjustment of the allocation of responsibilities between the Commonwealth, the Primary Health Networks, and the States to the effect that local hospital networks (Local Health Districts) become the provider of last resort for primary care and aged care. For this to be feasible nationwide, it would require creation of a new mechanism for funding of States to deliver that primary care and aged care, which goes beyond the current regime for partial Commonwealth funding for recognised activity under Activity Based Funding which falls within a growth cap, and a series of special-purpose grants to cover community health care programs.[119]

9.39 This may involve the extended use of the s 19(2) exemption, or it may not – noting that funding from the Medicare Benefits Scheme obtained via s 19(2) exemptions[120] might only cover part of the actual cost of delivery, with the balance borne by the State or within the existing NSW Health funding envelope.[121]

9.40 This would be a significant piece of national healthcare reform that would affect the delivery of primary care and aged care in all States, not only New South Wales. The evidence before the Special Commission did not substantially explore how any of this, in a practical sense, would work. Simply saying that

[119] Transcript of the Commission, 21 November 2024, T6530.8-20, T6538.43-45 (Smith); 18 November 2024, T6283.10 – T6286.7 (Kastoun & D'Amato).

[120] See existing consideration of the s 19(2) exemption to improve access to primary care in Exhibit D.1.151, NSW Health Guideline GL2023_019, *Improving Access to Primary Care in Rural and Remote Areas (s19(2) Exemptions) Initiative* [MOH.9999.0904.0001); Exhibit N.3.17, Rosemary Huxtable AO PSM, *Mid-Term Review of the National Health Reform Agreement Addendum 2020-2024 Final Report*, [SCI.0011.0585.0001 at 0042 and 0111-0112]; Transcript of the Commission, 16 October 2024, T5834.41, T5838.7, T5856.34 (General Practice Panel); 29 April 2024, T2543.1 (Willcox) re 4Ts model; Exhibit E.47, Statement of Mark Spittal (30 April 2024) [5], [53], [70], [151], [162], [138] [MOH.9999.1202.0001.

[121] Transcript of the Commission, 28 November 2023, T128.18-130.18 (Chant & Lyons); 29 April 2024, T2502.30-2503.42 (Daly); 23 May 2024, 3346.26-3348.5 (Astill); 16 April 2024, T2945.1 – T2943.35, T2975.10-2976.25, T2977.14 (Spittal).

"Ministry" could pursue streams of Commonwealth funding does not, with respect, grapple with the realities of intergovernmental healthcare funding arrangements.

9.41 An illustration of this point is seen in the way the *Final Report of the Royal Commission into Aged Care Quality and Safety* dated 1 March 2021 proposed a "New Aged Care System" built on Commonwealth legislation, Commonwealth governance and oversight of delivery. Under that system, the only roles envisaged for State governments are to collaborate on various national programs, including:

a. access for those in residential care or personal care at home to specialists and other health practitioners through Multidisciplinary Outreach Services in Local Hospital Networks (Recommendation 58);

b. access to outreach services for mental health care (Recommendation 59);

c. improving the transition between residential aged care and hospital care (Recommendation 66); and

d. improving data on the interaction between the health and aged care systems (Recommendation 67). The final report (Chapter 9 in particular) and the recommendations recognise that whilst the aged care system and the health care system interact, they are not the same system and there is no expectation or even contemplation of the idea of a State public healthcare provider assuming a responsibility to ensure provision of appropriate aged care.

9.42 **Fifth**, CA Submissions [605]-[607] when read together with Section 7 appear to envisage the following steps to occur *before* NSW Health significantly increases its involvement in the delivery of primary care in a given community:

a. The system-wide clinical services planning under recommendations 6-8, done in collaboration with "other stakeholders", which presumably must involve Primary Health Networks;

b. Identification through that process of any gap in the provision of primary care[122];

c. Identification of ways in which that gap could be filled, including the feasibility and cost of it being filled by the public health system[123];

d. Collaboration with the community and other providers of health services to determine how the gap is to be filled, and what funding is available for that to occur[124];

e. An assessment then as to whether NSW Health *should* fill that gap having regard to, among other things, the potential need to make "difficult decisions about how to prioritise the distribution of a limited budgetary envelope".[125]

9.43 Provided that Primary Health Networks are to lead the process of system-wide planning insofar as it concerns primary care, the above proposal appears generally consistent with the regime in the *Addendum to National Health Reform Agreement 2020-2025*.[126]

9.44 However, that same system-wide clinical services planning process might result in a conclusion that it is not feasible or appropriate for the Local Health District to fill the gap, or there are other healthcare services which should be prioritised in the absence of additional funding Whilst alternative providers (such as private markets) are not providing adequate primary care, whether through the Primary Health Networks or otherwise, there is a way to improve delivery in the short- or medium-term. In such scenarios, any recommendation

[122] CA Submissions [492c].
[123] CA Submissions [492d].
[124] CA Submissions [492f].
[125] CA Submissions [480].
[126] See also discussion in Transcript of the Commission, 29 April 2024, T2539-2541.40 (Willcox); Exhibit D.10, Statement of Deborah Willcox (9 April 2024) [20], [96] [MOH.9999.0981.0001].

that NSW Health "**ensure**" that adequate primary care is delivered by intervening first and securing funding later would be inconsistent with the very objective of the system-wide clinical services planning process recommended under Section 7 of CA Submissions.

Conclusion on recommendations 11, 12, and 14

9.45 Recommendations 11, 12 and 14 require NSW Health to increase involvement in the delivery of both primary care and aged care without Commonwealth agreement or support, in a way that would be inconsistent with the allocation of responsibilities agreed between the Commonwealth and all the States under the *Addendum to National Health Reform Agreement 2020-2025*, and (in the case of primary care) in a way which would trample over the existing regime by which primary care is already managed by Primary Health Networks albeit through joint planning and coordination with Local Health Districts.

9.46 At the heart of section 9 of CA Submissions is an assumption, most evident from CA Submissions [584], that because Local Health Districts have statutory power under State law to provide primary and aged care services beyond being a provider of last resort in emergency departments, this translates to a "role and responsibility" of the State (through NSW Health) itself to *ensure* the provision of these services regardless of the (inconsistent) regime in the *Addendum to National Health Reform Agreement 2020-2025*.

9.47 In the case of aged care, that would see NSW Health assuming responsibility for delivering services that are not only squarely within the Commonwealth realm of responsibility but also only ancillary to health services – including accommodation, and supervision and transportation of the elderly, with all their associated demands on capital (infrastructure and workforce). Although health services are often provided to the aged in a care setting, aged care is not synonymous with health services, but encompasses a much broader range of services not within the usual business of a public health system.

9.48 The proposed recommendation contemplates that all of this be required of NSW Health:

a. without any identification of a secured long-term funding source for NSW Health (either from the NSW Government or from the Commonwealth), beyond the possibility of "Ministry" asking for Commonwealth funding; and

b. regardless of whether the very system-wide clinical services planning sought under recommendations 6-8 determines that in a given community, such primary care and aged care intervention is needed, desirable, to be prioritised over other health services needed, feasible (including by reference to workforce and funding challenges) and the most cost-effective solution for that community.

9.49 NSW Health's alternative proposed recommendation 12 seeks to remedy these problems, in effect by:

a. removing any reference to aged care, which should remain within the Commonwealth's responsibilities;

b. acknowledging that Primary Health Networks will have lead responsibility for the planning of primary care services and this should be undertaken in a coordinated way with system-wide clinical services planning undertaken by NSW Health in accordance with the *Addendum to National Health Reform Agreement 2020-2025*; and

c. assessing through that planning the need, desirability, feasibility and cost of the Local Health District intervening to fill in any gap in primary care in each community;

d. by providing that, if this process determines that Local Health District intervention could and should occur, then before committing to it, NSW Health would seek Commonwealth funding for it.

Counsel Assisting's recommendation 13 [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.

NSW Health response to Counsel Assisting's recommendation 13

9.50 **In response to recommendation 13, NSW Health makes a number of comments, set out below.**

9.51 NSW Health has a role in training and support for primary care workers in hospital based and NSW Health community health settings, as can be seen in existing programs such as the rural generalist pathway to general practice under the single employer model[127], and the John Flynn Prevocational Doctors Program.[128]

9.52 NSW Health welcomes any opportunity to increase the number of regional training opportunities. It does not always have clear visibility and up-to-date awareness of the entire primary care workforce in each Local Health District, particularly the general practice workforce. As discussed above in relation to recommendations 11, 12 and 14, existing planning for primary care is led by Primary Health Networks although often with the participation of Local Health Districts.

9.53 Any system-wide planning process that concerns primary care, including the training of the primary care workforce, should similarly be led by the Primary

[127] Transcript of the Commission, 18 March 2024, T1218.27 - 1219.3 (Shenouda); Exhibit C.33.1, Statement of Jill Ludford (12 March 2024), [147]-[151] [MLH.0001.0016.0001]; Exhibit F.14, Outline of evidence of Sarah Wenham (7 May 2024) [49] [MOH.9999.1256.0001]; Exhibit L.3, Statement of Luke Sloane (3 October 2024) [52]-[57] [MOH.0011.0079.0001]; Exhibit H.5.21, Statement of Richard Griffiths (16 July 2024) [93] [MOH.0011.0022.0001].

[128] Exhibit H.5.21, Statement of Richard Griffiths (16 July 2024) [95] [MOH.0011.0022.0001]; Exhibit I.35, Statement of Nathan Oates (8 August 2024) [13]-[17] [MOH.0011.0046.0001]; Exhibit H.5.19, Statement of Linda MacPherson (12 July 2024) [86] - [88] [MOH.0011.020.0001]; Exhibit L.2, Statement of J Harris (2 October 2024) [34] - [40] [MOH.0011.0077.0001); Exhibit H.15, Statement of Josephine Burnand (11 July 2024) [66] [MOH.0011.0017.0001]; Exhibit L.4, Statement of Josephine Burnand (4 October 2024) [11] [MOH.0011.0080.0001].

Health Networks. This is consistent with the allocation of responsibilities under the *Addendum to National Health Reform Agreement 2020-2025*.

SECTION 10: THE HEALTH WORKFORCE

Counsel Assisting's recommendation 15 [763]

As of [sic] *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.

NSW Health response to Counsel Assisting's recommendation 15

10.1 **In response to recommendation 15, NSW Health makes a number of comments, set out below.**

Work underway

10.2 NSW Health already has significant efforts underway in respect of system-wide workforce planning, which include strategies and processes for engagement with Local Health Districts and other stakeholders. However, NSW Health accepts that there are opportunities to further centralise its current workforce planning activities and to improve the connectivity between Ministry and Local Health Districts in this respect.

10.3 Since 2011 NSW Health has adopted devolution and localism as two of its fundamental organising principles. This has seen clinical services planning occur at the Local Health District level.[129] The benefit of this approach has been greater local involvement in workforce planning, including by staff,

[129] Exhibit L.6, Statement of Philip Minns (8 October 2024) [12] [MOH.0011.0082.0001].

clinicians and local communities.[130] However, over time this localised approach has exposed a "missing middle function" between Local Health Districts and Ministry in the areas of service planning and configuration.[131] NSW Health has identified a need to reinstate this missing middle function so that there is greater alignment between the system level design undertaken by NSW Health (including its future health strategy[132]) and localised decision-making.[133]

10.4 Harnessing data will be key to improving the connection between system-wide workforce strategies and their implementation by Local Health Districts.

10.5 Any actions taken to further centralise workforce planning need to recognise that certain organisations and services within the NSW health system undertake their own workforce planning activities. For example, NSW Ambulance undertakes centralised workforce planning for its own workforce.[134] Any efforts towards greater centralisation should avoid diminishing localised and service-specific agency and decision-making.[135]

Workforce planning and modelling

10.6 Ministry recognises that it has a "helicopter view" of the NSW health system which puts it in a unique position to undertake, and assist others with, workforce planning.[136] It has a dedicated Workforce, Planning and Talent Development Branch which is responsible for developing, facilitating and evaluating health workforce strategies across the NSW health system to support the health workforce in delivering improved health outcomes for communities across NSW.[137] The Workforce, Planning and Talent

[130] Exhibit L.6, Statement of Philip Minns (8 October 2024) [12] [MOH.0011.0082.0001].
[131] Exhibit L.6, Statement of Philip Minns (8 October 2024) [14] [MOH.0011.0082.0001].
[132] Exhibit L.6, Statement of Philip Minns (8 October 2024) [7]-[9] [MOH.0011.0082.0001].
[133] Exhibit L.6, Statement of Philip Minns (8 October 2024) [14]-[16] [MOH.0011.0082.0001].
[134] Exhibit N4.8, Auditor-General for New South Wales, *Ambulance Services in regional New South Wales – Performance Audit* (28 June 2024), pp. 7, 43-44 and 59 [MOH.0010.0755.0001].
[135] Exhibit L.6, Statement of Philip Minns (8 October 2024) [14] [MOH.0011.0082.0001].
[136] Transcript of the Commission, 6 August 2024, T4762.4-10, 4672.23-26 (Griffiths).
[137] Exhibit H.5.21, Statement of Richard Griffiths (16 July 2024) [2] [MOH.0011.0022.0001].

Development Branch has the ability to influence workforce pipeline in a way that other parts of NSW Health does not.[138]

10.7 As part of fulfilling these responsibilities, the Workforce, Planning and Talent Development Branch have developed a number of plans and strategies, relevantly including the:

a. *NSW Health Workforce Plan 2022 – 2032*;[139]

b. *NSW Health Workforce Plan 2022 – 2032 Supplementary Plan*[140];

c. *NSW Health Talent Strategy 2022 – 2032*[141]*;* and

d. *Talent Strategy Implementation Plan.* [142]

10.8 The Workforce, Planning and Talent Development Branch also monitors and observes workforce trends and assesses the implementation of strategies to address workforce need.[143] It does so using data collected by NSW Health and held in the NSW Corporate Analytics Data Warehouse.

10.9 A further system-wide planning role played by Ministry is in industrial relations. The Workplace Relations Branch of NSW Health plays a key role in the setting of employment policy and strategy and ensuring that the labour costs incurred by the NSW Health service are sustainable.[144] Central to this is the role played by the Workplace Relations Branch in leading system-wide industrial relations for the NSW health system, including the conduct of industrial cases in the NSW Industrial Relations Commission.[145]

10.10 The Workforce, Planning and Talent Development Branch undertakes longer term workforce modelling and forecasting, across various clinical disciplines

[138] Transcript of the Commission, 6 August 2024, T476.4-10 (Griffiths).
[139] Exhibit A.48, *NSW Health Workforce Plan 2022-2032* [SCI.0001.0043.0001].
[140] Exhibit H.2.36, NSW Health, *NSW Health Workforce Plan 2022-2032: A Supplementary Guide* (24 April 2023) [MOH.0010.0275.0001].
[141] Exhibit H.2.29, NSW Health, *Talent Strategy 2022-2032* (June 2022) [MOH.0010.0271.0001].
[142] Exhibit H.2.31, NSW Health, *Talent Strategy 2022-2032 Horizon 1 Implementation Plan (Years 1 -3)* (2022) [MOH.0010.0272.0001].
[143] Exhibit H.5.21, Statement of Richard Griffiths (16 July 2024) [41] [MOH.0011.0022.0001].
[144] Exhibit H.5.23, Statement of Melissa Collins (17 July 2024) [25] [MOH.0011.0025.0001].
[145] Exhibit H.5.23, Statement of Melissa Collins (17 July 2024) [26] [MOH.0011.0025.0001].

and specialties, using a combination of data from the NSW Corporate Analytics Data Warehouse and national and international datasets.[146]

10.11 Workforce modelling undertaken by the Workforce, Planning and Talent Development Branch is done at a system level in respect of the professions that are required to be registered through the Australian Health Practitioner Regulation Agency.[147] The modelling undertaken considers both supply and demand.

10.12 In building a model for a specified profession, the Workforce, Planning and Talent Development Branch will typically:

a. consider the existing workforce stock;

b. overlay that with the academic/graduate pipeline for that profession; and

c. adjust that number by the number of anticipated exits into the future,

to obtain an indication of the likely workforce stock for that profession in the projected years.[148] In its analysis of these supply factors the Workforce, Planning and Talent Development Branch will also typically consider changing workforce expectations, global supply, Federal reforms including the National Disability Insurance Scheme, aged care, comparative rates of pay in other jurisdictions, private market/sector opportunities and graduate pipeline.[149]

10.13 After considering its anticipated supply, the Workforce, Planning and Talent Development Branch will then typically factor in anticipated demand, drawing from a number of different datasets and accounting for and consulting on[150] demand factors including community expectations, ageing population,

[146] Exhibit H.5.21, Statement of Richard Griffiths (16 July 2024) [41] [MOH.0011.0022.0001].
[147] Exhibit H.5.21, Statement of Richard Griffiths (16 July 2024) [44] [MOH.0011.0022.0001] (erroneously labelled 'Australian Health Professional Regulation Authority').
[148] Transcript of the Commission, 6 August 2024, T4775.25-30 (Griffiths).
[149] Exhibit H.5.21, Statement of Richard Griffiths (16 July 2024) [43] [MOH.0011.0022.0001].
[150] Transcript of the Commission, 6 August 2024, T4775.32-41 (Griffiths).

increasing health complexities, infrastructure redevelopment and population growth and mobility.[151]

10.14 The system-wide modelling undertaken by the Workforce, Planning and Talent Development Branch takes into account workforce supply across each of the Local Health Districts, and once the modelling is complete it is shared with Local Health Districts for incorporation into their own workforce plans.[152] The Workforce, Planning and Talent Development Branch also undertakes local workforce modelling in relation to certain clinical groups in conjunction with Local Health Districts.[153]

Collaboration

10.15 The Workforce, Planning and Talent Development Branch works with the Commonwealth regarding emerging areas of workforce need.[154]

10.16 Similarly, the Workforce, Planning and Talent Development Branch works closely with the specialist medical colleges regarding their training and accreditation requirements (particularly, supervision requirements) in an effort to ensure that those requirements do not act as a barrier to creating and maintaining the pipeline of trainees across the medical specialties.[155]

10.17 During 2023-2024, the Workforce, Planning and Talent Development Branch consulted with stakeholders, including the specialist medical colleges, university Deans, and TAFE, regarding supporting and increasing rural and regional training opportunities for medical and other clinical disciplines to address issues of workforce maldistribution.[156]

[151] Exhibit H.5.21, Statement of Richard Griffiths (16 July 2024) [43] [MOH.0011.0022.0001].
[152] Transcript of the Commission, 6 August 2024, T4776.11-19 (Griffiths).
[153] Transcript of the Commission, 6 August 2024, T4775.43 – 4776.9 (Griffiths).
[154] Transcript of the Commission, 6 August 2024, T4782.38-44 (Griffiths).
[155] Transcript of the Commission, 6 August 2024, T4783.2-31 (Griffiths).
[156] Transcript of the Commission, 6 August 2024, T4779.31 – 4780:23 (Griffiths).

Potential challenges

10.18 One of the challenges in implementing a greater centralised workforce planning function is the time and resources involved in the manual correlation of datasets received from various sources and stakeholders.[157] NSW Health does not have a system to automatically correlate data but considers that this challenge could be alleviated if data collected across the NSW health system was recorded in a consistent way.[158]

10.19 Similarly, there are restrictions on the use that can be made of some of the datasets collected by or provided to NSW Health, including medical information and information collected in measuring diversity indicators.[159]

10.20 Increasing centralised workforce planning also has the potential to burden rural and regional Local Health Districts with the highly manual task of collating local data, taking them away from their key function of delivering healthcare services.[160]

10.21 Even if a more centralised workforce planning function is established, these challenges are likely to persist, at least in the short term.

10.22 NSW Health has the capacity to influence the workforce pipeline, but that influence can be diluted by external factors over which it has no control. For example, there was evidence that changing social preferences can lead to less demand for permanent employment.[161] Additionally, there are multiple stakeholder groups who wield influence in this sphere: for example, NSW Health does not control the policy settings of other States and Territories. Nor does it control the policies of the Commonwealth, including as to the setting of university places, the activities of the National Disability Insurance Scheme

[157] Exhibit H.5.21, Statement of Richard Griffiths (16 July 2024) [146] [MOH.0011.0022.0001]; Transcript of the Commission, 6 August 2024, T4780.28-4781.40 (Griffiths).
[158] Transcript of the Commission, 6 August 2024, T4781.31-35 (Griffiths).
[159] Exhibit H.5.21, Statement of Richard Griffiths (16 July 2024) [146(b)] [MOH.0011.0022.0001]; Transcript of the Commission, 6 August 2024, T4781.42-4872.16 (Griffiths).
[160] Transcript of the Commission, 7 August 2024, T4818.21-43 (Minns).
[161] Exhibit H.5.21, Statement of Richard Griffiths (16 July 2024) [147] [MOH.0011.0022.0001].

and the aged care sector. Such matters bear upon NSW Health's workforce availability. So too do decisions made within the private health sector.

10.23 Additionally, the adversarial nature of the industrial disputation process[162], and the unavoidable need for the NSW Government to have wages and workforce policies that set the parameters within which NSW Health must negotiate with other parties[163], impede workforce planning.[164] The fact that industrial negotiations are often protracted[165], with the result that outcomes are not known at the workforce planning stage, imports an element of uncertainty into the planning process.

Counsel Assisting's recommendation 16 [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,

[162] Exhibit H.5.23, Statement of Melissa Collins (17 July 2024) [45] – [47] [MOH.0011.0025.0001].
[163] Exhibit H.5.23, Statement of Melissa Collins (17 July 2024) [42] – [43] [MOH.0011.0025.0001].
[164] Exhibit H.5.23, Statement of Melissa Collins (17 July 2024) [47] – [48] [MOH.0011.0025.0001].
[165] Exhibit H.5.23, Statement of Melissa Collins (17 July 2024) [47] – [48] [MOH.0011.0025.0001].

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.

NSW Health response to Counsel Assisting's recommendation 16

10.24 **In response to recommendation 16, NSW Health makes a number of comments, set out below.**

10.25 In respect to the matters identified in paragraphs a-c of recommendation 16, NSW Health acknowledges a need for consideration of greater central coordination between both its internal instrumentalities (i.e. Ministry, the Health Education and Training Institute and Local Health Districts and Specialty Health Networks) and external stakeholders, namely universities and TAFE. A review of current arrangements is required to determine what shape such arrangements should take and the appropriate means by which such reforms should be effected and would need to consider the different functions currently performed by various instrumentalities of NSW Health, including Health Education and Training Institute.

10.26 Funding appropriate to the approach that is adopted would need to be provided to support such a change or expansion.

Work underway

Nursing and midwifery clinical placements

10.27 The Health Education and Training Institute maintains the ClinConnect system used to facilitate student placements[166], with student placements undertaken and governed at the local level between the relevant public health organisation and the educational institution[167], as are the decisions about the number of student placements to be offered.[168] In some circumstances, Local Health

[166] Transcript of the Commission, 22 July 2024, T3792.7-15 (Solman).
[167] Exhibit H.5.11, Statement of Annette Solman (9 July 2024) [54] [MOH.0011.0012.0001].
[168] Exhibit H.5.11, Statement of Annette Solman (9 July 2024) [55] [MOH.0011.0012.0001].

Districts will liaise with local universities and TAFE campuses to arrange placements.[169]

10.28 The Chief Nursing and Midwifery Officer for NSW Health also has a role in respect of clinical placements for nursing and midwifery students through the biannual meetings held with Nursing and Midwifery University Deans and Heads of School where the quality of placements, expanding placement opportunities and maximising the student experience and work readiness are all discussed.[170]

10.29 Further, the number of clinical placements for students studying nursing and midwifery at university and the number of subsidised student places are determined by the Commonwealth and universities. Those allocations are processed via the ClinConnect platform. Neither the Health Education and Training Institute nor NSW Health has visibility over the allocation of those subsidised places.[171]

Medical graduates

10.30 The Health Education and Training Institute currently manages the allocation of medical graduates to intern positions across NSW Health. NSW Health understands that proposed recommendation 16(b) suggests an expansion of that role.

10.31 To the extent that the recommendation calls for an improvement in the use of the student pipeline to foster graduate placements, NSW Health accepts that should be pursued within the constraints of public sector employment discussed below.

10.32 In respect of the application and allocation of medical graduates to medical internship positions, the Health Education and Training Institute meets with NSW Medical Deans four times a year to discuss matters of common interest

[169] Transcript of the Commission, 22 July 2024, T3791.24-42 (Solman).
[170] Exhibit H.5.10, Statement of Jacqui Cross (8 July 2024) [9] [17] [MOH.0011.0007.0001].
[171] Exhibit H.5.10, Statement of Jacqui Cross (8 July 2024) [15] - [17] [MOH.0011.0007.0001].

including changes in medical school curriculum, predicted intern numbers and allocation processes for the following year.[172]

Specialist training

10.33 The Health Education and Training Institute oversees pre-vocational and medical specialty training (known as vocational training) through its networks. Its role in each vocational training network is slightly different.[173] The type of oversight varies across the different specialties and depending upon whether the network is operated by a medical college. The Health Education and Training Institute has no governance role over those vocational training networks established by medical colleges. The current vocational training networks established by the Health Education and Training Institute[174] are the Basic Physician Training, Psychiatry, Paediatrics, Emergency Medicine, Radiology, Advanced General Medicine and Medical Administration training networks.[175]

10.34 The Health Education and Training Institute's role in oversighting these networks is to monitor and review their performance and risk management. The Health Education and Training Institute is also a point of escalation when issues are unable to be resolved locally, including between the Health Education and Training Institute and the relevant Local Health District when issues have been identified that might place accreditation at risk.[176]

10.35 The Health Education and Training Institute has also played a role in establishing the State Training Councils for each of its vocational training networks[177], with representatives of the relevant medical colleges attending most meetings of each State Training Council.[178] The Health Education and

[172] Exhibit H.5.11, Statement of Annette Solman (9 July 2024) [56] – [57] [MOH.0011.0012.0001].
[173] Transcript of the Commission, 22 July 2024, T3813.5-22 (Burnand).
[174] There are other specialty training networks that are not conducted under the auspices of NSW Health, see Transcript of the Commission, 22 July 2024, T3813.37-47 (Burnand); Exhibit H.5.15, Statement of Josephine Burnand (11 July 2024) [44], [49] [MOH.0011.0017.0001].
[175] Exhibit H.5.15, Statement of Josephine Burnand (11 July 2024) [47] [MOH.0011.0017.0001].
[176] Exhibit H.5.15, Statement of Josephine Burnand (11 July 2024) [45] [MOH.0011.0017.0001].
[177] Exhibit H.5.15, Statement of Josephine Burnand (11 July 2024) [48] [MOH.0011.0017.0001].
[178] Exhibit H.5.15, Statement of Josephine Burnand (11 July 2024) [49] [MOH.0011.0017.0001].

Training Institute also provides a platform for the creation and dissemination of education resources for medical trainees which can be accessed via the Health Education and Training Institute's website.[179]

10.36 The Health Education and Training Institute and NSW Health should continue to work collaboratively with the specialist medical colleges to address future service and workforce needs, while maximising opportunities for recruitment in rural, regional and remote areas. The establishment of a more centralised statewide workforce planning function as proposed in Counsel Assisting's recommendation 15 will assist in better matching the number and location of placements and training positions within areas of future workforce need.

Potential challenges

10.37 There would be significant work involved in centralising and reallocating the existing responsibilities for the medical, nursing and allied health student cohorts as those responsibilities are currently split across Ministry, the Health Education and Training Institute, eHealth NSW and Local Health Districts and Specialty Health Networks.[180]

10.38 Counsel Assisting's recommendation 16(a) carries a significant undertaking in the Health Education and Training Institute assuming responsibility for the allocation of students to clinical placements; under the current arrangements, Local Health Districts perform this coordination function. Should the responsibility for coordinating clinical placements become more centralised, it is important that local engagement is maintained to ensure that the educational requirements of placements can be satisfied, that there are no logistical or service delivery difficulties created by proposed placement arrangements and that the necessary support structures are in place to ensure students have a positive experience while on placement, regardless of the NSW Health agency or instrumentality that takes on responsibility for it.

[179] Exhibit H.5.15, Statement of Josephine Burnand (11 July 2024) [46] [MOH.0011.0017.0001].
[180] Exhibit H.5.11, Statement of Annette Solman (9 July 2024) [52] – [55] [MOH.0011.0012.0001].

10.39 The "early recruitment" contemplated by Counsel Assisting's recommendation 16(b) may not always be practicable, given the requirements that apply to public sector recruitment processes which NSW Health must observe.[181] Those processes involve scrutiny of the general suitability of candidates, and a process of comparison with other candidates. It is not simply a matter of a NSW Health agency offering a full-time position to an intern without following an appropriate recruitment process.

10.40 Counsel Assisting's recommendation 16(c) contemplates expanding the Health Education and Training Institute's role to establish specialist medical training networks for *all* medical specialties. As described in preceding paragraphs, there are presently vocational training networks which have been established by the Health Education and Training Institute and other networks that have been established by certain of the medical specialist colleges. Separately, the medical specialist colleges are responsible for setting the standards and requirements for specialist training, accrediting training positions and managing the assessment and examination requirements placed on trainees.[182] In those circumstances, any work undertaken by NSW Health to establish further vocational training networks would require a collaborative process with the colleges to:

a. avoid duplication between any new and existing networks;

b. ensure that facilities within the networks are suitable training sites and able to comply with the relevant college's accreditation requirements; and

c. ensure that the structure of any new networks will allow trainees in those specialties to satisfy the training requirements set by the colleges.

[181] Exhibit H.5.21.2, Supplementary statement of Richard Griffiths (2 August 2024) [12]-[14] [MOH.0011.0039.0001]. See also s 7 of the *Government Sector Employment Act 2013* which sets out the government sector core values and Part 3 of the *Government Sector Employment (General) Rules 2014* which provides for "Merit-based employment" in the NSW Government sector.

[182] Exhibit H.5.15, Statement of Josephine Burnand (11 July 2024) [49] [MOH.0011.0017.0001].

Counsel Assisting's recommendation 17 [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 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.

NSW Health response to Counsel Assisting's recommendation 17

10.41 In response to recommendation 17, NSW Health makes a number of comments, set out below.

10.42 A legislated award reform process already exists under the *Industrial Relations Act 1996* which gives the Industrial Relations Commission of NSW the powers to address the objectives set out in paragraphs (a) (i) – (iii) of recommendation 17.

10.43 NSW Health notes that the timeframe for reform by the Industrial Relations Commission of NSW is a matter for that Commission and any new legislated process is a matter for the NSW Government.

10.44 Regarding paragraph (c) of recommendation 17, NSW Health also notes the recent amendment of cl 34 the *Health Services Regulation 2018* (NSW).[183] This amendment requires the Minister to appoint a judicial member of the Industrial Relations Commission of NSW (who has been nominated by the President of the Industrial Relations Commission of NSW for that purpose) as an arbitrator of a dispute regarding the terms and conditions and rate of remuneration of a visiting medical officer fee for service or sessional contract brought pursuant to ss 89 and 90 of the *Health Services Act 1997*.

Work underway

10.45 Award reform is achievable under the current legislative framework [184].

10.46 Examples of the recent efforts by NSW Health to achieve award reform are given in CA Submissions [727]. That (as Counsel Assisting notes) none has been successful might be eloquent as to the difficulties the process confronts.

10.47 As is acknowledged in CA Submissions [707], s 19 of the *Industrial Relations Act 1996* imposes an obligation on the Industrial Relations Commission of NSW to undertake a review of each NSW State award every three years. The stated purpose of such a review is to *"modernise awards, to consolidate awards relating to the same industry and to rescind obsolete awards."*[185]

[183] As amended by the *Health Services Amendment (Visiting Medical Officers) Regulation 2024*.
[184] Exhibit L.5, Statement of Melissa Collins (4 October 2024) [10]-[11] [MOH.0011.0081.0001 at 0002 - 0003].
[185] *Industrial Relations Act 1996*, s 19(2).

10.48 Further, ss 19(3) and (4) of the *Industrial Relations Act 1996* set broad parameters in respect of the matters that the Industrial Relations Commission of NSW must have regard to as part of any award review and significantly, s 19(6) provides that (emphasis added) *"The Commission is to make such changes to awards* ***as it considers necessary*** *as a result of a review."*

10.49 In addition to the award review mechanism provided for in s 19, the *Industrial Relations Act 1996* also facilitates award reform and modernisation via:

a. the ability to make new awards and vary existing awards, pursuant to part 1 of chapter 2;

b. mutual gains bargaining, pursuant to chapter 2A; and

c. the resolution of industrial disputes, pursuant to s 130.

10.50 To the extent that attempts at award reform have been hampered in the current legislative context, NSW Health contends that it is the result of several factors:

a. the wages policy and wages cap of former NSW Governments which disincentivised meaningful bargaining.[186] The ability of the Industrial Relations Commission of NSW to perform its award reform function following the removal of the wages cap is yet to be fully utilised.[187]

b. the delay in realising the benefits of measures implemented to modernise and improve the efficiency of awards, as against the adversarial and positional nature of industrial disputation, which can mean that unions are reluctant to agree to such changes in the absence of significant short-term benefits for their members.[188]

c. similarly, award variations require the consent of the relevant parties or will otherwise be subject to arbitration before the Industrial Relations Commission of NSW. This can make parties reluctant to agree to a

[186] Transcript of the Commission, 5 August 2024, T4633.18-36 (Collins).
[187] Exhibit L.5, Statement of Melissa Collins (4 October 2024) [14] [MOH.0011.0081.0001].
[188] Exhibit H.5.23, Statement of Melissa Collins (17 July 2024) [60]-[62] [MOH.0011.0025.0001]

variation unless they view it as benefiting their position or can leverage the request for their consent to the amendment to achieve another gain or outcome.[189]

d. ambiguous language in award provisions (and often outdated award provisions) can be used by parties to advance their position and hence efforts to modernise such wording can be perceived by industrial parties as being against their interest.[190]

e. Productivity reforms which can deliver additional wage and or condition increases are challenging in the health context. This challenge then extends to limiting the scope for NSW Health to bring forward wage and condition reforms which have cost implications for Government without off-setting productivity reform.[191]

10.51 Accordingly, NSW Health considers that the legislative amendment proposed by Counsel Assisting would not address the barriers to much needed award-reform.

10.52 Further, were legislative amendments enacted to give effect to this recommendation, the award review process proposed would likely be lengthy and involve significant input from stakeholders, principally NSW Health and industrial organisations. Indeed, the award modernisation process undertaken by the Australian Industrial Relations Commission referred to in CA Submissions [731]-[734] involved a lengthy consultation process which included the receipt of written submissions from stakeholders and hearings.[192] There are also questions about the utility of such an approach given the highly unique position that NSW Health finds itself in as the only employer covered by the NSW Health awards.

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189 Exhibit L.5, Statement of Melissa Collins (4 October 2024) [36(b)] [MOH.0011.0081.0001].

190 Exhibit L.5, Statement of Melissa Collins (4 October 2024) [36(c)] [MOH.0011.0081.0001].

191 Exhibit H.5.23, Statement of Melissa Collins (17 July 2024) [57], [60] [62] [MOH.0011.0025.0001], Exhibit L.5, Statement of Melissa Collins (4 October 2024) [36(6)] [50], [63] [MOH.0011.0081.0001]. Transcript of the Commission 5 August 2024 T4649.2-13, T4650.12- 4651.2 (Collins).

192 Fair Work Commission, *AIRC Award Modernisation Process 2008* (Web Page, 28 January 2025) <https://www.fwc.gov.au/hearings-decisions/major-cases/previous-major-cases/airc-award-modernisation-process-2008>.

There are a number of matters currently before the Industrial Relations Commission including in relation to Nurses, Midwives and Staff Specialist Psychiatrists and there is potential for more to be done through this process.

Counsel Assisting's recommendation 18 [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 [of] 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.

NSW Health response to Counsel Assisting's recommendation 18

10.53 **In response to recommendation 18(a) and (b) NSW Health makes a number of comments, set out below.**

10.54 **NSW Health identifies issues with recommendation 18(c).**

Work underway

10.55 In respect to recommendation 18(a), NSW Health has developed an analytic index which is used to identify trends and areas of concern within "units" (i.e. work teams identified by the relevant organisation) within the NSW health system from the data gathered from the annual People Matter Employee Survey.[193] Once trends and areas of concern are identified, a diagnostic

[193] Exhibit G.112, Statement of Philip Minns (7 June 2024) [18]-[19] [MOH.9999.1868.0001].

analysis is conducted on the results from specific questions of interest asked in the Survey.[194]

10.56 NSW Health also undertakes analysis of data from its clinical incident management system, ims+, to identify trends and areas of concern in relation to clinical incidents.[195] The data collected from ims+ regarding clinical incidents can also indicate a poor workplace culture.[196]

10.57 It is NSW Health's intention to commence providing the results of this analysis to the Chief Executives of the relevant entities at the same time as the Chief Executives are provided with their annual People Matter Employee Survey results.[197] It is hoped that providing this information to Chief Executives will facilitate more timely consultation between management with clinicians regarding local issues of concern.[198]

Potential challenges

10.58 The Health Secretary's power to make by-laws is conferred and conditioned by ss 39 and 60 of the *Health Services Act 1997*. Additionally, the governance structures of Local Health District boards are mandated by sch 4A of the *Health Services Act 1997* and include provisions regarding the interaction between boards and certain councils referred to in the Model By-Laws. Absent any legislative amendment, any changes proposed to the Model By-Laws would need to accord with these provisions of the *Health Services Act 1997*.

Reasons

10.59 The review of the Model By-Laws foreshadowed by recommendation 18 will include the consideration of potential options for enhanced consultation and feedback between clinicians and boards. In that context, it is premature to

194 Exhibit G.112, Statement of Philip Minns (7 June 2024) [20] [MOH.9999.1868.0001].
195 Exhibit G.112, Statement of Philip Minns (7 June 2024) [21] [MOH.9999.1868.0001].
196 Transcript of the Commission, 7 August 2024, T4849.26-40 (Minns).
197 Exhibit G.112, Statement of Philip Minns (7 June 2024) [22] [MOH.9999.1868.0001].
198 Transcript of the Commission, 7 August 2024, T4849.21-24 (Minns) and Exhibit G.112, Statement of Philip Minns (7 June 2024) [43]-[47] [MOH.9999.1868.0001].

propose a specific recommendation in the terms proposed by Counsel Assisting in paragraph (c).

10.60 Under the current legislative arrangements, a Local Health District board must invite the chair of the Medical Staff Executive Council for the District (or the chair of the Medical Staff Council if there is only one Medical Staff Council for the District) to attend meetings of the board.[199] NSW Health understands the recommendation to extend the standing invitation to the chairs of all councils, including Clinical Councils, to be invited to board meetings.

10.61 Under the current legislation, a board can invite any other person to attend any of its meetings[200], which may include representatives from Medical Staff Councils or Clinical Councils as it sees appropriate.[201]

10.62 NSW Health considers the current provisions, under which the board has the discretion to invite representatives from Medical Staff Councils and Clinical Councils to Local Health District board meetings, but not the obligation to do so, to be sufficient. This recommendation, if made, would also be likely to create practical difficulties in the conduct of board meetings, in some cases resulting in more additional attendees than board members. For example, in the case of the South Western Sydney Local Health District board, amendment to the Model By Laws in this manner would result in a right of attendance for 13 people in addition to the Board (1 District Medical Staff Executive Council chair, 5 Medical Staff Council chairs, 1 Mental Health Medical Staff Council Chair, 1 District Clinical Quality Council Chair and 5 Hospital Clinical Council Chairs).[202] The *Health Services Act 1997* requires Local Health District and Specialty Health Network boards to consist of 6 to 13 board members.

[199] *Health Services Act 1997*, sch 4A, cl 18(1)(b).
[200] *Health Services Act 1997*, sch 4A, cl 18(4).
[201] *Health Services Act 1997*, sch 4A, cl 18(3) and (4).
[202] Exhibit N4.17, *South Western Sydney Local Health District council organisation chart* [MOH.0010.0756.0001]).

Counsel Assisting's recommendation 19 [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.

NSW Health response to Counsel Assisting's recommendation 19

10.63 **In response to recommendation 19(a) – (c), NSW Health makes a number of comments, set out below. NSW Health identifies issues with recommendation 19(d), as set out below.**

10.64 NSW Health considers that there are benefits to undertaking a review of its current processes for dealing with workplace complaints and grievances, and that this review should identify actions to simplify and improve the current arrangements.

Work underway

10.65 Ministry sets the policy framework for complaints and grievances, and dispute resolution, but it does not oversee compliance with those policies and their implementation. NSW Health encourages the resolution of disputes at the local level, and Ministry is unlikely to become involved unless an independent third party is required (for example, where a complaint relates to a board member

or senior member of management) or where a circuit breaker is perceived to be warranted. Complaints and concerns are typically able to be resolved at the local level.[203]

10.66 While Local Health Districts and Specialty Health Networks are subject to the policies and procedures mandated by Ministry, they may also develop and implement their own local procedures.[204]

10.67 The key NSW Health policies relating to workplace grievances, complaints and dispute resolution, which apply across the State, are[205]:

a. PD2016_046 *Resolving Workplace Grievances*[206], which is directed to the resolution of grievances at the local level through self-resolution and manager assisted resolution (noting that it does not apply to complaints of discrimination, bullying, harassment or misconduct which are managed in accordance with other NSW Health policies);

b. PD2021_030 *Prevention and Management of Workplace Bullying*[207], which defines workplace bullying and sets out the process and timeframes for making and resolving complaints of bullying;

c. PD2018_031 *Managing Misconduct*[208], which sets out the procedures and timeframes for managing complaints of alleged misconduct;

d. PD2018_032 *Managing Complaints and Concerns About Clinicians*[209], which is used to manage serious complaints and concerns about clinicians related to their management of a patient or staff, and/or which

[203] Exhibit G.112, Statement of Philip Minns (7 June 2024) [6] [MOH.9999.1868.0001].
[204] Exhibit G.112, Statement of Philip Minns (7 June 2024) [13] [MOH.9999.1868.0001].
[205] Exhibit G.112, Statement of Philip Minns (7 June 2024) [11] [MOH.9999.1868.0001].
[206] Exhibit H.3.18, *Resolving Workplace Grievances,* NSW Health Policy Directive PD2016_046 (18 October 2016) [MOH .0002.0047.0001].
[207] Exhibit H.3.42, *Prevention and Management of Workplace Bullying,* NSW Health Policy Directive PD2021_030 (3 August 2021) [MOH.0002.0087.0001].
[208] Exhibit B.23.119, *Managing Misconduct,* NSW Health Policy Directive PD2018_31 (7 September 2018) [MOH.0001.0391.0001].
[209] Exhibit D.1.187, *Managing Complaints and Concerns about Clinicians,* NSW Health Policy Directive PD2018_032 (7 September 2018) [MOH.9999.0933.0001].

is conduct that is required to be notified to an external agency or requires a disciplinary response;

e. PD2021_017 *Service Check Register for NSW Health*[210], which sets out the rules for using the service check register for staff with pending and finalised matters of serious misconduct; and

f. PD2021_031 *Prevention and Management of Unacceptable Workplace Behaviours – JMO Module*[211], which outlines the considerations and processes for managing allegations of unacceptable workplace behaviour made against junior medical officers.

10.68 NSW Health has separate policies and procedures related to complaints from patients and/or their families.[212]

10.69 NSW Health has online Addressing Grievances and Concerns Portals: one for managers and one for staff (although all aspects of each Portal are accessible by all staff members).[213] Each NSW Health entity is required to implement or "host" the Addressing Grievances and Concerns Portals.

10.70 The Addressing Grievances and Concerns Portals are not complaints lodgement systems. Rather, they provide:

a. managers with user friendly tools (such as "step through" menus) to help them assess a complaint or concern, select and apply the right policy or procedure and to manage complaints or concerns that are made; and

b. staff members to understand the purpose and application of each policy (including through the use of case examples) and whether they have grounds to make a complaint, and the category it falls into,

[210] Exhibit H.3.40, *Service Check Register for NSW Health,* NSW Health Policy Directive PD2021_017 (24 June 2021) [MOH.9999.0132.0001].
[211] Exhibit H.3.43, *Prevention and Management of Unacceptable Workplace Behaviours in NSW Health – JMO Module,* NSW Health Policy Directive PD2021_031 (3 August 2021) [MOH.9999.1319.0001].
[212] Exhibit G.112, Statement of Philip Minns (7 June 2024) [12] [MOH.9999.1868.0001].
[213] Exhibit G.112, Statement of Philip Minns (7 June 2024) [29] [MOH.9999.1868.0001].

with the ability to click-through to the full policy or procedure document on both Portals.[214]

10.71 The Addressing Grievances and Concerns Portals were developed with the intent of improving the capability of NSW Health managers to manage and resolve disputes, and to ensure a standardised approach to complaint management across NSW Health, whilst preserving local decision making and resolution of disputes.[215] Given the size of its workforce (approximately 180,000 employees) NSW Health prioritises the speedy and local resolution of minor workplace grievances and low level complaints, which the Addressing Grievances and Concerns Portals are directed towards achieving.[216]

10.72 For a staff member who is considering whether they have grounds to make a complaint, the Addressing Grievances and Concerns Portals provide a series of "step through" questions or prompts to assist the staff member in determining the kind or category that their concern falls into and the level of seriousness of the concern or complaint.[217] Where a complaint or concern is assessed as low level, the staff portal will direct the staff member to resources and toolkits for the self-resolution of the issue.[218] Where a complaint is assessed as serious (and non-clinical), the staff portal will step through the stages of the investigation process should a complaint be made, including the possible outcomes.[219] For more serious complaints, the Addressing Grievances and Concerns Portals will also indicate the circumstances that might see the outcome of the investigation include notification to an external body such as the Independent Commission Against Corruption or the Australian Health Practitioner Regulation Agency.[220]

10.73 NSW Health has also undertaken a review of its misconduct policy framework to consolidate the misconduct, concerns and complaints about clinicians and

[214] Exhibit G.112, Statement of Philip Minns (7 June 2024) [14]-[15] [MOH.9999.1868.0001].
[215] Exhibit G.112, Statement of Philip Minns (7 June 2024) [14]-[15] [MOH.9999.1868.0001].
[216] Exhibit G.112, Statement of Philip Minns (7 June 2024) [23] [MOH.9999.1868.0001].
[217] Exhibit G.112, Statement of Philip Minns (7 June 2024) [27]-[28] [MOH.9999.1868.0001].
[218] Exhibit G.112, Statement of Philip Minns (7 June 2024) [28] [MOH.9999.1868.0001].
[219] Exhibit G.112, Statement of Philip Minns (7 June 2024) [32]-[33] [MOH.9999.1868.0001].
[220] Exhibit G.112, Statement of Philip Minns (7 June 2024) [33] [MOH.9999.1868.0001].

child-related allegation processes into a single document.[221] The revised policy is yet to be published.

Potential challenges

10.74 A recommendation in line with paragraph (d) of this recommendation, that NSW Health implement a right of external review as part of its workplace complaints and grievances policy, has potentially significant practical implications, especially given the size and complexity of the NSW Health workforce. There is the potential for a high number of matters to be sent for external review and a high volume of work involved in managing those reviews and ensuring the timely notification of the outcome to the persons involved. Further, if such a review was required to be undertaken by a person "*external to the local* organisation", it is likely to be a time-consuming process as the person conducting the review would need to become familiar with the policies, procedures and nature of the local organisation, in addition to the factual matters under review.

10.75 Counsel Assisting's submissions do not specify who might be a person "*external to the local organisation*". It is common for persons engaged in the NSW health system to have worked in multiple locations and for a number of organisations within the system and, therefore, appointing a person who is "external to the local organisation" may not ensure impartiality or independence.

10.76 NSW Health is prepared to consider including a right of internal review, where there are grounds to do so, as part of its review of existing policies regarding workplace complaints and grievances which may include a requirement that any such review is undertaken by an appropriately senior officer within NSW Health who is independent from the original process. It is noted that an internal review process will be resource intensive and require additional resources to implement.

[221] Exhibit G.112, Statement of Philip Minns (7 June 2024) [47] [MOH.9999.1868.0001].

10.77 NSW Health is limited in what it can achieve through top-down policy changes, with meaningful cultural change needing to come from local leadership and initiatives. NSW Health's endeavours to empower and upskill local managers and supervisors to address complaints, concerns and grievances locally and close in time to the issue arising recognise that need.[222]

Counsel Assisting's recommendation 20 [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.

NSW Health response to Counsel Assisting's recommendation 20

10.78 **In response to recommendation 20, NSW Health makes a number of comments, set out below.**

10.79 NSW Health's ability to gather, collate and disseminate information and data regarding its workforce wellbeing is constrained by existing privacy laws and regulations that restrict the kinds of data that can lawfully be collected and reported.

Work underway

10.80 NSW Health collects data from a variety of sources, to measure a range of matters. Most data that NSW Health collects is sourced from the NSW Health payroll system (which feeds into NSW Health's Corporate Analytics Data Warehouse).[223] NSW Health also collects data from the People Matter Employee Survey conducted across the NSW public service by the NSW Public Service Commission.[224]

[222] Exhibit G.112, Statement of Philip Minns (7 June 2024) [45] [MOH.9999.1868.0001].
[223] Exhibit H.5.21, Statement of Richard Griffiths (16 July 2024) [13] [MOH.0011.0022.0001].
[224] Exhibit H.5.21, Statement of Richard Griffiths (16 July 2024) [13(j)] [MOH.0011.0022.0001].

10.81 The data that is collected by NSW Health relates to a variety of workforce matters, including staff satisfaction.

10.82 In addition to receiving the annual results of the People Matter Employee Survey, NSW Health receives a unique "culture index" from the NSW Public Sector Commission which is not reported across other government departments of agencies.[225] The culture index provides NSW Health with a general sense of the level of satisfaction that its workforce has with it as an organisation.[226] NSW Health's culture scores have improved over the period 2012 to 2023, from 46 per cent in 2012 to 61 per cent in 2023.[227]

10.83 NSW Health releases $4.6 million in funding annually from the Workforce, Planning and Talent Development budget to 22 NSW Health organisations to fund culture initiatives directed towards addressing the findings of the previous year's People Matter Employee Survey. The funding is conditional on the NSW Health organisations submitting a *Culture and Safety Action Plan* detailing the initiatives they propose to undertake using the funds.[228]

10.84 The Workforce, Planning and Talent Development Branch of NSW Health has developed the *NSW Health Culture and Staff Experience Framework*[229] and a *Framework in Practice*[230] which set out NSW Health's core values and set the agenda for creating a positive workplace culture within NSW Health.[231]

10.85 The Workforce Planning and Talent Development Branch is also in the process of establishing the Culture and Staff Experience Portal to host culture and wellbeing resources for all NSW Health organisations and affiliated health organisations to access and use.[232]

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225 Exhibit H.5.21, Statement of Richard Griffiths (16 July 2024) [97]-[99] [MOH.0011.0022.0001].
226 Transcript of the Commission, 6 August 2024, T4775.11-16 (Griffiths).
227 Exhibit H.5.21, Statement of Richard Griffiths (16 July 2024) [102] [MOH.0011.0022.0001].
228 Exhibit H.5.21, Statement of Richard Griffiths (16 July 2024) [103] [MOH.0011.0022.0001]; Exhibit H.5.22, Statement of Philip Minns (17 July 2024) [45] [MOH.0011.0024.0001].
229 Exhibit H.2.54, NSW Health, *Culture and Staff Experience Framework* (June 2024) [MOH.0010.0278.0001].
230 Exhibit H.2.55, NSW Health, *NSW Health Culture and staff Framework in Practise* [MOH.0010.0277.0001].
231 Exhibit H.5.21, Statement of Richard Griffiths (16 July 2024) [106] [MOH.0011.0022.0001].
232 Exhibit H.5.21, Statement of Richard Griffiths (16 July 2024) [106] [MOH.0011.0022.0001].

10.86 It is difficult for NSW Health to drive local cultural change, and the daily workplace experiences in a person's workplace are typically significantly shaped by local leadership and its response to the issues that emerge.[233] NSW Health continues to work to empower and enable local leadership to address matters of culture, including wellbeing, within their organisation. [234]

Potential challenges

10.87 The success of the initiatives implemented by the Chief Wellness Officer in the Sydney Local Health District, including the data collected about workforce wellbeing, is in part due to the fact that those initiatives evolved locally.[235] Imposing requirements in a top-down fashion can be met with resistance at the local level (likely the source of the most granular data), particularly where local initiatives are already in place.[236] NSW Health has to balance the extent to which it prescribes requirements for Local Health Districts and other public health organisations, with the provision of "helpful guidance".[237]

10.88 Separately, it is challenging to collect and collate granular data with respect to matters of workforce wellbeing across a large workforce.[238] The analysis of the data must account for variables within the workforce, including those the product of local idiosyncrasies.[239] Further, data anonymity requirements place a limitation on the extent to which NSW Health can "drill down" on the whole of workforce data that is collected.[240]

Other issues raised in Section 10 of Counsel Assisting's Submissions

10.89 CA Submissions [621] refers to the Health Secretary's employer functions conferred by ss 116 and 116A of the *Health Services Act 1997*. Counsel Assisting submits:

[233] Exhibit G.112, Statement of Philip Minns (7 June 2024) [45] [MOH.9999.1868.0001].
[234] Exhibit G.112, Statement of Philip Minns (7 June 2024) [45] [MOH.9999.1868.0001].
[235] Transcript of the Commission, 7 August 2024, T4831.3-11 (Minns).
[236] Transcript of the Commission, 7 August 2024, T4831.3-11 (Minns).
[237] Transcript of the Commission, 7 August 2024, T4831.13-20 (Minns).
[238] Transcript of the Commission, 7 August 2024, T4829.34-4830.8 (Minns).
[239] Transcript of the Commission, 7 August 2024, T4829.34-4830.1 (Minns).
[240] Transcript of the Commission, 7 August 2024, T4830.1-8 and 35-42 (Minns).

> "…Those functions can be, and to a large extent have been, delegated by the Secretary…"

In support, Counsel Assisting reference s 21(1) of the *Health Administration Act 1982* and the NSW Health's *Combined Delegations Manual.*[241]

10.90 The Health Secretary has delegated a number of her employer functions.[242]

10.91 The function conferred by s 116A(1) of the *Health Services Act 1997*, (*viz* to "*fix the salary, wages and conditions of employment of staff employed under this Part in so far as they are not fixed by or under any other law"*), is exercised via the making of Determinations. That function has been delegated to only certain senior officers of Ministry. This function has not been delegated to staff of NSW Health or other public health organisations.[243]

10.92 With respect to the discussion in CA Submissions regarding specialist medical colleges, [645] states, *inter alia* (footnotes omitted):

> "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…"

10.93 The Special Commission saw at least three examples of specialist medical colleges using the accreditation process to influence or agitate industrial outcomes.[244] NSW Health accepts that the practice is not pervasive, but submits that the examples provided are of significance given the actions of the relevant colleges, and the extent to which those actions disrupted the operation of those facilities while attempts were made to address the issues raised by them. Further, the issues identified in these examples echo the

[241] Exhibit H.1.0 and Exhibit D.1.54, NSW Health, *Combined Delegations Manual* (22 May 2015) [MOH.9999.0817.0001].
[242] For example, see Exhibit H.1.0 and Exhibit D.1.54, NSW Health, *Combined Delegations Manual* (22 May 2015) S125, S127, S161, A327 [MOH.9999.0817.0001].
[243] Exhibit H.5.23, Statement of Melissa Collins (17 July 2024) [39] [MOH.0011.0025.0001]; Exhibit H.1.0 and Exhibit D.1.54, NSW Health, *Combined Delegations Manual* (22 May 2015) S117, S120, S125, S127, S210, S217 [MOH.9999.0817.0001].
[244] Exhibit H.5.30, Statement of Graeme Loy (25 July 2024) [29]-[37] [MOH.0011.0030.0001]; Exhibit H.5.32, Statement of Teresa Anderson (30 July 2024) [94]-[111] [MOH.0011.0034.0001]; Exhibit H.5.33, Statement of Jo Karnaghan (8 November 2024) [38]-[50] [MOH.0011.0088.0001].

concerns raised during the *Independent Review of the Procedural Aspects of Accreditation Processes by the National Health Practitioner Ombudsman.*[245]

10.94 CA Submissions [647] states, *inter alia*, in respect of specialist medical colleges (footnotes omitted):

> "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…"

10.95 NSW Health disagrees with this proposition. The capacity of the specialist medical colleges to influence the number and distribution of trainees in NSW is significant and is seen in the:

a. training networks that some of the specialist medical colleges have established, which they administer, and which are specific to their specialty[246];

b. selection of the specific sites where accredited positions will be offered[247];

c. ability of the Colleges to select new sites for accreditation in rural/regional settings in conjunction with the Federal Department of Health and Aged Care[248]; and

d. control the Colleges exercise over training requirements.[249]

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[245] Exhibit H.5.19.1, Statement of Linda MacPherson (12 July 2024) [18](c) and [107]-[117] [MOH.0011.0020.0001]; Exhibit H.2.39, National Health Practitioner Ombudsman, *Processes for progress, A roadmap for greater transparency and accountability in specialist medical training site accreditation* (October 2023) [MOH.0010.0053.0001].

[246] Exhibit H.6.6, Statement of the Royal Australian and New Zealand College of Radiologists (15 July 2024) [37]-[43], [SCI.0011.0182.0001]; Exhibit H.5.15, Statement of Josephine Burnand (11 July 2024) [49] [MOH.0011.0017.0001].

[247] Exhibit H.5.1, Statement of Karen Murphy (12 July 2024) [9] [MOH.0011.0019.0001]; Exhibit I.36, Statement of Serena Ayers (8 August 2024) [10]-[12] MOH.0011.0047.0001].

[248] Exhibit H.6.6, Statement of the Royal Australian and New Zealand College of Radiologists (15 July 2024) [73]-[75] [SCI.0011.0182.0001].

[249] Exhibit L.17, Statement of Benhy Samadi (30 September 2024) [22] [SCI.0011.0465.0001]; Exhibit H.5.33, Statement of Jo Karnaghan (8 November 2024) [45] [MOH.0011.0088.0001]; Transcript of the Commission, 23 July 2024, T3871.3-20 (Nogajski); Transcript of the Commission, 24 July 2024, T3951.7-22 (Moyle); Transcript of the Commission, 23 May 2024, 3290.13-3291.2 (Wenham); Exhibit H.2.32, Australian Government Department of Health and Aged Care, *How Accreditation Practices Impact Building a Non-General Practice Rural Specialist Medical Workforce Report* [SCI.0011.0137.0001 at 0042, 0061].

10.96 CA Submissions [675] refers to the sharing of information by NSW Health with external stakeholders, including industrial organisations and universities, regarding workforce matters:

> "…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."

10.97 The concerns raised by NSW Health's witnesses regarding the sharing of workforce data are more appropriately described as concerns that data may be misinterpreted, misrepresented or misused by stakeholders or the public[250], rather than that it will be "weaponised against it by stakeholders". Plainly, data being misrepresented could see the public unjustifiably lose confidence in the NSW Health system: the Special Commission heard evidence[251] about, for example, the implications of the misrepresentation of vacancy data, were it to be published. Appropriate caveats or qualifications could be placed upon such data when shared[252], but none will eliminate the risk of data being misused or misrepresented.[253]

10.98 In any case, there was evidence before the Special Commission of information being shared with stakeholders. For example, NSW Health shares information with:

a. the Rural Doctors Association and the Australian Medical Association (NSW) Limited as part of the quarterly meetings of the rural employment arrangements working party[254];

[250] Transcript of the Commission, 5 August 2024, T4657.15-32 (Collins); Transcript of the Commission, 6 August 2024, T4788.14 - 4789.1 (Griffiths); Transcript of the Commission, 7 August 2024 T4817.4-46 (Minns).
[251] Transcript of the Commission, 6 August 2024, T4788.30 - 4789.1 (Griffiths).
[252] Transcript of the Commission, 5 August 2024, T4656.38-42 (Collins).
[253] Transcript of the Commission, 6 August 2024, T4788.30 - 4789.1 (Griffiths); Transcript of the Commission, 7 August 2024, T4815.28 – 4816.14 (Minns).
[254] Transcript of the Commission, 5 August 2024, T4656.38 – 4657.7 (Collins).

b. the Australian Salaried Medical Officers' Federation in relation to NSW Health initiatives such as the presence of paramedics in hospital emergency departments and assistants in medicine[255]; and

c. universities and specialist medical colleges, which receive information regarding workforce modelling.[256]

10.99 Separately, many of the requests for data that are made are for datasets that cannot be produced automatically from NSW Health's systems or are for data not routinely collected by NSW Health, and which would create a significant workload (especially at the local level) if they were required to be compiled.[257]

10.100 These matters should be taken into account in reaching any findings in relation to its practices regarding the collection and sharing of data.

10.101 CA Submissions [727(b)] refers to "mutual gains bargaining" between the Australian Salaried Medical Officers Federation and NSW Health commencing on 15 December 2023. This is not correct. Mutual gains bargaining between these parties commenced on 22 July 2024.[258]

10.102 CA Submissions [743]-[750] refer to matters that occurred at Concord Hospital between late 2022 and mid-2024, in the context of examining potential ambiguity in the Model By-Laws and the role of Medical Staff Councils. These events, and the extent to which the relationship between the Medical Staff Council at Concord Hospital and the executive of the Sydney Local Health District (including its Chief Executive) deteriorated are not, on the evidence received by the Special Commission, in any way typical of the relationship between Medical Staff Councils and the boards of Local Health Districts. Nevertheless, as noted above, NSW Health intends to review the Model By-Laws.

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255 Transcript of the Commission, 5 August 2024, T4655.21-34 (Collins).

256 Transcript of the Commission, 6 August 2024, T4785.13-23 (Griffiths).

257 Transcript of the Commission, 7 August 2024, T4816.16-47, 4818:21-43 (Minns); Transcript of the Commission, 6 August 2024, T4787.5-17 (Griffiths); Exhibit H.5.21, Statement of Richard Griffiths (16 July 2024) [146] [MOH.0011.0022.0001].

258 Exhibit H.1.126, Melissa Collins, *Table of impediments posed by Awards to efficiency of health system* (4 August 2024) [MOH.0010.0454.0001 at 0004].

10.103 NSW Health does not however agree with several aspects of CA Submissions' characterisation of the circumstances at Concord Hospital.

10.104 The first matter is the suggestion, at CA Submissions [744], that it is "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. In circumstances where NSW Health has a devolved approach to governance[259], the evidence did not explore what a "satisfactory", level of Ministry involvement would be.

10.105 The second matter is the suggestion, at CA Submissions [747], that in providing a letter to Dr Cheung about his proposed terms of reference for the Medical Staff Council, it "should have been obvious" that this action would likely have been viewed by Dr Cheung as suggesting that disciplinary procedures would be "weaponised against him". This suggestion should be rejected, as Dr Cheung never gave this evidence. He in fact agreed that if Dr Anderson perceived that there was a legal issue with the draft terms of reference and asked that it be changed, that was not an unreasonable position for her to take.[260] The final sentence of CA Submissions [747] then proceeds on an assumption that such a "perception" held by Dr Cheung was "reinforced" by subsequent disciplinary action. Again, Dr Cheung never gave this evidence.

10.106 If the Commissioner considers it necessary to make any assessment as to how the Sydney Local Health District executives' actions might have been perceived by Dr Cheung in the context of his broader dispute with those executives, that assessment should be informed by the totality of Dr Cheung's evidence.[261]

10.107 CA Submissions [756] refers to NSW Health's current policy framework as it relates to the escalation of complaints, or avenues of review or appeal

[259] Exhibit H.5.23, Statement of Melissa Collins (17 July 2024) [29] [MOH.0011.0025.0001].
[260] Transcript of the Commission, 31 July 2024, T4364.4-22 (Cheung).
[261] See for example Exhibit H5.32.4, MOH.0010.0393.0001; Transcript of the Commission, 31 July 2024, T4367.5 – 4368.1, T4395.20-33, T4396.30-36 (Cheung).

available to clinicians who are unhappy with the outcome of an investigation or complaint process. In addition to those avenues, Visiting Medical Officers may appeal certain decisions affecting their appointment to the Minister for Health via a Committee of Review pursuant to Chapter 8 of the *Health Services Act 1997.* Further, where a staff member considers that there has been serious wrongdoing, he or she can make a public interest disclosure pursuant to NSW Health's PD_2023_026 *Public Interest Disclosures.*[262]

[262] Exhibit B.23.118, *Public Interest Disclosures,* NSW Health Policy Directive PD2023_018 (3 October 2023) [MOH.0001.0151.0001].

SECTION 11: AFFILIATED HEALTH ORGANISATIONS

Preliminary matters

11.1 Counsel Assisting's proposed recommendations on this issue are addressed below, but some preliminary matters warrant emphasis.

11.2 First, precise language is important here: the term 'Affiliated Health Organisations' describes, and should only describe, the organisations listed in Column 1 of Schedule 3 to the *Health Services Act 1997*. Moreover, there is a danger in ascribing that title to organisations listed in Schedule 3 other than in respect of the *recognised establishments or recognised services* they provide that are listed in Column 2 of Schedule 3. So, for example, it is imprecise to refer to Karitane as an Affiliated Health Organisation in respect of *all* of the services it provides. That is so because *some* of the services it supplies (e.g. virtual residential parenting services) are not itemised in Column 2 of Schedule 3.

11.3 The distinction is not merely semantic: the substantive implication of Schedule 3 recognition is a reasonable expectation of recurrent funding from the NSW Health system on the basis the services form part of the public health system under the *Health Services Act 1997.*[263] While, as Counsel Assisting note (CA Submissions [872]), the *Health Services Act 1997* does not compel the funding of establishments and services listed in Schedule 3 (indeed the contrary is true, as made clear by references to "if any" in ss 127(2) and 129), the addition of an establishment or service to Schedule 3 creates an expectation of ongoing funding, even if the mechanism by which this is provided via annual subsidies. The reality is that for so long as a service is included in Schedule 3, the public can reasonably expect such a service to be funded from year to year and that expectation informs NSW Health's approach to funding Schedule 3 services and establishments. If a service previously funded on a temporary or time-limited basis was to be added to Schedule 3, the implications for NSW Health's budget is, in effect, that a grant-funded service moves into the base, for funding

[263] *Health Services Act 1997,* s 6(c).

purposes. This means that continuing annual amendments to Schedule 3, as contemplated by Counsel Assisting's proposed recommendation discussed below, at least insofar as they involve additions to include new services or establishments, will necessarily increase the base funding required.

11.4 It is not clear whether Counsel Assisting's proposed recommendations regarding Affiliated Health Organisations recognises this distinction.

11.5 Secondly, there are important matters of historical context concerning Affiliated Health Organisations and the services they provide to the public health system that are illuminating. Affiliated Health Organisations are largely the product of historical arrangements. Their status reflects custom and practice over many decades.[264] Not all facilities or services provided by an Affiliated Health Organisation (including services funded by NSW Health) are recognised as part of the public health system. Affiliated Health Organisations may receive funding through additional revenue streams, including grants and donations. Affiliated Health Organisations should not be seen as one party in the equivalent of a public-private partnership, or as simply eligible recipients of grant funding. Their position under the statutory framework of the *Health Services Act 1997* is unique, because while section 127(2) (described below) makes clear that the Minister is to determine the subsidy payable to Affiliated Health Organisations "if any" (the implication being there is no statutory guarantee of such a subsidy being paid), the status of recognised establishments and recognised services listed in Schedule 3 to the *Health Services Act 1997* as part of the public health system creates an expectation of ongoing funding for such services. This might be seen as consistent with the fact that Affiliated Health Organisations by their recognised establishments and recognised services are contributing to meeting the ongoing service needs of one or more Local Health Districts.

11.6 The historical origins of the services provided by Affiliated Health Organisations were described in the second reading speech for the *Health*

[264] Transcript of the Commission, 29 April 2024, T2526.42-2527.3 (Daly).

Services Bill 1997, when the concept was first enacted. The then Minister for Health stated: [265]

> "The religious and charitable sector has historically been an integral part of the New South Wales health system. Under the Health Services Bill this will not change. … These are currently listed in the third and fourth schedules to the Public Hospitals Act and include institutions such as St Vincent's Hospital, Darlinghurst and the New South Wales College of Nursing. The bill introduces the term affiliated health organisation to describe these organisations in recognition of both their integral role in the public health system and their status as non-government organisations.
>
> Many of these organisations are engaged in a range of philanthropic activities, some of which are not related to the health system. The bill clearly identifies those services and facilities which fall within its purview. …
>
> The bill recognises the integral role of affiliated health organisations in the public health system and the need to ensure they are effectively networked with area health services where appropriate. Clauses 129 and 130 of the bill provide that the functions of determining funding for, and the making of, a performance agreement with an affiliated health organisation may be delegated to an area health service. This will enable area health services to more effectively integrate affiliated health organisations located within their geographic areas into the overall planning and delivery of health services."

11.7 The provisions said by the Minister in the second reading speech to be for the purpose of ensuring affiliated health services are more effectively integrated into the "overall planning and delivery of health services" within Local Health Districts continue in the current *Health Services Act 1997*. The current provisions of the *Health Services Act 1997* enable the Minister to have regard to such matters as he or she thinks fit in determining what amount of money (if any) is to be paid to each Affiliated Health Organisation out of money appropriated from the Consolidated Fund. [266]

11.8 The *Health Services Act 1997* recognises in section 129 that the Minister may delegate to any Local Health District the function of determining both the subsidy (if any) to be received by any Affiliated Health Organisation for its recognised establishments and recognised services (defined by reference to

[265] Legislative Assembly, *Hansard*, 12 November 1997 (Dr Refshauge).
[266] *Health Services Act 1997*, s 127(2).

establishments and services listed in Column 2 of Schedule 3 to the Act); and the conditions (if any) that should attach to that subsidy. Section 130 of the *Health Services Act 1997* relates to "performance agreements" between Local Health Districts and Affiliated Health Organisations they subsidise. Where such an agreement is in place, the Affiliated Health Organisation must "as far as practicable, exercise its functions in accordance with the performance agreement"[267] and is required to report results of performance under such an agreement during a financial year to the Local Health District within three months of the end of that year.[268] The relevant Local Health District is to evaluate the results of the Affiliated Health Organisation's performance under a performance agreement for each financial year and report those to the Health Secretary, who may make such recommendations to the Minister concerning the results reported as they think fit.[269]

11.9 Against that background, Counsel Assisting's recommendations are addressed next.

Counsel Assisting's recommendation 21 [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.

NSW Health response to Counsel Assisting's recommendation 21

11.10 **NSW Health identifies a number of issues with recommendation 21, as set out below.**

[267] *Health Services Act 1997*, s 130(3).
[268] *Health Services Act 1997*, s 130(4).
[269] *Health Services Act 1997*, s 130(5) and (6).

11.11 NSW Health recognises there is an opportunity to refine current arrangements in respect of Affiliated Health Organisations. It submits that the following is an appropriate recommendation in lieu of proposed recommendation 21:

> *NSW Health should review the governance and management of Affiliated Health Organisations to streamline current arrangements.*

Reasons

11.12 Counsel Assisting's proposed recommendation 21 does not reflect the fact that some Affiliated Health Organisations deliver services locally to one or two Local Health Districts and that those services have a variety of scale and scope. [270] For those organisations, NSW Health's position is that the relationships should remain localised.

11.13 A review of the governance and management of the other Affiliated Health Organisations would enable current arrangements to be refined without imposing a one-size-fits all approach. Imposing a requirement for negotiations in relation to service agreements to be conducted centrally would, without any corresponding gain, risk loss of local relationships and knowledge which are important in achieving the best outcomes for local communities. Ministry acknowledges that there are improvements and standardisations that could be made to the process of negotiating service agreements with Affiliated Health Organisations and proposes the alternative recommendation set out above with a view to advancing that work.

11.14 Affiliated Health Organisations also access benefits by virtue of being recognised as part of the public health system: (see CA Submissions [875] regarding iCare insurance coverage). The template service agreement issued to Local Health Districts for negotiation with Affiliated Health Organisations

[270] See Exhibit D.8, Statement of Matthew Daly (9 April 2024), [16] [MOH.9999.0976.001].

requires that they negotiate, on the same basis as other facilities within the Local Health Districts, access to:[271]

a. training programs, particularly mandatory training run by the Health Education and Training Institute;

b. NSW Support programs offered by pillar organisations;

c. access to other NSW Health systems (such as ims+) conducive to the fulfilment of the Affiliated Health Organisation's service, quality and safety and clinical training obligations;

d. agreed and clearly articulated information management support for IT hardware, software and systems support and integration;

e. access to capital support and the Asset Replacement and Refurbishment Plan where services are situated on NSW Health property;

f. Employee Assistance Program services; and

g. access to Local Health District Training and Development Services and courses.

11.15 Mr Daly, Deputy Secretary, System Sustainability and Performance, deposed that in his view it would not assist Affiliated Health Organisations were they to operate under service agreements with Ministry, given their existing strengths within their particular local communities. Mr Daly's observation is that Affiliated Health Organisations' independent status, connections with their patient cohorts and communities, their "philanthropic pull" and their mission-driven nature enabled them to deliver services very well[272]; and that improvements could be made to the *NSW Health Performance Framework* to provide

[271] See eg Exhibit D.60, *Unsigned Service Agreement between South Western Sydney Local Health District and Karitane*, p. 13 [SCI.0008.0042.0001].

[272] Transcript of the Commission, 29 April 2024, T2526.44-2527.3 (Daly).

stronger guidance to Local Health Districts when assessing Affiliated Health Organisation performance.[273]

11.16 Mr Daly's evidence was that if an Affiliated Health Organisation persuaded a Local Health District of its capacity to deliver services within that Local Health District (being a Local Health District outside of the Affiliated Health Organisation's 'home' Local Health District), the Local Health District could purchase those services through a separate service agreement with the Affiliated Health Organisation or there could be movement of funds between Local Health Districts, with the 'home' Local Health District providing additional funds to the Affiliated Health Organisation, just as there is movement of funds between Local Health Districts for other needs.[274]

11.17 It was suggested to Mr Daly that a better way of managing those relationships between Affiliated Health Organisations and multiple Local Health Districts would be for there to be, instead, a single relationship between the Affiliated Health Organisation and Ministry. Mr Daly did not regard this as providing any significant advantage, pointing out that Ministry is "a long way from community needs and community understandings" and that managing relationships with Affiliated Health Organisations from Ministry would not mean that the relationship would be managed better "particularly in terms of financial advantage, to that [Affiliated Health Organisation]".[275] That is because unless an Affiliated Health Organisation is truly providing a statewide service, Ministry officers would "have far less understanding and potential support, being in the centre, rather than being in the district where the population and the proposed services would be delivered."[276]

11.18 Mr Daly drew a distinction between services that were truly statewide services (under the *New Technologies and Specialised Services Guideline*, in which case Ministry could assist in negotiating volumes and price through the

[273] Exhibit D.8, Statement of Matthew Daly (9 April 2024) [75] [MOH.9999.0976.0001 at 0018].
[274] Transcript of the Commission, 29 April 2024, T2525.4-15 (Daly).
[275] Transcript of the Commission, 29 April 2024, T2525.17-27 (Daly).
[276] Transcript of the Commission, 29 April 2024, T2526.13-19 (Daly).

Specialty Services and Technology Evaluation Unit, which as described above provides oversight of supra-LHD services); and those Affiliated Health Organisations providing services in more than one Local Health District. His evidence was that in the latter case, there is no impediment (other than support from the Chief Executive of the Local Health District(s) outside the Affiliated Health Organisation's "home" Local Health District) to movement of funds from one Local Health District to another to supplement the Affiliated Health Organisation's funding under the Service Agreement with their "home" Local Health District.[277] Mr Daly's evidence was that such movements of funds between Local Health Districts occur "not infrequently".[278]

11.19 Mr Daly's views were consistent with the evidence before the Special Commission from Mr Danos, Chair of the Northern Sydney Local Health District Board, concerning Royal Rehab. Mr Danos' evidence was that the Local Health District is aware of the circumstances of Royal Rehab's patients and local knowledge of those patients which would be lost if the Service Agreement was administered through Ministry.[279] Adjunct Professor Schembri, Chief Executive of Northern Sydney Local Health District, saw arguments both ways whether Royal Rehab's Service Agreement should be managed centrally rather than by the Northern Sydney Local Health District, but the majority of patients treated by Royal Rehab were moved from the spinal units at Royal North Shore Hospital to Royal Rehab, and were thus "very much embedded in the patient flows of our district".[280] Similarly, Ms Willcox described the "significant advantages" of Affiliated Health Organisations being "embedded" in Local Health Districts, given that Local Health Districts are the "implementation arm" of Ministry.[281]

11.20 NSW Health accepts that there are improvements that could be made to streamline the process of negotiating services agreements with Affiliated Health Organisations. Ms Willcox appreciated the "efficiency and logic" for a

[277] Transcript of the Commission, 29 April 2024, T2525.37-2526.6 (Daly).
[278] Transcript of the Commission, 29 April 2024, T2526.6 (Daly).
[279] Transcript of the Commission, 29 April 2024, T2573.8-23 (Danos).
[280] Transcript of the Commission, 22 April 2024, T2290.3-7 (Schembri).
[281] Transcript of the Commission, 29 April 2024, T2553.5-17 (Willcox).

single service agreement with Ministry. She explained that Ministry had been in discussions with both Tresillian and Karitane and the Chief Executives of the South Western Sydney and Sydney Local Health Districts to see how the work of negotiating the service agreements might be better streamlined and to work towards more cohesive planning for the year ahead to mitigate against financial pressures and provide greater alignment in relation to the need and desire for their services.[282]

11.21 Ms Willcox described "active discussions" within Ministry about what may be an appropriate and more centralised approach to supporting Affiliated Health Organisations in delivering services and simplifying administrative arrangements.[283] Ms Willcox's evidence was that there is an annual process between Ministry and Tresillian and Karitane discussing services provided by them, outcomes, their budget positions and preparation for the following years' service model; together with quarterly performance meetings with Local Health Districts, and although it was "early days", the intention is to have the Local Health Districts bring forward more information quarterly about the functions of the Affiliated Health Organisations and their performance, so that the process was not only an annual one.[284] Ms Willcox has also established a Health Services Association Group, which involved her meeting with Affiliated Health Organisations regularly to talk about statewide or thematic issues that they were confronting, in order to try to navigate those issues collectively.[285]

11.22 The Special Commission has before it evidence from Affiliated Health Organisations, as well as from Ms Willcox, as to their views on the benefits of Affiliated Health Organisation services being administered through Ministry (See CA Submissions [854] and references cited therein). Counsel Assisting recognise (CA Submissions [854]) that Local Health Districts "enjoy obvious advantages in being able to assess the needs of their respective communities more directly than Ministry" but submit that there are benefits to services being

[282] Transcript of the Commission, 29 April 2024, T2551.22-39 (Willcox).
[283] Transcript of the Commission, 29 April 2024, T2553.9-17 (Willcox).
[284] Transcript of the Commission, 29 April 2024, T2551.46-2552.11 (Willcox).
[285] Transcript of the Commission, 29 April 2024, T2552.13-20 (Willcox).

administered by Ministry where services are being delivered statewide. Notwithstanding this, the proposed recommendation is not limited to Affiliated Health Organisations delivering services statewide (nor do Counsel Assisting identify what it would mean for an Affiliated Health Organisation to deliver services statewide in this context). Instead, it is suggested that every Affiliated Health Organisation should enter into a single service agreement with the Secretary, regardless of the scale or nature of the services provided by the Affiliated Health Organisation. NSW Health submits that is not the best approach, and that its proposed alternative recommendation better accommodates variation between different Affiliated Health Organisations and facilitates a more bespoke approach.

11.23 Proposed recommendation 21 reflects a flawed assumption that all services provided by Affiliated Health Organisations and funded by NSW Health are of the same nature, whereas there are two relevant types of services:

a. services provided by Affiliated Health Organisations that are recognised services in Schedule 3 of the *Health Services Act 1997* – these services form part of the public health system. Whilst these services (as well as services provided by Local Health Districts and Statutory Health Corporations) are nominally funded on an annual basis under Chapter 10 of the *Health Services Act 1997*, because such services form part of the public health system, it is implicit in the structure of the Act that there will be ongoing funding made available for such services (that is, that while funding may be paid annually it will, inevitably, be provided each and every year), with the quantum of the annual subsidy a matter for the Minister to determine having regard to relevant considerations, including the overall amount of the annual appropriation to NSW Health; and

b. other services provided by Affiliated Health Organisations that are funded by NSW Health organisations. Such services may be funded by specific grants or alternatively purchased as procured services. In either case,

such services are funded for a defined period of time, regulated by the applicable funding or service agreement, and do not form part of the public health system for the purpose of the Act (such that there should be no expectation of any ongoing funding for them, beyond the defined period in which they are funded to be provided).

11.24 Some Affiliated Health Organisations receive funding under both mechanisms. The proposed recommendation reflects the risk of conflation of the two. Thus, for example, Section 11.6 of Counsel Assisting's submissions (Management and funding services delivered by Affiliated Health Organisations) lists (CA Submissions [851]) a "range of different arrangements" under which Affiliated Health Organisations receive funding, some of which involve the funding of recognised services pursuant to Schedule 3 of the *Health Services Act* 1997 and some of which fall into the second category described in sub-paragraph (b) above. In that second category fall those arrangements listed in CA Submissions [851(b)], namely Service Agreements between Affiliated Health Organisations and multiple Local Health Districts involving the provision of services in each of those Local Health Districts, many of which are described by Counsel Assisting as "time limited" (CA Submissions [855]).

Counsel Assisting's recommendation 22 [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.

NSW Health response to Counsel Assisting's recommendation 22

11.25 **In response to recommendation 22, , NSW Health makes a number of comments, set out below.**

Work underway

11.26 As described by Ms Willcox, Ministry has been in discussions with both Tresillian and Karitane and the Chief Executives of the South Western Sydney and Sydney Local Health Districts with the aim of working towards more cohesive planning to mitigate against financial pressures and provide greater alignment in relation to the need and desire for their services.[286]

Potential challenges

11.27 As Counsel Assisting correctly submit (CA Submissions [859]) the evidence suggests that the expansion of services operated by Affiliated Health Organisations and the implementation of new services to meet service gaps is generally led by Affiliated Health Organisations and based on their own internal planning and strategy. That is not surprising given the independent status of Affiliated Health Organisations. As discussed below in relation to proposed recommendation 23, NSW Health submits that it is not intended that Schedule 3 reflect an ever-increasing range of services provided by Affiliated Health Organisations, recognised for the purposes of the *Health Services Act 1997,* with the expectation of continued funding by NSW Health.

Counsel Assisting's recommendation 23 [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.

NSW Health response to Counsel Assisting's recommendation 23

11.28 **In response to recommendation 23, NSW Health makes a number of comments, set out below.**

[286] Transcript of the Commission, 29 April 2024, T2551.22-39 (Willcox).

11.29 NSW Health accepts that there was evidence before the Special Commission supporting a finding that, at least in certain respects, the description of recognised services of one Affiliated Health Organisation (Karitane) described in Schedule 3 of the *Health Services Act 1997* was out of date. In some cases, the listed service had ceased. Periodic review of Schedule 3 to ensure it remains current is appropriate. However, given the historical context explained above, that exercise should not extend to enlarging the services listed in Schedule 3.

11.30 A periodic review of Schedule 3 may ensure its accuracy, but the creation of an annual review could create an expectation of annual addition of services provided by Affiliated Health Organisations. This may include an expectation on the part of Affiliated Health Organisations that new services will be added to Schedule 3, even though NSW Health may have taken a deliberate decision to grant funds for particular services in a time-limited way or up to a certain level. Services provided by Affiliated Health Organisations should not be added to Schedule 3 simply because they have previously been provided with grant funds by NSW Health.

11.31 The proposed recommendation may also reflect an inaccurate understanding of the process by which Schedule 3 may be amended. Any change to Schedule 3 involves a process of legislative amendment, which entails the Minister for Health making a decision to seek such an amendment, something which can only occur after he or she has taken into account a range of policy considerations and arrived at the view that ongoing services of the relevant kind ought to be provided by the relevant Affiliated Health Organisation and at the relevant location(s) and that those services ought to be funded on an ongoing basis. It is not the case (as is suggested by the evidence of Adjunct A/Prof Mills, Chief Executive Officer of Tresillian, seemingly accepted at CA Submissions [868]) that the amendments in 2018 and 2020 in respect of Tresillian's services were achieved simply through "email correspondence to the NSW Health legal branch". A detailed policy and financial assessment is

required before a recommendation can be made to the Minister (and before the Minister can make a decision) to seek an amendment to Schedule 3. As reflected in the advice given to Adjunct A/Prof Mills in 2024 concerning Tresillian's services at Macksville Hospital and Karitane's services at Campbelltown Hospital (see CA [878]), this is very much a policy decision.

11.32 The potential for misunderstanding of the process required for a service to be added to Schedule 3 is also reflected elsewhere in CA's submissions. Counsel Assisting submit (CA Submissions [880]) that clear advice should be given to the Affiliated Health Organisation "where a new service is established" as to whether that service is intended to form part of that Organisation's "recognised services" (the implication seemingly being that this is a reference to "recognised services" for the purpose of Schedule 3). That is not a decision that can necessarily be made upon the establishment of a new service. In many instances it will be necessary for there to be an assessment by NSW Health of the service being provided over a period of time, before it is possible to provide advice to an Affiliated Health Organisation as to whether there may be potential for the service to be added to Schedule 3 as a "recognised service".

Counsel Assisting's recommendation 24 [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.

NSW Health response to Counsel Assisting's recommendation 24

11.33 **NSW Health identifies a number of issues with recommendation 24, as set out below**.

Reasons

11.34 The introduction of an independent "structured process", presumably to be conducted by an "independent umpire" able to be called upon unilaterally by either the Affiliated Health Organisation or Ministry to resolve disputes regarding funding, is inconsistent with the legislative framework under the *Health Services Act 1997*, which provides that the amount of subsidy payable to Affiliated Health Organisations is to be determined by the Minister.[287]

11.35 NSW Health accepts that there have been difficulties resolving funding disputes between Affiliated Health Organisations and Local Health Districts (and Ministry). Its proposed alternative to recommendation 21 (a review of governance of Affiliated Health Organisations) would involve consideration of how the current arrangements for negotiating service agreements could be streamlined and disputes resolved more effectively.

Other issues raised in Section 11 of Counsel Assisting's Submissions

11.36 Counsel Assisting submit (CA Submissions [800]) that 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". This reflects an assumption about what is the "cost of doing so". Costs incurred by Affiliated Health Organisations reflect decisions taken by individual Affiliated Health Organisations concerning the configuration of their services, full time equivalent numbers, marketing, staff wages and supply contracts. These decisions and their cost implications are not articulated in a service agreement but will translate into potential disparity between funding provided under a service agreement and the "costs" of doing so.

[287] See *Health Services Act 1997,* ss 127(2) and 129.

11.37 CA Submissions at [800] also does not take into account the variation in cost between facilities for the provision of the same services. Where possible, benchmarking Affiliated Health Organisation services and NSW public hospitals can provide a clearer picture of where efficiencies may be possible in the provision of Affiliated Health Organisation services.[288]

11.38 Counsel Assisting submit (CA Submissions [830], [831]) that the evidence supports a conclusion that there is "no real process of negotiation" as to the funding to be provided to Affiliated Health Organisations. Although it is unclear what is meant by a "real process of negotiation", NSW Health observes that there is a process that allows Affiliated Health Organisations to seek funding growth, routinely and on an ad hoc basis. This occurs at the Local Health District Level rather than through Ministry, mirroring the approach for Local Health Districts in relation to their engagement of particular facilities.[289] On occasion Local Health Districts have supported Affiliated Health Organisations by offering assistance to prepare a business case for the purpose of seeking additional funding, as for example with the Northern Sydney Local Health District in relation to Royal Rehab funding in 2024 (cf CA Submissions [832]).[290] Royal Rehab has not submitted a business case in response to Adjunct Professor Schembri's written invitation to do so: further evidence to that effect can be provided if required.

11.39 Ministry and Local Health Districts should not be expected to accept costs presented by Affiliated Health Organisations without appropriate supporting data providing NSW Health visibility in relation to asserted underfunding. Ministry and Local Health Districts thus rely on the co-operation of and

[288] As to the utility of benchmarking, see Exhibit D.8, Statement of Matthew Daly (9 April 2024), [79]-[80] [MOH.9999.0976.0001 at 0019].

[289] Transcript of the Commission, 22 April 2024, T2283.23-2284.30 (Schembri).

[290] Cf CA's Submissions, [832]. Transcript of the Commission, 18 April 2024, T2116.37-2117.28; T2121.25-2126.3 (Mackay); Transcript of the Commission, 22 April 2024, T2285.6-2286.14 (Schembri); see also Exhibit D.90, *Letter from Anthony Schembri to Matthew Mackay* (17 April 2024) [MOH.9999.1110.0001].

transparency by Affiliated Health Organisations to enable review of their financial position.[291]

11.40 Sophisticated methodologies are applied to determine the cost of efficiently delivering services in the NSW public health system, including the use of benchmarking. As Ms Willcox explained by reference to the example of Karitane, when an Affiliated Health Organisation is experiencing financial pressures, one of the first steps in the process of negotiating an agreement for funding is to understand the reasons and the drivers for those pressures.[292] NSW Health has requested additional data and in some cases independent reviews have been conducted in relation to the costs of provision of services by Affiliated Health Organisations. This does not reflect the absence of any process of negotiation, but rather an attempt to understand the funding requests being made by Affiliated Health Organisations. Local Health Districts have also offered to assist Affiliated Health Organisations in supporting requests for additional funding. An independent review of the accuracy of Royal Rehab's as-reported costs was conducted in 2023[293], but Ms Willcox's evidence was that even after that review was conducted it was not possible for Royal Rehab to reach an agreement as to its funding.[294] As Adjunct Professor Schembri explained, he has requested a business case from Royal Rehab to support the provision of additional funding:[295] no such business case has been provided by Royal Rehab to date.

11.41 Counsel Assisting appear to imply (CA's Submissions [834]) that, where service agreements are due for renewal, there is a general practice of ceasing funding for Affiliated Health Organisations until a new service agreement is entered into. That is not so: for example, funding for Royal Rehab's recognised

[291] Exhibit N4.10, Statement of Alfa D'Amato dated 23 July 2024, at [5]-[6] [MOH.0011.0029.0001 at .0001] (by reference to the example of St Vincent's Health Network).
[292] Transcript of the Commission, 29 April 2024, T2550.38-2551.13 (Willcox).
[293] Exhibit D.129, Taylor Fry, *Draft Independent review of Royal Rehab cost estimates* (13 June 2023) [SCI.0008.0082.0001].
[294] Transcript of the Commission, 29 April 2024, T2548.38-2549.4 (Willcox).
[295] Transcript of the Commission, 22 April 2024, T2285.6-2286.14 (Schembri); see also Exhibit D.90, *Letter from Anthony Schembri to Matthew Mackay* (17 April 2024) [MOH.9999.1110.0001].

establishments and services has continued absent a current service agreement.[296]

11.42 The position is different in relation to non-Schedule 3 services provided by Affiliated Health Organisations pursuant to grants or time-limited contracts. In those instances, Ministry properly requires a fully executed contract and assurances that contractual obligations including service delivery milestones and financial reporting are being met (or will be met) before payments can be made. This can, at times, delay the payment process.

11.43 Counsel Assisting refer (CA Submissions [834]) to evidence of delays in payments to Tresillian. This has at times related to the provision of services that were not recognised establishments or recognised services for the purpose of Schedule 3 of the *Health Services Act 1997*.

11.44 Counsel Assisting propose a distinction between own source revenue (unrelated to the services provided pursuant to a services agreement) and patient fees (CA Submissions [841]), implying (CA Submissions [842]) that own source revenue should only be accounted for in service agreements for Affiliated Health Organisations if that revenue was derived from services the subject of the service agreement. Mr Daly noted that it has been a longstanding feature of what used to be called third schedule hospitals that they contribute charitable funding to supplement the services funded by government.[297]

11.45 NSW Health submits that costs and revenue associated with functions performed by Affiliated Health Organisations that are not part of the public health system should not be accounted for in service agreements for Affiliated Health Organisations. On the other hand, it is appropriate for own source operating revenue, including philanthropic donations, to be accounted for in service agreements between Local Health Districts and Affiliated Health Organisations if that revenue relates to the provision of public health services. Philanthropic contributions to Local Health Districts are at times made on the

[296] See eg Transcript of the Commission, 18 April 2024, T2103.4-8 (Mackay).
[297] Transcript of the Commission, 29 April 2024, T2520.18 (Daly).

basis of the role of Local Health Districts as public health providers. Affiliated Health Organisations, to the extent they have recognised establishments and recognised services pursuant to Schedule 3, play a similar role as part of the public health system and have the potential to attract philanthropic contributions on that basis. That said, as a general matter, given the limited visibility that NSW Health (including Local Health Districts) have in relation to Affiliated Health Organisations' cash inflows and own source revenue, in general revenue accounted for in service agreements between Local Health Districts and Affiliated Health Organisations consists predominantly of patient fees. The limited visibility is exemplified by the St Vincent's Service Agreement: it records no 'own source revenue'[298], despite being the recipient of charitable donations and other revenue streams.

11.46 The problem of limited visibility assumes heightened significance because the range of services provided by most Affiliated Health Organisations include services that are not public health services. NSW Health needs to be able to differentiate the costs of, and revenue derived from, public health functions performed under service agreements, from costs and revenue not associated with performance of those functions.

[298] Exhibit G.29.8, *Service Agreement between St Vincent's Hospital Sydney and NSW Health 2022-2023,* [SVH.9999.0002.0066] (Service Agreement showing 0 for all own source revenue categories).

SECTION 12: PROCUREMENT

Counsel Assisting's recommendation 25 [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.*

NSW Health response to Counsel Assisting's recommendation 25

12.1 **In response to recommendation 25, NSW Health makes a number of comments, set out below.**

Work underway

12.2 Counsel Assisting has described (CA Submissions [926]) NSW Health's recent and ongoing reform of its procurement framework via the Procurement Reform Program. NSW Health continues to pursue procurement reform strategies which, as described by Mr Gendy, Chief Procurement Officer, NSW Health, include the implementation of a new Operating Model.[299] The Procurement Reform Program aims to deliver the necessary foundational changes required to manage procurement more effectively, and to support value-based healthcare.[300]

[299] Exhibit B.5, Statement of Michael Gendy (31 January 2024) [30(a)], [64(a)]. [MOH.0001.0434.0001 at 0006, 0021].
[300] Exhibit B.5, Statement of Michael Gendy (31 January 2024) [93], [96]. [MOH.0001.0434.0001 at 0031, 0034].

12.3 NSW Health recognises the desirability of developing and implementing clear and specific processes for embedding value-based healthcare in its procurement processes.

12.4 The proposed recommendation is also consistent with one of the Strategic Procurement Branch's actions set out in *Future Health*, which involves embedding value-based healthcare into system-wide procurement activity.[301] NSW Health intends that the Strategic Procurement Branch will work with HealthShare NSW, eHealth NSW, the Agency for Clinical Innovation and the Clinical Excellence Commission to discuss and present the agreed principles of value-based procurement with suppliers and industry to reinforce NSW Health's focus on value-based procurement.

Counsel Assisting's recommendation 26 [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.

NSW Health response to Counsel Assisting's recommendation 26

12.5 **In response to recommendation 26, NSW Health makes a number of comments, as follows.**

[301] Exhibit B.5, Statement of Michael Gendy (31 January 2024) [48(h)] [MOH.0001.0434.0001 at 0016].

Work underway

12.6 Counsel Assisting has referred (CA Submissions [983]) to the implementation of a new Contract Management Framework within NSW Health as part of the new Operating Model being developed via the Procurement Reform Program. Working towards improved monitoring of the performance of suppliers of goods and services will form an aspect of the implementation of that framework. Counsel Assisting state (CA Submissions [983]) that it is "not immediately apparent" how that new framework will result in effective contract and performance management. Further evidence on this subject could be supplied if that would assist the Special Commission.

12.7 Ms Rechbauer, then Chief Executive of HealthShare NSW, deposed that the Procurement Reform Program was in part a response to the NSW Auditor-General's report to Parliament in October 2019, and implemented with a view to having a material impact on the contract management issues identified by the Auditor General.[302] The Program contemplates resources being redirected as automation increases, and automation of processes providing a greater level of information. The additional full-time equivalent staff referred to by Counsel Assisting will be able to analyse that data, in order to "provide information to the system to improve".[303]

Other issues raised in Section 12 of Counsel Assisting's Submissions

12.8 Counsel Assisting submit (CA Submissions [942]) that 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. NSW Health acknowledges this point and sees opportunities to improve in this area.

12.9 In the overall context of the NSW Government Procurement Framework, "value for money" is a broader concept than is "value-based healthcare". A

[302] Transcript of the Commission, 23 February 2024, T961.10-18 (Rechbauer).
[303] Transcript of the Commission, 23 February 2024, T960.9-961.18 (Rechbauer).

range of criteria beyond monetary value is documented and required to be incorporated into procurement plans and tender evaluation processes under NSW Government procurement policies: for example, under the NSW Government *Procurement Policy Framework*[304] and the NSW Government *Small and Medium Enterprise and Regional Procurement Policy*[305] (referred to by Counsel Assisting at CA Submissions [895]), the preference for products produced locally and regionally and that are materially identical to products produced overseas is seen as delivering economic value to local NSW communities. In relation to value-based healthcare specifically, present processes for incorporating suitable non-price criteria are reflected in the role of Technical Evaluation Committees.[306]

12.10 There may be further opportunities to improve the incorporation of value-based criteria into procurement plans and tender-evaluation processes. While value-based criteria are currently determined by a customised approach depending on the particular tender process being conducted, there is an opportunity for a common set of evaluation criteria specifically related to clinical outcomes to be introduced into NSW Health procedures as a starting point for personnel to draw upon. There is also potential to reinforce value-based healthcare principles in procurement by further training offered by Ministry's Strategic Procurement Branch.

12.11 Counsel Assisting submit that clinicians do not "ordinarily" have input into the negotiation of a contract (CA Submissions [943]). Conflict of interest considerations in the supplier/clinical relationship render it appropriate for clinician involvement in the negotiation of contracts to be limited to clinically significant matters. However, at present, clinicians are called upon on an as-needs basis during negotiations and through the life of contracts to comment and support contract management personnel on key clinical aspects.[307] NSW Health considers that there is an opportunity to better document the

[304] Exhibit B.23.016, NSW Government, *Procurement Policy Framework* (April 2022) [MOH.0001.0132.0001].
[305] Exhibit B.23.018, NSW Government, *Small and Medium Enterprise and Regional Procurement Policy* [MOH.0001.0417.0001].
[306] Transcript of the Commission, 23 February 2024, T902.29-39; T908.15-909.13 (Rechbauer).
[307] Transcript of the Commission, 23 February 2024, T899.28-30; T904.3-42 (Rechbauer).

importance of engaging clinical expertise throughout the lifecycle of a procurement process, not only at the planning stages but during the product specification and negotiation phases. It envisages that the work to be done in response to proposed recommendation 25 would enable such documentation to be developed.

12.12 Counsel Assisting further submit that the absence of a documented and systematic approach to embedding value-based considerations in the process means there is an absence of mechanisms in place to ensure this occurs in every instance (CA Submissions [944]). This is an area of future opportunity, whereby HealthShare NSW can work with Ministry, Agency for Clinical Innovation and Clinical Excellence Commission to test how value-based healthcare can better be integrated into procurement processes from end to end. There is further empirical research to be done to establish meaningful correlations between products and their features and patient outcomes over time, in order to build an evidence base for future procurements. This will also assist NSW Health in the development and utilisation of future value-based criteria for procurement. NSW Health submit that a feasible category in which such empirical research might commence is prosthetics, to the extent that these products are attributable to individual patients and data collection on patient outcomes is possible over time.

12.13 Counsel Assisting note (CA Submissions [949]) that the Key Performance Indicators set out in HealthShare NSW's *Statement of Service* do not require it to embed value-based healthcare into its procurement processes. That is true, but the Statement of Service refers, under "Future Health actions and performance initiatives", to scaling successful value-based healthcare initiatives at state and local level, and to completing a refresh of all procurement category strategies, including identification of opportunities to drive better value. [308]

[308] Exhibit B.23.139, *HealthShare NSW Statement of Service 2023-2024*, p. 18 [MOH.9999.0010.0001 at .0020].

12.14 Consistent with proposed recommendation 25 and as part of the work it envisages in response to that recommendation if made, NSW Health proposes that HealthShare NSW will work with Ministry, Agency for Clinical Innovation and Clinical Excellence Commission to determine whether there are any Key Performance Indicators that could be added to its *Statement of Service* and be measurable and meaningful with regard to embedding value-based healthcare into its procurement processes.

12.15 Counsel Assisting properly accept (CA Submissions [961]) that NSW Health takes seriously the concept of equity, and that several important initiatives involving procurement activity have been implemented in the "area of equity generally". Counsel Assisting submit (CA Submissions [961]) that equity "is not a concept that seems to have been analysed or operationalised with any rigour in the context of NSW Health's ordinary procurement practices". NSW Health accepts there is scope for further analysis of the use of its purchasing power to better achieve equity in the system.

12.16 Counsel Assisting suggests equity in procurement could be achieved in various ways including allowing Local Health Districts to negotiate alone to pursue lower prices outside of statewide contracts (CA Submissions [968]). The integrity of centralised procurement processes should be maintained, given they are a key enabler of coverage for all NSW Health entities.[309]The proposed course risks unintentionally incentivising suppliers to differentiate between Local Health Districts and thereby disadvantage particular hospitals or Local Health Districts.

12.17 NSW Health acknowledges there are opportunities for improvement and for further analysis in relation to achieving equity in procurement across geographical locations and that there may be no 'template' solution for doing so.[310] Where there are additional costs to a Local Health District in using or accessing a statewide contract, in theory a funding mechanism could be devised to address these variances, consistent with the evidence of Mr

[309] Transcript of the Commission, 23 February 2024, T1007.11-13 (Gendy).
[310] Transcript of the Commission, 23 February 2024, T1006.30-39 (Gendy).

Gendy.[311] Mr Gendy deposed to a process for off-contract exceptions to be provided, but under current arrangements a variance of this type would still need to be referred to the relevant State contract owner for centralised management, to ensure consistency across the State.[312]

12.18 Counsel Assisting submits (CA Submissions [970]) that the principal object of centralised procurement should be to ensure that NSW Health achieves the best value for money spent and that HealthShare NSW should not strive to achieve common pricing for any item in all circumstances. NSW Health agrees with this characterisation, with the qualification that it submits that HealthShare NSW does not strive to take a "one-size fits all" approach to achieving common pricing across all contracts and categories.

12.19 HealthShare NSW's role is, relevantly, to deliver the greatest value for money across the system and this involves finding equilibrium in relation to common pricing, given the considerations referred to by Counsel Assisting in relation to total expenditure system-wide. In relation to pricing for rural and remote Local Health Districts and hospitals, product and freight costs are currently separated, so that the variable freight costs may be identified, including by Local Health Districts incurring those freight costs.[313] NSW Health submits that the manner in which variances incurred by Local Health Districts in particular categories of location (such as rural and remote Local Health Districts) may be addressed through funding adjustments should be further explored as between Ministry and Local Health Districts.

12.20 Counsel Assisting refers (CA Submissions [971) to the need for careful monitoring to determine what arrangement will deliver greatest value system-wide, and submit that pricing should be adjusted for rural and remote Local Health Districts if they are required to pay more for a particular item rather than equalising pricing through procurement that sacrifices system-wide value. There is some logic to the position set out by Counsel Assisting concerning

[311] Transcript of the Commission, 23 February 2024, T1006.16-1007.3 (Gendy).
[312] See Transcript of the Commission, 23 February 2024, T895.13-30 (Rechbauer).
[313] See eg Exhibit B.8, Statement of Mark Spittal (6 February 2024) [69] (MOH.0001.0263.0001 at 0015-16].

adjustments to rural and remote Local Health Districts, but NSW Health does not accept that HealthShare NSW presently seeks to equalise pricing in a manner that "unnecessarily sacrifices systemwide value".

12.21 Modelling of the kind referred to by Counsel Assisting has been undertaken on a case-by-case basis to date by category teams[314] (as in relation to the nursing agency contract and various metropolitan and regional panel arrangements for Facilities Management contracts).

12.22 Counsel Assisting submit (CA Submissions [979]) that there appears to be no process for measuring or evaluating the value achieved by a procurement activity, including whether it meets value-based criteria included in the tender evaluation process. NSW Health does not agree there is no such process, although it acknowledges there are areas for improvement. At present, many value-based criteria are assessed during the tender evaluation process, prior to progression to contracting. The relative importance of such value-based criteria is reflected in tender weighting criteria.[315]

12.23 Systematic measuring and assessment of the benefits of procurement is undertaken in several ways. All Whole of Health and Whole of Government contracts managed by HealthShare NSW have a Contract Management Plan and Benefits Realisation Plan.[316] Contract managers administer those plans, with benefits reported monthly. Category plans are also developed and updated annually, addressing category accomplishments, challenges and opportunities, with information sharing amongst category and contract managers through the Contract Networking Group.[317] NSW Health accepts, however, that existing mechanisms for reporting of procurement benefits are largely focused on financial benefits. Following further analysis by the Strategic Procurement Branch in conjunction with the Agency for Clinical Innovation and the Clinical Excellence Commission in relation to measurement of non-

[314] Transcript of the Commission, 23 February 2024, T897.23-898.14 (Rechbauer).
[315] See Transcript of the Commission, 23 February 2024, T1008.2-18 (Gendy).
[316] Exhibit B.5, Statement of Michael Gendy (31 January 2024) [72(g)] [MOH.0001.0434.0001 at 0025-0026]; Exhibit B.23.001, *NSW Health, Procurement Procedures (Goods & Services),* Version 1.0, June 2022 [MOH.0001.0366.0001 at 0057- 0058].
[317] See Exhibit B.11, Statement of Carmen Rechbauer (12 February 2024) [60] [MOH.9999.0009.0001 at 0017]; Transcript of the Commission, 23 February 2024, T959.4-27 (Rechbauer).

financial benefits of procurement, there may be an opportunity for such benefits reporting to be expanded to include tracking of non-financial benefits, particularly in clinical categories such as prostheses where such benefits may be more readily measurable.

12.24 Counsel Assisting submit at (CA Submissions [983] that the main action that NSW Health appears to have taken in response to the Auditor-General's report of October 2019 in relation to contract management has been to implement the new Operating Model as part of the Procurement Reform Program. The evidence may not bear this out, and can be supplemented if required, but all recommendations made by the Auditor-General referring to HealthShare NSW have been addressed.

12.25 NSW Health acknowledges that there are areas for improvement and further work in respect of contract management. Implementation of the NSW Health Procurement Reform Program continues. Consistent with recommendation 26, Ministry's Strategic Procurement Branch intends to work with HealthShare NSW, eHealth NSW and Local Health Districts to develop and implement a systematic approach to monitoring the value of contract management and contract handovers to Local Health Districts. This will involve developing measurable key performance indicators of the kind referred to in proposed recommendation 26.

SECTION 13: INNOVATION

Counsel Assisting's recommendation 27 [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.

NSW Health response to Counsel Assisting's recommendation 27

13.1 **In response to recommendation 27, NSW Health makes a number of comments, set out below.**

13.2 It is desirable to give increased priority to research that can inform the best ways to promote innovation and systemic reform in the delivery of healthcare.

13.3 Having regard to the structural focus of the Agency for Clinical Innovation and its limited involvement in setting research priorities, NSW Health considers that the Innovation recommendations proposed by Counsel Assisting would be more effective if they were directed to the Division of Clinical Innovation and Research rather than solely to the Agency for Clinical Innovation.

13.4 In relation to low value care, NSW Health considers that it is important to engage the community, including through Local Health Advisory Committees and Local Health District Boards, to better communicate the challenges caused by low value care and the need for improved use of available funds.

Work underway

13.5 The creation of the Division of Clinical Innovation and Research in February 2023 provides an opportunity to better integrate clinical and health system perspectives in the setting of research priorities to support innovation, from downstream research to implementation in practice. That said, the Special Commission received evidence of ongoing efforts by the Division, including the Agency for Clinical Innovation, to prioritise research that contributes to system innovation.[318]

13.6 One of the main priorities identified in the *Agency for Clinical Innovation Strategy 2023-2026* is to reduce unwarranted clinical variation and promote high-value care by using:[319]

a. analytics to show variation in whether, how, and how well care is delivered; and

b. novel approaches to identify, assess and propose innovations to address variation.

13.7 Such work is illustrated by a project developed through the ACI Redesign School in collaboration with NSW Health Pathology, which targeted the use of pathology tests in Intensive Care Units on a routine basis rather than according to clinical need.[320] Implementation at four sites demonstrated that interventions such as education, data dashboards, audit and feedback could lead to a decrease in unnecessary pathology testing across seven of eight testing categories without an increase in adverse clinical outcomes.

13.8 This project has resulted in the creation of a platform that is being rolled out in more clinical settings by the Intensive Care NSW team at the Agency for Clinical Innovation, although it has not yet been implemented across the

[318] Transcript of the Commission, 10 December 2024, T6874.40-6875.12 (Nutbeam).
[319] Exhibit B.23.050, NSW Agency for Clinical Innovation, *Strategy 2023-2026* (2023) p 6, [MOH.0001.0350.0001 at 0006].
[320] Exhibit B.3, Statement of Jean-Frederic Levesque (30 January 2024) [54], [MOH.0001.0435.0001 at 0015-0016].

State.[321] The next stage will be to expand the project to emergency departments.[322]

13.9 The Agency for Clinical Innovation provides guidance to clinicians to reduce unwarranted clinical variation and discourage low value care. One of the main strategies used by the Agency for Clinical Innovation is to develop clinical practice guides to clarify the current standard of practice across its 42 clinical networks, and to develop tools to identify, measure and address clinical variation.[323]

13.10 This approach was illustrated by the evidence heard by the Special Commission in relation to the clinical practice guide, *Value-based surgery*, which was introduced in November 2023.[324] The guide summarises the status of the evidence in specific surgical areas, and provides advice to clinicians with regard to how to assess whether patients would benefit from it, and how to engage with the patients.[325] The guide recommends that Local Health Districts put in place a local review panel for surgical activity, to:[326]

a. approve or reject discretionary surgery;

b. add procedures to a list of cosmetic and discretionary surgery; and

c. consider recommendations for admission accompanied by clinical justification to be made to the facility's clinical director of surgery and the review panel.

13.11 The guide also seeks to encourage more consistency in surgery by:

[321] Transcript of the Commission, 26 February 2024, T1060.8-13 (Levesque).
[322] Transcript of the Commission, 26 February 2024, T1060.28-34 (Levesque).
[323] Transcript of the Commission, 26 February 2024, T1068.13-23 (Levesque).
[324] Exhibit B.23.064, Agency for Clinical Innovation, *Clinical Practice Guide Value-Based Surgery* (November 2023), [MOH.0001.0282.0001]; see also Transcript of the Commission, 26 February 2024, T1062.41-1063.41 (Levesque).
[325] Transcript of the Commission, 26 February 2024, T1063.01-18 (Levesque).
[326] Exhibit B.23.064, Agency for Clinical Innovation, *Clinical Practice Guide Value-Based Surgery* (November 2023), [MOH.0001.0282.0001 at 0004, 0008].

a. establishing a monitoring and reporting framework to identify individuals within a Local Health District whose rate of performing listed operations is outside a norm established by peers; and

b. discussing strategies to address this in a multidisciplinary team process.[327]

13.12 The Division of Clinical Innovation and Research is currently working on a new NSW Health Research and Innovation Strategy, based on extensive consultation with the health system, industry, the university sector, consumers and experts.[328] The strategy is expected to be finalised and launched in 2025. A top priority for the strategy will be:

> "More tactical support and oversight in implementation of research and innovation priorities, including the identification of innovations or models of care that represent "game-changers", as well as the implementation of metrics and key performance indicators, to set objectives and drive performance with LHDs".[329]

13.13 NSW Health considers that this priority is consistent with the approach reflected in recommendation 27.

Potential challenges

13.14 The Agency for Clinical Innovation (and indeed the Division of Clinical Innovation and Research as a whole) has only limited capacity to set research priorities within a complex system involving a range of participants and funding sources.[330] While the Division of Clinical Innovation and Research can determine research priorities in relation to the programs it administers, it has only limited ability to influence the research priorities of the universities and the

[327] Exhibit B.23.064, NSW Agency for Clinical Innovation, *Clinical Practice Guide Value-Based Surgery* (November 2023), p 9, [MOH.0011.0282.0001 at 0012].
[328] Exhibit N.3.12, Supplementary Statement of Jean-Frederic Levesque (19 June 2024) [4a] [MOH.0006.0038.0001 at 0001].
[329] Exhibit N.3.12, Supplementary Statement of Jean-Frederic Levesque (19 June 2024) [44a], [MOH.0006.0038.0001 at 0011].
[330] Transcript of the Commission, 10 December 2024, T6880.45-47 (Nutbeam).

Commonwealth funding bodies, the National Health and Medical Research Council and the Medical Research Future Fund.[331]

13.15 The evidence before the Special Commission suggested that the Agency for Clinical Innovation has a role to play in identifying system priorities for innovation, including through its clinical networks.[332] However, the evidence also highlighted the need for a range of dialogues with the Office for Health and Medical Research, the Chief Executives of the Local Health Districts and the Clinical Excellence Commission to ensure that research priorities are better aligned to the needs of the health system.[333] As was observed by Dr McNamara, Chief Executive of the Sax Institute, "it can't all be driven from one group, despite the best intentions".[334]

13.16 The proposed recommendation should reflect the fact that the Division of Clinical Innovation and Research operates in the context of a complex research ecosystem, much of which is outside of its control. This was explained by Professor Nutbeam, Professor of Public Health at the University of Sydney and Executive Director of Sydney Health Partners:

> "As I mentioned very early on, we do have these enormous funding agencies in the National Health and Medical Research Council, Medical Research Future Fund, who support a lot of discovery research, a lot of the efficacy research that we've described earlier that helps us build evidence of what are the best things to do, creates a pipeline of discoveries that might lead to improved health practice.
>
> The question is, in that ecosystem, what role does a state ministry have and can it best play? I think the feedback that the ministry has received through their consultation process is that it's largely at the far end of the research pipeline; it's at the translation end; it's how you take what we've learned from discovery science and randomised trials and other forms of outstanding

[331] Transcript of the Commission, 10 December 2024, T6876.30-6877.11 (Nutbeam); see generally Exhibit N.3.12, Supplementary Statement of Jean-Frederic Levesque (19 June 2024) [33] [MOH.0006.0038.0001 at 0008].
[332] Transcript of the Commission, 10 December 2024, T6882.30-43 (Milat).
[333] Transcript of the Commission, 10 December 2024, T6882.30-43 (Milat); T6884.15-22, T6885.3-7 (Milat); T6886.30-6887.1 (Nutbeam).
[334] Transcript of the Commission, 10 December 2024, T6866.41-43 (McNamara). A similar point was made by Prof Wolfenden at T6872.8-14.

> research - how do we get that implemented in practice in ways that deliver better outcomes for the community in New South Wales."[335]

13.17 The recommendation also refers to the need to "empower" staff to respond to unwarranted clinical practice variation, low value care, and over-investigation, over-diagnosis and over-treatment.

13.18 The practical meaning of 'empowerment' in this context is not clear. The CA Submissions [1043] speak broadly about there being "little central guidance or support" for reducing unwarranted clinical variation and disinvesting in low value care. The CA Submissions [1043] go on to explain that "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". The CA Submissions [1045] cite evidence from doctors experiencing pressure from patients and their families, and also from nurses and allied health staff. This evidence suggests that the pressure to provide low value care often arises for patients near the end of life [336] and that talking to patients and families in such circumstances is "extremely confronting".[337]

13.19 While NSW Health recognises that staff should always be, and feel, free to speak up about observed clinical practices that concern them, seen in the above context, the issue is, in fact, not one of empowerment. Rather, the issue is the extent to which individual doctors should be discouraged from providing low value care in certain circumstances and, in turn, what kind of clinical guidance and education should be provided in relation to their use of resources.[338] As explained above, the Agency for Clinical Innovation is already providing guidance, including in the form of clinical practice guides.

13.20 The challenges in relation to low value care were summarised by Adjunct Professor Levesque, Deputy Secretary for Clinical Innovation and Research at NSW Heath, who explained:

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[335] Transcript of the Commission, 10 December 2024, T6877.4-22 (Nutbeam).
[336] Transcript of the Commission, 14 November 2024, T6024.38-6026.40 (Hislop).
[337] Transcript of the Commission, 14 November 2024, T6026.44-6027.1 (Hislop).
[338] See in particular Transcript of the Commission, 14 November 2024,T6029.39-6030.37 (Begbie).

> "The reality is that in many clinical areas, it's a bit of a grey zone. The literature says - you know, when they assess certain types of surgery, they may say 50 per cent of patients received surgery and did not benefit from it. At times it is because of their age, at times it's because they had other conditions that were preventing the surgery from being effective for that patient. That's why, in our models of care for those procedures, we're not saying "Don't do it", because the reality is that those procedures are still useful for some patients. What we're saying is, "You need to have a multidisciplinary team discussion in place so that your colleagues will help you to decide if that patient will benefit from surgery."[339]
>
> "So that's where we're trying to work through that, you know, encouraging and convincing the system, because we know that ultimately, at the end of the day, for those procedures, it's the clinical team and the patients that will have to make the decision. It's not the role of ACI to govern that, you know? But ACI, of course, when a procedure is no longer perceived as being the gold standard, we have the responsibility to make it clear in our models of care and our clinical practice guide."[340]

13.21 In relation to unwarranted clinical variation, the Special Commission heard that there may be resistance to changing practices from clinicians and that this requires education of both clinicians and patients, as well as appropriate change management and outpatient support.[341] Evidence in the literature demonstrates that supporting the adoption of new practices across complex healthcare systems requires time and effort.[342]

Counsel Assisting's recommendation 28 [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.

[339] Transcript of the Commission, 26 February 2024, T1061.22-34 (Levesque).
[340] Transcript of the Commission, 26 February 2024, T1061.36-44 (Levesque).
[341] Transcript of the Commission, 26 February 2024, T1066.44-1067.9 (Levesque).
[342] Transcript of the Commission, 26 February 2024, T1067.11-29 (Levesque)

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.*

NSW Health response to Counsel Assisting's recommendation 28

13.22 **In response to recommendation 28, NSW Health makes a number of comments, set out below.**

13.23 NSW Health considers that investment in research and innovation should be focused on improving health outcomes and delivering health system management benefits. In this context, community needs and priorities should inform research funding but should not be the sole consideration. It is important to use research, identify emerging technologies and promising innovations to prioritise innovations that are potential `game-changers' and understanding system changes that will allow an innovation's potential to be realised. [343]

13.24 For the reasons explained above, the Innovation recommendations proposed by Counsel Assisting would be more effective if directed to the Division of Clinical Innovation and Research rather than solely to the Agency for Clinical Innovation.

Work underway

13.25 The Agency for Clinical Innovation has only limited capacity to shape research priorities. However, the evidence presented to the Special Commission clearly demonstrated that it is driving innovations that deliver community and systemic benefits.

13.26 In his evidence to the Special Commission, Adjunct Professor Levesque pointed to several examples of activities and programs led and supported by

[343] Exhibit B.3, Statement of Jean-Frederic Levesque (30 January 2024), pp 9 and 39, particularly [32(e)], [110(c)] [MOH.0001.0435.0001 at 0009 and 0039].

the Agency for Clinical Innovation that have broad application or otherwise address health issues of concern to the community. These examples included:

a. **Leading Better Value Care program:** this was an extensive program focused on specific clinical areas such as "osteoporotic refracture, chronic obstructive pulmonary disease, bronchiolitis, chronic wounds, renal supportive care, chronic heart failure, hip fracture and diabetes".[344] In particular, the osteoporotic fracture aspect of the program focused on increasing the volume of patients being assessed for risk of fractures.[345] Similarly, the renal supportive care aspect of the program sought to implement clinics to provide alternatives to dialysis, with a view to achieving better outcomes for patients and reducing the need for expanded dialysis services.[346]

b. **Telestroke program:** the program introduced a new virtual model for remote care in regional centres to better assess potential stroke patients with the support of neurological specialists at Prince of Wales Hospital in Sydney.[347] The program helps regional emergency doctors to more accurately identify potential stroke patients and administer time-critical treatments such as thrombolysis or transferred for endovascular clot retrieval, for patients who need them.[348] Initially piloted in Hunter New England and Mid North Coast Local Health Districts, the program is now statewide.[349]

c. **Emergency Care Assessment and Treatment program:** this program introduces a new model of care to support the delivery of evidence-based, nurse-initiated care in emergency departments.[350] It includes the

[344] Transcript of the Commission, 26 February 2024, T1100.44-1101.1 (Levesque); Exhibit B.3, Statement of Levesque (30 January 2024) [85[c]) [MOH.0001.0435.0001]; Exhibit B.59, *Leading Better Value Care*, NSW Health [SCI.0003.0021.0001].

[345] Transcript of the Commission, 26 February 2024, T1101.5-1101.15 (Levesque). Exhibit B.3. Statement of Jean-Frederic Levesque (30 January 2024) [85[c]) [MOH.0001.0435.0001).

[346] Transcript of the Commission, 26 February 2024, T1101.17-31 (Levesque).

[347] Transcript of the Commission, 26 February 2024, T1044.10-35 (Levesque). Exhibit B.3, Statement of Jean-Frederic Levesque (30 January 2024) [82], [MOH.0001.0435.0001]

[348] Transcript of the Commission, 26 February 2024, T1044.32-1045,01, T1097.42-44 (Levesque).

[349] Transcript of the Commission, 26 February 2024, T1043.23-38, T1045.19-26 (Levesque).

[350] Exhibit B.3, Statement of Jean-Frederic Levesque (30 January 2024) [51] – [52], [MOH.0001.0435.0001]; Exhibit N.3.12, Supplementary Statement of Jean-Frederic Levesque (19 June 2024) [22]-[23] [MOH.0006.0038.0001 at 0005].

development of protocols in 73 different clinical areas and dealing with matters such as wound management or respiratory deterioration.[351] It aims to give nurses all of the guidance needed to start treatment as quickly as possible in a standardised way, and improve the patient experience.[352]

13.27 Investment is focused on innovations that are likely to have system management benefits. In particular, the *Agency for Clinical Innovation Strategy 2023-2026* makes clear that its future work will focus on innovations that address priority challenges: "We will focus our work on issues related to the integration of care, reducing unwarranted clinical variation, redesigning healthcare to facilitate the adoption of new health technologies, support the implementation of virtual and digitally enabled models of care".[353]

13.28 The Special Commission received evidence in relation to the Intensive Care Unit Exit Block initiative.[354] The initiative included:

a. gathering of local site specific and statewide data; and

b. providing central support to local ICU teams for project implementation using standard templates and tools.

13.29 The initiative has led to the development of specific improvement measures which are reportable to Ministry. Clinical teams in hospitals are able to track exit block on a specific dashboard on the Patient Flow Portal, which enables them to monitor and modify local initiatives to improve patient flow into and out of Intensive Care units.[355]

[351] Transcript of the Commission, 26 February 2024, T1058.25-31 (Levesque).
[352] Transcript of the Commission, 26 February 2024, T1058.33-37 (Levesque); Exhibit B.3, Statement of Jean-Frederic Levesque (30 January 2024) [51] [MOH.0001.0435.0001].
[353] Exhibit B.23.050, Agency for Clinical Innovation, *Strategy 2023-2026* (2023) p 16 [MOH.0001.0350.0001 at 0016].
[354] Exhibit N.3.11, Statement of Nhi Nguyen (18 June 2024) [12]-[20] [MOH.0006.0036.0001 at 0003-0005]; see also Exhibit N.3.11.8, Agency for Clinical Innovation, *Guiding principles to optimise intensive care capacity: a whole of hospital approach to improving patient flow* (October 2019) [MOH.0006.0032.0001].
[355] Exhibit N.3.11, Statement of Nhi Nguyen (18 June 2024) [17] [MOH.0006.0036.0001 at 0004].

13.30 Dr Nguyen explained that: "The project is a good example of how a signal from clinicians matched that from the system overall and resulted in a coordinated statewide program to address the challenge from different angles".[356]

Potential challenges

13.31 There are challenges in giving effect to the intent of the proposed recommendation, as worthy as it is. Some of these are illustrated by the evidence of Mr Jennings, Co-Chair of the Agency for Clinical Innovation Musculoskeletal Network and Director Allied Health at Liverpool Hospital, who deposed about models of care and innovation in the context of the Musculoskeletal Network.[357] Mr Jennings observed that there are particular challenges in accurately evaluating models of care and collecting and measuring patient data in circumstances where: [358]

a. models of care integrate primary and community-based care;

b. longitudinal health outcomes are supported by primary and secondary prevention; and

c. the data includes patient reported experience and outcome measures.

13.32 In this context, Mr Jennings explained that longer term monitoring of health outcomes would be assisted by making it easier to assess primary care data together with acute care hospital data.[359]

13.33 In relation to clinical trials, Professor Alexander, Director of Laboratory Research and Senior Staff Specialist at The Children's Hospital at Westmead, and Head of the Gene Therapy Research Unit at the Sydney Children's Hospitals Network and the Children's Medical Research Institute, gave evidence that most new therapies are developed overseas and enter Australia as clinical trials.[360] He cited as examples emerging gene therapy and cell

[356] Exhibit N.3.11, Statement of Nhi Nguyen (18 June 2024) [18] [MOH.0006.0036.0001 at 0004].
[357] Exhibit N.3.9, Statement of Matthew Jennings (18 June 2024) [MOH.0006.0018.0001].
[358] Exhibit N.3.9, Statement of Matthew Jennings (18 June 2024) [17]-[19] [MOH.0006.0018.0001 at 0005].
[359] Exhibit N.3.9, Statement of Matthew Jennings (18 June 2024) [21] [MOH.0006.0018.0001 at 0006].
[360] Exhibit N.3.8, Statement of Ian Alexander (17 June 2024) [8]-[12] [MOH.0006.0024.0001 at 0003-0004].

therapies, which are likely to pose challenges for the readiness of the NSW health system, which has only limited ability to manage the cost structure of such innovations.[361] Prof Alexander explained it is very difficult to prospectively evaluate the costs and benefits of clinical and technical innovations that are still in development.[362]

Other issues raised in Section 13 of Counsel Assisting's Submissions

13.34 In response to recommendations27 and 28, NSW Health makes a number of comments, set out below.

Organisational roles

13.35 The Agency for Clinical Innovation, the Office for Health and Medical Research and the Critical Intelligence Unit operate as part of the Division of Clinical Innovation and Research, which was formed in February 2023.[363]

13.36 The roles of the Office for Health and Medical Research and the Agency for Clinical Innovation are complementary but distinct, reflecting a sequential alignment in the continuum of innovation.[364] In the case of the Agency for Clinical Innovation, its function is determined by the Minister.[365]

13.37 The role of the Office for Health and Medical Research is to improve NSW's capacity to deliver world class health and medical research through facilitating engagement with industry and government stakeholders and assisting with the development of statewide strategic research priorities.[366] In addition to supporting innovation through appropriate policy frameworks, it administers funding programs "that support research infrastructure and innovation as well

[361] Exhibit N.3.8, Statement of Ian Alexander (17 June 2024) [8]-[9] [MOH.0006.0024.0001 at 0003].
[362] Exhibit N.3.8, Statement of Ian Alexander (17 June 2024) [11] [MOH.0006.0024.0001 at 0004]. A similar comment was made by Jean-Frederic Levesque at Transcript of the Commission, 26 February 2024, T1031.02.-17 (Levesque).
[363] Exhibit B.3, Statement of Jean-Frederic Levesque (30 January 2024) [6] and [10] [MOH.0001.0435.0001 at 0001-0002].
[364] Exhibit B.3, Statement of Jean-Frederic Levesque (30 January 2024) [5] [MOH.0001.0435.0001 at 0002].
[365] Exhibit B.023.048, *Agency for Clinical Innovation Determination of Functions* (21 August 2023) [MOH.0001.0345.0001].
[366] Exhibit B.3, Statement of Jean-Frederic Levesque (30 January 2024) [11] [MOH.0001.0435.0001 at 0002-0003]; see also Transcript of the Commission, 26 February 2024, T1024.38-1025.15 (Levesque).

as supporting investment in the development and commercialisation of medical devices and related technologies".[367]

13.38 In turn, the Agency for Clinical Innovation's role focuses on the assessment and adoption of innovations in clinical practice.[368] Although part of its role includes leading "the generation and use of evidence and research to catalyse, assess, adopt and evaluate innovations in clinical practice", it has only a limited role in setting research priorities.

13.39 Having regard to the structural focus of the Agency for Clinical Innovation and its limited involvement in setting research priorities, NSW Health considers that the recommendations proposed by Counsel Assisting would be more effective if they were directed to the Division of Clinical Innovation and Research rather than solely to the Agency for Clinical Innovation.

Burden of disease and/or issues of community concern

13.40 The CA Submissions suggest that innovations should be prioritised based on the burden of disease or health issues that are of primary concern to the community.[369] These community considerations should inform system innovation, but they should not be the predominant focus.

13.41 Evidence before the Special Commission demonstrates that innovation at the State and local levels may be informed by a range of considerations.[370] For example, in South Western Sydney Local Health District, relevant factors include service planning, health outcomes, patient experience, and economic efficiencies.[371] Each such factor may involve both short and long-term outcomes.

[367] Exhibit B.3, Statement of Jean-Frederic Levesque (30 January 2024) [11] [MOH.0001.0435.0001 at 0003].
[368] See Exhibit B.023.048, Agency for Clinical Innovation, *Determination of Functions* (21 August 2023) [MOH.0001.0345.0001 at 0001].
[369] CA Submissions, [1019].
[370] Exhibit N.3.9, Statement of Matthew Jennings (18 June 2024) [34]-[37] [MOH.0006.0018.0001 at 0010-0011].
[371] Exhibit N.3.9, Statement of Matthew Jennings (18 June 2024) [37] [MOH.0006.0018.0001 at 0011].

13.42 The *Agency for Clinical Innovation Strategy 2023-2026* adopts a 'pipeline of innovation' approach.[372] This is complemented by an enhanced pipeline of innovation in the upcoming NSW Health Research and Innovation Strategy, which is to be published in 2025. This will be a focus of the Division of Clinical Innovation and Research.

13.43 Criteria for the pipeline will be established to create consistency and may include disease burden as one criterion amongst many. Investment decisions consider priorities across a broad range of clinical areas and involve due consideration of the broader funding environment.

Dementia

13.44 The CA Submissions refer to the national impact of dementia and suggest that dementia is not identified as a focus for the Agency for Clinical Innovation or the Office for Health and Medical Research.[373]

13.45 The role of the Division of Clinical Innovation and Research in relation to dementia was not explored in the evidence before the Special Commission, but there was evidence that dementia remains a priority condition for NSW Health[374]. Publicly available materials (cited below) demonstrate that too.

13.46 The Agency for Clinical Innovation has produced various resources for clinicians and others working with people with dementia, including through its Aged Health Network.[375] For example, as part of a joint initiative between the Agency for Clinical Innovation and Ministry, clinical experts from across NSW came together to develop a centralised list of screening and assessment tools for clinicians caring for older people which was published in 2021. These tools

[372] Exhibit B.23.050, NSW Agency for Clinical Innovation, *Strategy 2023-2026* (2023), pp 14-15 [MOH.0001.0350.0001 at 0014-0015].
[373] CA Submissions, [1019].
[374] Transcript of the Commission, 31 November 2023, T80.06 - 11(Willcox); Exhibit A.14, *Future Health: Guiding the next decade of care in NSW 2022-2032* (May 2022) [SCI.0001.0010.0001 at 0028]; Exhibit A.49, *NSW Regional Health Strategic Plan 2022-2032* (February 2023) [MOH.0001.0372.0001 at 0046]; Exhibit B.23.094, *Clinical Services Plan 2019 – 2025*, NSW Health Pathology (2021) [MOH.0001.0384.0001 at 0077].
[375] These resources are publicly available online at https://aci.health.nsw.gov.au/networks/aged-health.

can be used to help identify cognitive and mental health needs in older people.[376]

13.47 The Commonwealth devotes very considerable resources to dementia, including in relation to dementia research. Between 2014-2019 the Commonwealth allocated $200 million to dementia research through the National Health and Medical Research Council.[377] In addition, the Medical Research Future Fund is investing $185 million over 10 years to improve outcomes for people living with dementia.[378]

13.48 The Agency for Clinical Innovation is the NSW representative on the Commonwealth's Jurisdictional Working Group for the *National Dementia Action Plan 2024-2034*. The Agency for Clinical Innovation is assessing its future approach to dementia in light of the *National Dementia Action Plan 2024-2034*, which was released in December 2024.

Innovation priorities

13.49 NSW Health does not agree that "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 economically and improve the health of many more people".[379]

13.50 There needs to be a strengthened focus on models of care, including alternative models of care, that reduce variation, support improved outcomes and experiences for patients, and deliver allocative efficiency. However, innovations that benefit small patient cohorts (such as spinal cord injury or

[376] These tools are publicly available online at https://aci.health.nsw.gov.au/networks/aged-health/resources/older-people.
[377] *National Dementia Action Plan 2024-2034*, p 77. This is publicly available online at https://www.health.gov.au/sites/default/files/2024-12/national-dementia-action-plan-2024-2034.pdf.
[378] Australian Institute of Health and Welfare, *Dementia in Australia*. An online summary of this Web Report is publicly available at https://www.aihw.gov.au/reports/dementia/dementia-in-aus/contents/national-policy-response-to-dementia#Dementia-research.
[379] CA Submissions, [1020].

paediatric rheumatology) also need to be supported, as well as research and innovation in new and emerging areas.

13.51 Insofar as the recommendations stress the need to invest in prevention, it is important to note that prevention is generally not within the remit of the Division of Clinical Innovation and Research, as models of care generally involve a focus on patients undergoing care for a clinical condition. Prevention is addressed where appropriate to support the trajectory of care. There is also a focus within models of care on alternative or conservative treatment pathways in lieu of traditional care.

13.52 It is also necessary to bear in mind that the Commonwealth is investing significant funding in preventative and public health research. In 2024, the Commonwealth announced targeted funding of $545.1 million towards research that tests innovative approaches to preventative and public health over the next ten years from 2024-25.[380]

13.53 This funding complements NSW's Prevention Research Support Program, which provides funding support for NSW research organisations conducting prevention and early intervention research that aligns with NSW Health priorities.[381] The program funding supports research infrastructure and strategies to build research capability and translate evidence from research into policy and practice.

Coordination with Clinical Excellence Commission

13.54 NSW Health does not agree that there is a lack of coordination between the Agency for Clinical Innovation and the Clinical Excellence Commission guiding where innovation is likely to have the greatest benefit in terms of risk reduction.[382]

[380] Information about the Commonwealth funding for the Preventive and Public Health Research initiative is publicly available online: https://www.health.gov.au/our-work/mrff-preventive-and-public-health-research-initiative.

[381] Exhibit N.1.3, Sax Institute Expert Report 3, *Building capabilities to drive health system improvements* (29 November 2024) [46] [SCI.0011.0605.0001 at 0011].

[382] CA Submissions, [1021].

13.55 The evidence to the Special Commission only touched upon the relationship between the two bodies.[383] However, there is publicly available material about partnerships involving the Agency and the Clinical Excellence Commission: significantly, this includes the Leading Better Value Care program,[384] which was the subject of evidence at hearing.[385] Nevertheless, there is scope to build on and enhance existing relationships and partnership work between the two agencies.

Innovation exchange

13.56 NSW Health does not agree that the use of the Innovation Exchange is *ad hoc* or that few of the published initiatives have been adopted elsewhere.[386] In the period from 1 January to 2 November 2023, there were 46,790 page views on Innovation Exchange, which points to a strong level of interest across Local Health Districts.[387] Over time, it is expected that the Innovation Exchange will increasingly encourage Local Health Districts to consider existing models of care already operating in the system, rather than creating their own from scratch.

13.57 There may be opportunities to improve the spread and scale of published innovations through the pipeline of innovation currently being operationalised.[388] The pipeline of innovation is explained in the *Agency for Clinical Innovation Strategy 2023-2026*.[389]

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[383] See, eg, Exhibit N.3.6, Statement of Trevor Chan (17 June 2024) [18] [MOH.0006.0001.0001 at 0004]. Dr Chan refers to liaison with the Clinical Excellence Commission in relation to the Emergency Care Assessment and Treatment program: in particular, how best to monitor the process and identify matters requiring clinical risk intervention; Exhibit B.23.167, *Understanding the process to develop a Model of Care, An ACI Framework* (May 2013) [MOH.0001.0283.0001 at 0008].

[384] See online at https://aci.health.nsw.gov.au/statewide-programs/lbvc.

[385] See, eg, Transcript of the Commission, 26 February 2024, T1100.41-1102.24 (Levesque).

[386] CA Submissions, [1027].

[387] Exhibit B.3, Statement of Jean-Frederic Levesque (30 January 2024) [68b] [MOH.0001.0435.0001 at 0022-0023].

[388] Exhibit B.3, Statement of Jean-Frederic Levesque (30 January 2024) [94], [110a], [113d] [MOH.0001.0435.0001 at 0034, 0038, 0041].

[389] Exhibit B.23.050, NSW Agency for Clinical Innovation, *Strategy 2023-2026* (2023), pp 14-15, [MOH.0001.0350.0001 at 0014-0015].

13.58 The CA Submissions [1049] – [1053] refer to the recommendations of the *Mid-Term Review of the National Health Reform Agreement Addendum 2020-2025, Final Report.* In this context, it is suggested that the role of the Agency for Clinical Innovation will need to be adapted to align with initiatives arising from the Mid-Term Review.[390]

13.59 The negotiations for the next addendum to the *National Health Reform Agreement* are still being undertaken and the recommendations of the *Mid-Term Review of the National Health Reform Agreement Addendum 2020-2025, Final Report* are being considered as part of this process. That said, the Agency for Clinical Innovation has positive relationships with relevant federal agencies and has developed processes for ensuring its future efforts are aligned with the expected outcomes of the *Mid-Term Review of the National Health Reform Agreement Addendum 2020-2025, Final Report*.

[390] CA Submissions, [1053].

SECTION 14: FIRST NATIONS HEALTHCARE

Preliminary matter

14.1 In these submissions, NSW Health refers to "Aboriginal health" and "Aboriginal people". This is consistent with the terminology used across its policy documents.

Counsel Assisting's recommendation 29 [1137]

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

NSW Health response to Counsel Assisting's recommendation 29

14.2 **In relation to recommendation 29, NSW Health makes a number of comments, set out below.**

14.3 Improved health outcomes for Aboriginal people are most likely to be achieved where there is a co-ordinated, whole-of-government approach to help address the social and other determinants of health.

Work underway

14.4 NSW Health has a strong focus on improving Aboriginal health outcomes and closing the gap. To this end, it has:

a. structures in place to facilitate the management and delivery of health services, including:

i. by requiring that at least one Board member of each Local Health District Board have expertise, knowledge or experience in relation to Aboriginal health;

ii. incorporating Key Performance Indicators related to Aboriginal health in service agreements for Local Health Districts and Specialty Health Networks;[391]

iii. requiring NSW Health organisations to prepare an Aboriginal Health Impact Statement in the early stages of service planning;[392] and

iv. reallocating responsibility for the Centre for Aboriginal Health so that it reports directly to the Office of the Secretary[393];

b. developed a range of policies, plans and organisational tools, including the *Aboriginal Health Plan 2024-2034* and the *NSW Aboriginal Health Governance, Shared Decision Making and Accountability Framework*;[394]

c. enhanced its programs and relationships with a range of Aboriginal communities and health organisations; and

d. implemented programs to address racism and improve cultural safety.

14.5 Many of the factors that influence population morbidity and mortality fall within what is described as the "social determinants" of health: these include housing, education, water and employment.[395] There are also individual factors such as diet, exercise, smoking and alcohol consumption.

14.6 Thus, the health gap between Aboriginal and non-Aboriginal people is significantly affected by differences in employment, income, education and

[391] Exhibit N.3.30, Joint Statement of Ashley Brown, Phillip Bannon and Nathan Jones (10 December 2024) [72] [MOH.0011.0096.0001 at 0014-0015].

[392] Exhibit E.2, *Aboriginal Health Impact Statement*, NSW Health Policy Directive PD2017_034 (29 September 2017) [SCI.0009.0019.0001]. See the sections headed "Purpose" and "Mandatory Requirements" at 0002.

[393] Exhibit N.3.30, Joint Statement of Ashley Brown, Phillip Bannon and Nathan Jones (10 December 2024) [11] [MOH.0011.0096.0001 at 0003].

[394] Exhibit N.3.30, Joint Statement of Ashley Brown, Phillip Bannon and Nathan Jones (10 December 2024) [21]-[31] [MOH.0011.0096.0001 at 0004-0006]; Exhibit N.3.31, *Aboriginal Health Plan 2024-2034* [MOH.0010.0733.0001]; Exhibit N4.11, *NSW Aboriginal Health Governance, Shared Decision Making and Accountability Framework* (27 September 2024) [MOH.0010.0740.0001].

[395] Transcript of the Commission, 15 May 2024, T2897.2-21 (Hawthorn); Exhibit A.1, *Joint Report of Nigel Lyons, Kerry Chant and Deborah Willcox* (17 November 2023) [173] [MOH.9999.0001.0001].

housing, as well as personal risk factors such as smoking, diet, physical exercise level and high blood pressure.[396]

14.7 NSW Health collaborates with other government agencies to improve service delivery for Aboriginal people. In addition to evidence about Ministry initiatives[397], the Special Commission heard evidence from, for example, the Chief Executive of Murrumbidgee Local Health District about cross-portfolio work being done with the Riverina Murray Regional Alliance: NSW Health is working with Treasury and the Department of Aboriginal Affairs to develop a business case for a health and wellbeing service with a particular focus on people with drug addiction.[398] This work is addressing one of three priority areas identified by the Riverina Murray Regional Alliance.

Potential challenges

14.8 Clearly, many of the determinants of Aboriginal health are outside the control of health services.[399] NSW Health recognises the reality that achieving a co-ordinated, whole of government approach to Aboriginal health is beyond the scope of NSW Health's programs and resources.

Counsel Assisting's recommendation 30 [1138]

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.

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396 Exhibit M.16, *Australia's Health 2024: Data Insights*, [SCI.0011.0499.0001 at 0173, 0180, 0182-0183, 0190]; Exhibit N.1.3, Sax Institute Expert Report 2, *Strengthening the focus on prevention of chronic disease through applying evidence-based insights* (29 November 2024) [19]-[22] [SCI.0011.0608.0001 at 0007].

397 Exhibit A.1, Joint Report of *Nigel Lyons, Kerry Chant and Deborah Willcox* (17 November 2023) [176(e)] [MOH.9999.0001.0001]; Exhibit A.53, *Joint Report of Alfa D'Amato and Deborah Willcox* (27 November 2023) [112]-[113] [MOH.9999.0005.0001]; Exhibit N.3.31, NSW Health, *NSW Aboriginal Health Plan 2024-2034: Sharing Power in System Reform* (October 2024) [SCI.0011.0744.0001 at 0047, 0059]; Exhibit A.59, NSW Health, *The First 2000 Days Framework* (8 February 2019) [SCI.0001.0051.0001 at 0014, 0024]; Exhibit B.23.024, NSW Health, *NSW Health Regional Health Strategic Plan 2022-2032* (February 2023) [MOH.0001.0372.0001 at 0043]; Exhibit N.30, Joint statement of Ashley Brown, Phillip Bannon and Nathan Jones (10 December 2024) [22], [24], [31], [34] [MOH.0011.0096.0001]; Exhibit N.3.29, Statement of Dr Jan Fizzell (9 December 2024) [11(c)], [11(f)] [MOH.0011.0094.0001].

398 Transcript of the Commission, 22 March 2024, T1704.34-1705.15 (Ludford).

399 Exhibit N.1.3, Sax Institute Expert Report 2, *Strengthening the focus on prevention of chronic disease through applying evidence-based insights* (29 November 2024) [SCI.0011.0608.0001 at 0012-0013].

NSW Health response to Counsel Assisting's recommendation 30

14.9 **In response to recommendation 30, NSW Health makes a number of comments, set out below.**

Work underway

14.10 There is a clear recognition across the State that improving Aboriginal health requires better collaboration and service planning between Local Health Districts and Aboriginal community organisations.[400] As the Deputy Board Chair of Southern NSW Local Health District explained:

> "We've got to remember that the critical thing that needs to be done together in relation to that is health service planning. So health service planning more generally. The Aboriginal communities need to be significantly engaged in that, and I think they are, but there is always room for improvement, and it needs to be ongoing. And they need to be particularly engaged in the provision of specific services for their Aboriginal communities."[401]

14.11 The Special Commission heard evidence about work already underway across NSW to improve collaboration with Aboriginal communities and organisations. This included evidence from Local Health Districts about how they are engaging with Aboriginal Controlled Community Health Organisations (**ACCHOs**) and other Aboriginal community bodies in relation to clinical service planning. The following are a few examples.

Far West Local Health District

14.12 Far West Local Health District has been engaging at Board level with local ACCHOs to work on service planning[402] and has an *Aboriginal Health Framework*.[403] It also consults regularly with the Aboriginal community working parties under the Murdi Paaki Regional Assembly to develop community action

[400] Exhibit N.3.30, Joint Statement of Ashley Brown, Phillip Bannon and Nathan Jones (10 December 2024) [42] [MOH.0011.0096.0001]; Exhibit N.3.31, *Aboriginal Health Plan 2024-2034* [MOH.0010.0733.0001 at 0016].
[401] Transcript of the Commission, 16 August 2024, T5054.7-15 (Clout).
[402] Transcript of the Commission, 23 May 2024, T3258.14-39 (Pearce).
[403] Exhibit E.31, *Far West Local Health District Aboriginal Health Framework 2021* [SCI.0009.0011.0001].

plans for each town within the Local Health District.[404] In turn, the Local Health District consults with other community organisations, such as Local Health Advisory Councils, to ensure that it receives a range of Aboriginal perspectives.[405]

14.13 This has already led to changes in service planning for local Aboriginal communities within the Local Health District. In particular, the Special Commission heard evidence that work with community members in Wilcannia has led to the development of a new dialysis service which not would otherwise have been established.[406]

Mid North Coast Local Health District

14.14 Mid North Coast Local Health District has an *Aboriginal Health Strategic Framework 2024 – 2034*.[407] Collaborations at Mid North Coast Local Health District include Chronic Care Program in Kempsey with the Durri Aboriginal Medical Service and the Primary Health Network. The Local Health District's Director Integrated Care, Allied Health and Community Services explained the program in her statement:

> "There has been active partnership with Durri AMS [Aboriginal Medical Service] and the PHN [Primary Health Network] to ensure that there is proactive collaboration, engagement in a number of community engagement programs focused on health and wellbeing, as well as regular clinical meetings to coordinate clinical care for shared patients and their families. It has taken time and work to reduce structural and systemic barriers arising through various funding streams across MNC Local Health District [Mid North Coast Local Health District], AMS and PHN to work cohesively for our community."[408]

14.15 The program supports patients with chronic disease in a seamless way so that they do not need to navigate their interactions with three different systems

[404] Transcript of the Commission, 23 May 2024, T3330.21-31 (Astill); T3332.31-37 (Astill); T3333.12-16 (Astill); Exhibit F.22, Outline of Evidence of Justin Files (undated) [14] [MOH.9999.1262.0001].
[405] Transcript of the Commission, 23 May 2024, T3331.16-26 (Astill).
[406] Transcript of the Commission, 23 May 2024, T3334.5-17 (Astill).
[407] Exhibit K.21, *Darrundaygirr darruyaygam maabu-daariwaygam Girrwaanbigundi, Improving the health and wellbeing of Aboriginal People, Aboriginal Health Strategic Framework 2024 - 2034* (2024) [SCI.0011.0414.0001].
[408] Exhibit K.52, Statement of Jill Wong (6 September 2024) [28] [MOH.0011.0061.0001 at 0007].

(general practice, Aboriginal Medical Service and the Local Health District); instead, clinicians work together based on who is best placed to take the lead in relation to particular aspects of a patient's care.[409] Anecdotal feedback indicates that the program provides a positive or more seamless experience for patients than does accessing services in the usual way.[410]

Southern NSW Local Health District

14.16 Southern NSW Local Health District has a broad partnership with the Katungul Aboriginal Corporation across a range of clinical areas, such as immunisation, otitis media and breast screening.[411] The Chief Executive of Katungul Aboriginal Corporation is a member of the Board sub-committee in relation to Aboriginal Health.

14.17 In addition, the Local Health District has been working with Katungul Aboriginal Corporation in relation to the development of a new "Birthing on Country" model of care for birthing services at the Eurobodalla Regional Hospital.[412]

Western NSW Local Health District

14.18 Western NSW Local Health District has an *Improving Aboriginal Health Strategy 2018 – 2023.*[413] Since 2022, Western NSW Local Health District has also been implementing a Meaningful Engagement program, which operates at three levels of engagement (local or place-based; sub-regional; and organisational). The two sub-regional committees are of particular relevance for Aboriginal people and have links respectively to the Three Rivers and Murdi Paaki Regional Assemblies.

14.19 The two committees have been established to have a key role in co-design of solutions to challenges for health services into the future. There has been

[409] Transcript of the Commission, 18 September 2024, T5312.37-5313.24 (Wong).
[410] Transcript of the Commission, 18 September 2024, T5313.20-24 (Wong).
[411] Transcript of the Commission, 16 August 2024, T5093.34-5094.1 (Bennett).
[412] Transcript of the Commission, 16 August 2024, T5093.39-5093.44 (Bennett); see also Exhibit I.34, Statement of Rebekah Bowman (7 August 2024) [26] [MOH.0011.0045.0001 at 0006].
[413] Exhibit E.13, *Western NSW Local Health District, Improving Aboriginal Health Strategy, 2018 – 2023* (2018) [SCI.0009.0037.0001].

strong participation and engagement by members, and the initiation of local projects in specific communities arising from the committee priorities.[414] Aboriginal members make up about 50 per cent of the committees.[415]

Potential challenges

14.20 As service planning typically happens at the Local Health District level, in practice there can be variable outcomes in terms of prioritisation of Aboriginal health and engagement with Aboriginal communities and stakeholders. Local Health Districts typically have their own Aboriginal Health Plans, but such plans are not always current and there are sometimes delays in updating them.[416]

14.21 Even where there is collaboration, there may be different perceptions of how the relationship is working. During his evidence to the Special Commission, the Chief Executive of Western NSW Local Health District, reflected on the evidence of the Murdi Paaki representatives and summarised the challenge in this way:

> "I absolutely do not wish to reject the testimony that was heard, because, as you will know from any other court process, you can have two witnesses to an event who have entirely different views of what actually occurred as a matter of fact, and my responsibility as chief executive, and I think the health system's responsibility, is not only to open the door so that people can have a voice, but when they speak, to listen, rather than refute."[417]

14.22 Collaboration needs to be embedded so that it becomes more consistent across the health system and less dependent on personalities. The *NSW Health Aboriginal Governance, Shared Decision Making and Accountability Framework* is expected to contribute significantly to this process.[418] This

[414] Exhibit E.45, Outline of Evidence of Maryanne Hawthorn (30 April 2024) [15] [MOH.9999.1196.0001 at 0003]; see also Transcript of the Commission, 15 May 2024, T2885.30-33 (Hawthorn); Transcript of the Commission, 16 May 2024, T2986.37-2987.8 (Spittal).

[415] Transcript of the Commission, 16 May 2024, T2984.25-28 (Spittal).

[416] Exhibit N.3.30, Joint Statement of Ashley Brown, Phillip Bannon and Nathan Jones (10 December 2024) [42] [MOH.0011.0096.0001 at 0008].

[417] Transcript of the Commission, 16 May 2024, T2986.22-35 (Spittal).

[418] Exhibit N.3.30, Joint Statement of Ashley Brown, Phillip Bannon and Nathan Jones (10 December 2024) [29]-[30] [MOH.0011.0096.0001 at 0006]; Exhibit N4.11, *NSW Aboriginal Health Governance, Shared Decision Making and Accountability Framework* (27 September 2024) [MOH.0010.0740.0001].

framework was developed in partnership with the Aboriginal Health and Medical Research Council of NSW and is based on an extensive consultation and co-design process over a three-year period with Aboriginal and non-Aboriginal people across NSW.

Counsel Assisting's recommendation 31 [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;*

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.*

NSW Health response to Counsel Assisting's recommendation 31

14.23 **In response to recommendation 31a and 31c, NSW Health makes a number of comments, set out below**.

14.24 **NSW Health identifies issues with recommendation 31b, as set out below**.

14.25 Flexibility must be accompanied by agreed outcomes and measures to ensure accountability within the context of planned services developed in collaboration.

Work underway

14.26 In relation to recommendation 31a, the *Aboriginal Health Plan 2024-2034* recognises that the Aboriginal Community Controlled Health sector needs

stable, equitable, and long-term funding so that organisations can operate in a financially and logistically sustainable manner.[419]

14.27 Ministry provides recurrent grant funding to ACCHOs through the Ministerially Approved Grant program.[420] The majority of this funding has not been increased substantially over time apart from Consumer Price Index increases and the inclusion of a small number of new ACCHO providers. Advantages of this recurrent model are certainty of ongoing funding and sustainability.

14.28 NSW Health also provides program funding to ACCHOs through programs for Alcohol and Other Drugs, Mental Health, Child and Maternal Health and Oral Health.[421] The Centre for Aboriginal Health has recently been working with other branches of Ministry to ensure that there are quarantined ACCHO grant funding opportunities across all new relevant programs.[422]

14.29 In relation to recommendation 31c, NSW Health is aware of the need to address this issue and is seeking to do this by adopting less rigid Key Performance Indicators that are outcome-focussed and avoiding withdrawal of services when there are challenges related to meeting such indicators.[423]

14.30 In recognition of the rigidity of some government funding and reporting requirements, the Centre for Aboriginal Health is intending to negotiate more flexibility with the ACCHOs in relation to program delivery and scope for the next funding agreement cycle commencing in July 2025.[424]

[419] Exhibit N.3.31, *Aboriginal Health Plan 2024-2034* (October 2024) p 18 [SCI.0011.0744.0001 at 0022].
[420] Exhibit N.3.30, Joint Statement of Ashley Brown, Phillip Bannon and Nathan Jones (10 December 2024) [65] [MOH.0011.0096.0001 at 0013].
[421] Exhibit N.3.30, Joint Statement of Ashley Brown, Phillip Bannon and Nathan Jones (10 December 2024) [66] [MOH.0011.0096.0001 at 0013].
[422] Exhibit N.3.30, Joint Statement of Ashley Brown, Phillip Bannon and Nathan Jones (10 December 2024) [90] [MOH.0011.0096.0001 at 0018].
[423] Exhibit N.3.30, Joint Statement of Ashley Brown, Phillip Bannon and Nathan Jones (10 December 2024) [84] [MOH.0011.0096.0001 at 0017].
[424] Exhibit N.3.30, Joint Statement of Ashley Brown, Phillip Bannon and Nathan Jones (10 December 2024) [85] [MOH.0011.0096.0001 at 0017].

Potential challenges

14.31 Grant funding may have difficulty in keeping up with demographic shifts in some regions, particularly due to population growth or emerging health priorities.[425] Aboriginal organisations can face challenges in addressing the needs of their communities when they have large transient populations and health priorities can shift from month to month.[426]

14.32 Additionally, not all ACCHOs receive funding for each program. Decisions as to which ACCHO receives funding for a particular program reflect an historical funding arrangement that has not kept up with emerging need or demographic trends.[427]

Reasons

14.33 In relation to recommendation 31b, funding of health services needs to take account of local circumstances and the strengths and capabilities of different organisations delivering services in the community.

14.34 While ACCHOs should be the *preferred* service delivery provider for most programs or services that are primarily for Aboriginal people, mainstream providers could be enabled to offer a culturally safe and responsive service option for Aboriginal clients who choose not to attend ACCHOs or are unable to access ACCHOs for geographical or other reasons.[428] Creating a presumption that Aboriginal healthcare funding within mainstream services ought to be re-directed to ACCHOs may hinder improvements to the delivery of culturally safe and responsive services for Aboriginal people.

14.35 Any process of the type contemplated by the recommendation would require Commonwealth involvement to implement.

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[425] Exhibit N.3.30, Joint Statement of Ashley Brown, Phillip Bannon and Nathan Jones (10 December 2024) [65] [MOH.0011.0096.0001 at 0013].
[426] Exhibit N.2.3, Transcript of the Commission (27 November 2024) T6639.31-6640.7 (Simon).
[427] Exhibit N.3.30, Joint Statement of Ashley Brown, Phillip Bannon and Nathan Jones (10 December 2024) [66] [MOH.0011.0096.0001 at 0013].
[428] Exhibit N.3.30, Joint Statement of Ashley Brown, Phillip Bannon and Nathan Jones (10 December 2024) [89] [MOH.0011.0096.0001 at 0018].

Counsel Assisting's recommendation 32 [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.

NSW Health response to Counsel Assisting's recommendation 32

14.36 **In response to recommendation 32, NSW Health makes a number of comments, set out below.**

14.37 NSW Health acknowledges that the streamlining and rationalisation of reporting requirements for ACCHOs would be beneficial. However, as the majority of funding for primary care ACCHOs is provided by the Commonwealth [429], any such process is unlikely to significantly assist ACCHOs unless the Commonwealth is involved.

Work underway

14.38 Evidence from the Centre for Aboriginal Health highlights the substantial work being undertaken by the Centre, including in relation to ACCHOs. [430] It identifies measures that have been taken to reduce the reporting burden on New South Wales ACCHOs, such as by accepting national Key Performance Indicators that the ACCHOs are already using in their reporting to the Commonwealth Department of Health and Aged Care. [431]

14.39 The Centre for Aboriginal Health is planning further amendments to improve reporting requirements in the upcoming NSW Health agreement negotiations commencing 1 July 2025.

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[429] Exhibit N.3.30, Joint Statement of Ashley Brown, Phillip Bannon and Nathan Jones (10 December 2024) [62]-[64] [MOH.0011.0096.0001 at 0013].

[430] Exhibit N.3.30, Joint Statement of Ashley Brown, Phillip Bannon and Nathan Jones (10 December 2024) [MOH.0011.0096.0001].

[431] Exhibit N.3.30, Joint Statement of Ashley Brown, Phillip Bannon and Nathan Jones (10 December 2024) [84] [MOH.0011.0096.0001 at 0017].

Potential challenges

14.40 NSW Health is open to reforming reporting requirements in a way that maintains accountability for public funds. However, as noted above, such reform requires Commonwealth involvement to make a meaningful difference to ACCHOs.

Counsel Assisting's recommendation 33 [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.

NSW Health response to Counsel Assisting's recommendation 33

14.41 **In response to recommendation 33, NSW Health makes a number of comments, set out below.**

Work underway

14.42 The importance of a strong Aboriginal workforce is recognised in the *NSW Aboriginal Health Plan 2024-2034*.[432] This supports "improved cultural safety, holistic approaches to the cultural and social determinants of health, [and] stronger relationships of trust between patients and health organisations and delivers better outcomes for Aboriginal people".[433]

14.43 NSW Health has implemented initiatives to enhance its Aboriginal workforce across the State and at all levels of the health system. This has led to an increase in the proportion of the workforce that identifies as Aboriginal. However, further work is required to achieve the 3.43 per cent target set under

[432] Exhibit N.3.31, *NSW Aboriginal Health Plan 2024-2034* (October 2024), [SCI.0011.0744.0001 at 0032-0035].
[433] Exhibit N.3.31, *NSW Aboriginal Health Plan 2024-2034* (October 2024) [SCI.0011.0744.0001 at 0032].

the *National Aboriginal and Torres Strait Islander Health Workforce Strategic Framework and Implementation Plan 2021-2031*.[434]

14.44 Such initiatives include targeted programs to encourage Aboriginal people into clinician roles: for example, the Aboriginal Medical Pathways program for Aboriginal doctors in rural areas[435], the Aboriginal Nursing and Midwifery Strategy[436], and the Aboriginal Allied Health Cadetship program.[437] Significantly, the Aboriginal nursing and midwife workforce has grown from 847 full-time equivalents in 2019 to 1178 full-time equivalents in 2023.[438]

14.45 Such programs are often supported by scholarships, such as the NSW Health Aboriginal Nursing and Midwifery Undergraduate Scholarships, Aboriginal Enrolled Nurse to Registered Nurse Scholarships, and the Aboriginal Rural Allied Health University Student Scholarships.[439]

14.46 The Special Commission heard from Local Health Districts who are collaborating with ACCHOs to improve the Aboriginal workforce in areas of need: for example, Western NSW Local Health District has been working with Aboriginal Medical Services and the Mental Health Commission in Coonabarabran and Gilgandra to pilot mental health peer navigators.[440] The Local Health District is looking to establish at least seven full-time equivalents in local communities with funded positions.

Potential challenges

14.47 There is opportunity for greater collaboration and coordination between it and the ACCHO sector in relation to workforce issues. This is needed to promote optimal use of scarce resources, such as where sharing resources would facilitate the creation of full-time positions.

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[434] Exhibit N.3.30, Joint Statement of Ashley Brown, Phillip Bannon and Nathan Jones (10 December 2024) [49]-[53] [MOH.0011.0096.0001 at 0010-0011].
[435] Exhibit A.14, *Future Health: Guiding the next decade of care in NSW 2022-2032* (May 2022) [SCI.0001.0010.0001 at 0042].
[436] Exhibit H.5.10, Statement of Jacqui Cross (8 July 2024) [47]-[54] [MOH.0011.0007.0001 at 0010-0011].
[437] Exhibit A.49, *NSW Regional Health Strategic Plan 2022-2032* (February 2023) [MOH.0001.0372.0001 at 0025].
[438] Exhibit H.5.10, Statement of Jacqui Cross (8 July 2024) [48] [MOH.0011.0007.0001 at 0010-0011].
[439] Exhibit H.5.21, Statement of Richard Griffiths (16 July 2024) [87d], [87e], [87k] [MOH.0011.0022.0001 at 0025-0026].
[440] Transcript of the Commission, 15 May 2024, T2811.5-36 (McFarlane).

14.48 NSW Health is seeking to expand its Aboriginal clinician workforce. It currently has less than half of the Aboriginal Health Practitioners it needs.[441] Aboriginal Health Practitioners have training equivalent to an Enrolled Nurse. Significant work is required across the system to increase the uptake of Aboriginal Health Practitioners in a range of settings and ensure those employed in these positions utilise their full clinical scope of practice. A Ministry-led working group has been established to support the promulgation of Aboriginal Health Practitioner roles in both Aboriginal health and mainstream settings.[442]

14.49 Even where funding is available, existing programs do not always achieve the desired uptake among potential Aboriginal employees: for example, the Northern NSW Local Health District has had difficulty in attracting applicants for its Aboriginal nursing and midwifery cadetship, notwithstanding that the program is well advertised.[443]

Other issues raised in Section 14 of Counsel Assisting's Submissions

14.50 There are some matters raised in the CA Submissions that NSW Health considers require further clarification or response. These are addressed below.

Racism and cultural safety

14.51 CA Submissions [1075] suggest that the *NSW Aboriginal Health Plan 2024-2034* does not identify what actions are to be taken if substantiated instances of racism occur within the system. CA Submissions [1076] also note that the *Mid-Term Evaluation of the Aboriginal Health Plan 2013-2023* recommended further actions to address racism but suggest that it is "somewhat unclear" to what extent these were implemented.

14.52 In this regard, CA Submissions do not reference the broader context and thus may convey the incorrect impression that NSW Health's response to issues of

[441] Exhibit N.3.30, Joint Statement of Ashley Brown, Phillip Bannon and Nathan Jones (10 December 2024) [57] [MOH.0011.0096.0001 at 0011].
[442] Exhibit N.3.30, Joint Statement of Ashley Brown, Phillip Bannon and Nathan Jones (10 December 2024) [57] [MOH.0011.0096.0001 at 0011].
[443] Transcript of the Commission, 17 September 2024, T5250.21-31 (Richter); Exhibit K.36, Statement of Jennifer Richter (5 September 2024) [21] [MOH.0011.0056.0001 at 0005].

racism and cultural safety is uncertain and half-hearted. The opposite is true. This is discussed further below.

14.53 Progress has been made. While the *Mid-Term Evaluation of the NSW Aboriginal Health Plan 2012-2023* noted overall moderate progress against Strategic Direction 5 (Cultural safety in health settings), it also noted clear 'areas of success' in specific areas of implementation. These included: [444]

a. implementation of mandatory Aboriginal cultural safety training for all staff;

b. increasing numbers of NSW Health staff identifying as Aboriginal;

c. more Aboriginal staff in higher paid roles; and

d. a reduction in the rate of incomplete emergency department visits among Aboriginal patients.

14.54 The *Mid-Term Evaluation* also observed that some 89 per cent of Aboriginal patients rated their hospital care as either good or very good overall. [445] However, NSW Health accepts that much work still needs to be done to eliminate all forms of racism from the health system.

14.55 There was evidence before the Special Commission in relation to issues of racism and cultural safety. A Joint Statement of Ms Brown, Director of the Centre for Aboriginal Health, Mr Jones, Associate Director of the Centre for Aboriginal Health and Mr Bannon, Director of the Centre for Aboriginal Health[446] canvassed initiatives in this area and was tendered. The witnesses were not called. The Joint Statement is not referred to in CA Submissions.

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[444] Exhibit E.1, *Mid-Term Evaluation of the NSW Aboriginal Health Plan 2013-2023* (May 2019) [SCI.0009.0020.0001 at 0093].

[445] Albeit based on 2014 data: Exhibit E.1, *Mid-Term Evaluation of the NSW Aboriginal Health Plan 2013-2023* (May 2019) [SCI.0009.0020.0001 at 0077]. See also Exhibit M.1.10, *Experiences of adults admitted to hospital in 2023* (August 2024), p. 12: [SCI.0011.0525.0001 at 0012].

[446] Exhibit N.3.30, Joint Statement of Ashley Brown, Phillip Bannon and Nathan Jones (10 December 2024) [MOH.0011.0096.0001].

14.56 The Joint Statement provides a useful overview of the current work being undertaken by the Centre for Aboriginal Health and Ministry in relation to racism and cultural safety.[447]

14.57 Importantly, Ministry is currently leading the development of a NSW Health Racism and Accountability Framework designed to comprehensively identify, quantify and address interpersonal and institutional racism within the NSW Health system.[448] This project will include reviewing, strengthening and developing new incident management, complaint and human resources policies, procedures and processes to ensure that instances of racism and discrimination are managed in ways that are appropriate, timely, culturally safe, and contribute to continual quality improvement.

14.58 NSW Health acknowledges that the health system's response to racism needs to be stronger and better coordinated: it anticipates the Racism and Accountability Framework will provide a comprehensive, unified approach to managing racism across and throughout the system.

14.59 Other measures include:[449]

a. initial scoping for the development of a system-wide cultural safety audit tool;

b. the proposed establishment of a NSW Health Incident Management Cultural Council to assess incidents and make recommendations to support culturally safe service delivery and improvements to organisational culture;

c. the development of the Aboriginal Cultural Engagement Self-Assessment Tool, an annual continuous quality improvement mechanism for Local Health Districts and Specialty Health Networks to quantify, monitor and

[447] Exhibit N.3.30, Joint Statement of Ashley Brown, Nathan Jones and Phillip Bannon (10 December 2024) [92]-[96], [MOH.0011.0096.0001 at 0019-0020].
[448] Exhibit N.3.30, Joint Statement of Ashley Brown, Nathan Jones and Phillip Bannon (10 December 2024) [96a], [MOH.0011.0096.0001 at 0020].
[449] Exhibit N.3.30, Joint Statement of Ashley Brown, Nathan Jones and Phillip Bannon (10 December 2024) [96b]-[96d] [MOH.0011.0096.0001 at 0020].

improve the cultural and clinical safety of their facilities and services for Aboriginal patients.

14.60 Instances of racism are managed in line with NSW Health policies. Depending on the nature and severity of an incident, possible issues of racism are currently managed under a variety of pathways, including through the ims+ Incident Management System, the *Incident Management Policy* [450], the *Managing Misconduct Policy*[451], the *NSW Health Code of Conduct*[452], and the *Prevention and Management of Bullying in NSW Health*. [453] Both the *Prevention and Management of Workplace Bullying* and *Managing Misconduct* Policy Directives are under review.

14.61 NSW Health's Code of Conduct is being updated to expressly include a zero-tolerance approach to racism. This will improve the ability of NSW Health organisations to respond strongly to incidents of racism committed by staff.

14.62 Other interim measures may be needed before the Racism and Accountability Framework is finalised. Implementation planning for the *Aboriginal Health Plan* will help identify areas of need and possible interventions that may be required. In addition, a gaps analysis is to be undertaken for the Racism and Accountability Framework.

14.63 The Racism and Accountability Framework builds on other key policies launched in the second half of 2024, including the *Reconciliation Action Plan*, the *Aboriginal Health Plan 2024-2034*, and the *Aboriginal Health Governance, Shared Decision Making and Accountability Framework*.

Respecting the Difference Training

[450] Exhibit D.1.34, *Incident Management*, NSW Health Policy Directive PD2020_047 (14 December 2020) [MOH.9999,0803.0001].
[451] Exhibit B.23.119, *Managing Misconduct*, NSW Heath Policy Directive PD2018_031 (7 September 2018) [MOH.0001.0391.0001].
[452] Exhibit B.23.030, *NSW Health Code of Conduct,* NSW Health Policy Directive PD2015_049 (16 December 2015) [MOH.0001.0146.0001].
[453] Exhibit H.3.42, *Prevention and Management of Bullying in NSW Health,* NSW Health Policy Directive PD2021_030 (3 August 2021) [MOH.0002.0087.0001].

14.64 CA Submissions [1080] question whether addressing racism and unconscious bias through "Respecting the Difference" training is a sufficient response to real barriers to access experienced by Aboriginal people. CA Submissions [1081] also query whether there is any monitoring of the effectiveness of such training.

14.65 NSW Health acknowledges that racism presents an ongoing and significant barrier to accessing care, especially when it contributes to adverse events for Aboriginal patients. These events profoundly affect Aboriginal communities and contribute to Aboriginal people feeling that they may not be provided with safe, high quality or culturally appropriate care.

14.66 Completion of "Respecting the Difference" training, both online and face to face, is mandatory for all NSW Health employees.[454] It is an important strategy to increase cultural awareness of all staff. However, as might be clear from the above submissions, "Respecting the Difference" training is just one part of a comprehensive response to racism that is being progressed by NSW Health. Other measures include:

a. Ongoing initiatives undertaken by Local Health Districts and Specialty Health Networks to improve organisational culture through training, leadership programs and quality improvement. Employee experiences of racism are also monitored via the annual People Matters Employee Survey.[455]

b. Development by Ministry of a package for leaders called "Lead the Difference"[456] in addition to a review of the structure, resources and method of delivery of "Respecting the Difference" training. This is an

[454] Exhibit E.4, *Aboriginal Cultural Training – Respecting the Difference*, NSW Health Policy Directive PD2022_028 (15 July 2022) [SCI.0009.0017.0001]; See also, Exhibit H.3.45, Aboriginal Cultural Training – Respecting the Difference (15 July 2022) [MOH.0010.0312.0001], Exhibit K.64, Aboriginal Cultural Training – Respecting the Difference, NSW Health Policy Directive PD2022_028 (15 July 2022) [MOH.0010.0644.0001].

[455] Exhibit H.7.12.55, *NSW People Matter Employee Surgery 2023* [SCI.0012.0003.0001 at 0003].

[456] Exhibit H2.29, *NSW Health Talent Strategy 2022-2032* (July 2022) [MOH.0010.0271.0001 at 0028].

extension learning package to support people leaders to enact change in culture and behaviour in the workplace.

c. The establishment, in June 2024 by the Clinical Excellence Commission, of an Aboriginal and Torres Strait Islander Patient and Community Serious Incident Review subcommittee to the Clinical Risk Action Group, which is the peak safety and quality committee responsible for assessing and responding to serious clinical adverse events. Consistently with its terms of reference[457], the new subcommittee will review serious clinical incidents involving Aboriginal people and provide advice on statewide safety risks and process improvements. This will help to address racism as a contributing factor to adverse events, rebuild community trust after such incidents and improve cultural safety in NSW Health services. The subcommittee had its first meeting in late October 2024.

d. The NSW Aboriginal Health Dashboard, which provides an annual snapshot of key measures reflecting the response of Local Health Districts and Specialty Health Networks to the health needs of local Aboriginal communities.[458] Such dashboards are shared with the Aboriginal Health and Medical Research Council of NSW and individual ACCHOs.

Planning and funding services with ACCHOs

14.67 The CA Submissions highlighted evidence that was critical of various aspects of the relationship between the health system and ACCHOs. The criticisms contend:

a. a lack of local planning of services and facilities with ACCHOs;[459]

[457] Exhibit N4.9, Terms of Reference, Aboriginal and Torres Strait Islander Patient and Community Serious Incident Review (SIR) Sub-Committee (3 July 2024) [MOH.0010.0757.0001].
[458] Exhibit N.3.31, *Aboriginal Health Plan 2024-2034* (October 2024) [SCI.0011.0744.0001 at 0055].
[459] CA Submissions, [1088]-[1089].

b. uncoordinated collaboration at a clinical service level, which tends to be based on the willingness of individuals to work together;[460]

c. ACCHOs lack autonomy to pool their resources or reallocate them in ways that would better reflect community priorities;[461]

d. ACCHOs receive little funding for health promotion and preventive care;[462]

e. reporting requirements for funding are onerous, taking up resources that could be put to better use;[463]

f. the targets and performance indicators ACCHOs are required to report against focus on outputs and there is no reporting on outcomes.[464]

14.68 The criticisms are not without foundation and reflect the perspectives of some witnesses who gave evidence to the Special Commission. However, the Special Commission heard other perspectives, including those provided by the witnesses from the Centre for Aboriginal Health referred to above.

14.69 NSW Health acknowledges that the prioritisation of Aboriginal health and engagement with Aboriginal communities varies across Local Health Districts [465] and that further work is required to ensure more meaningful partnerships between ACCHOs and Local Health Districts. However, as might be clear from the response to recommendation 30 above, a number of Local Health Districts are already moving in this direction.

14.70 It is important that ACCHOs and Local Health Districts work collaboratively to develop integrated service models, share resources and workforce, and create pathways that support access to priority services for Aboriginal people. There are examples of where this is already occurring: South Western Sydney Local

[460] CA Submissions, [1090].
[461] CA Submissions, [1101].
[462] CA Submissions, [1101].
[463] CA Submissions, [1108].
[464] CA Submissions, [1109].
[465] Exhibit N.3.30, Joint Statement of Ashley Brown, Nathan Jones and Phillip Bannon (10 December 2024) [42], [MOH.0011.0096.0001 at 0008].

Health District and Tharawal Aboriginal Medical Service have a well-established partnership model that enables integrated service models, collaborative population health initiatives, mechanisms to support service coordination, planning and engagement in Local Health District governance structures.[466]

14.71 The recently launched *NSW Health Aboriginal Governance, Shared Decision Making and Accountability Framework* is intended to facilitate the development, maintenance and monitoring of shared decision-making and genuine partnership across NSW Health, and between NSW Health organisations and the community-controlled sector. While leadership and personal dynamics will always be important, embedding collaboration at a system level is intended to make such collaboration less dependent on personalities.

14.72 NSW Health considers that there are opportunities to increase investment in preventative care and health promotion, including by improving collaboration between Local Health Districts and ACCHOs. Such collaboration can build on existing Aboriginal Health Promotion and Prevention programs including the Knockout Challenge and Aboriginal Go 4 Fun programs.[467]

14.73 As noted in its response to recommendation 32 above, NSW Health has already been working to reduce the burden of financial reporting for ACCHOs.[468] It accepts the Commonwealth Department of Health and Aged Care Key Performance Indicators for most reporting requirements for ACCHOs and this has significantly reduced duplication of staff time and resources.[469] These indicators primarily measure activity data or 'outputs' and the Centre for Aboriginal Health acknowledges that reporting on medium to longer term

[466] Exhibit N.3.3N.0, Joint Statement of Ashley Brown, Nathan Jones and Phillip Bannon (10 December 2024) [48] [MOH.0011.0096.0001 at 0010].
[467] Exhibit N.3.30, Joint Statement of Ashley Brown, Nathan Jones and Phillip Bannon (10 December 2024) [41] [MOH.0011.0096.0001 at 0008].
[468] Exhibit N.3.30, Joint Statement of Ashley Brown, Nathan Jones and Phillip Bannon (10 December 2024) [83]-[84] [MOH.0011.0096.0001 at 0017].
[469] Exhibit N.3.30, Joint Statement of Ashley Brown, Nathan Jones and Phillip Bannon (10 December 2024) [84] [MOH.0011.0096.0001 at 0017].

outcomes is to be preferred for assessing and monitoring service performance.[470]

Aboriginal Health Plan

14.74 The CA Submissions take issue with certain aspects of the *Aboriginal Health Plan 2024-2034*, *viz* that:

a. many of the issues identified in the previous *Aboriginal Health Plan* and mid-term evaluation have been carried over into the new plan for 2024-2034;[471]

b. the new plan does not allocate specific responsibilities for achieving the identified strategies and there is to be a separate implementation plan;[472]

c. it is not known what funding will be provided to support implementation.[473]

14.75 However, there are important matters of context, explained below, not recognised in the CA Submissions.

14.76 Evidence provided by the Centre for Aboriginal Health gives an overview of the significant steps taken by NSW Health to elevate Aboriginal health across the system and provide better opportunities for Aboriginal people to lead and inform the work being undertaken.[474] This has included establishing a peak NSW Aboriginal Health Transformation Committee, creating an Executive Director for Aboriginal Health with a direct reporting line to the Secretary, and elevating the roles of Directors of Aboriginal Health into Local Health District executive leadership teams across the system.

[470] Exhibit N.3.30, Joint Statement of Ashley Brown, Nathan Jones and Phillip Bannon (10 December 2024) [71]-[73] [MOH.0011.0096.0001 at 0014-0015].
[471] CA Submissions, [1121].
[472] CA Submissions, [1122].
[473] CA Submissions, [1123].
[474] Exhibit N.3.30, Joint Statement of Ashley Brown, Nathan Jones and Phillip Bannon (10 December 2024) [11]-[20] [MOH.0011.0096.0001 at 0003-0004].

14.77 As explained in the Joint Statement, the purpose of the *Aboriginal Health Plan* is twofold:[475]

> "Firstly, it is to focus on sharing power that comes from self-determination and influence, enabling Aboriginal people to make the decisions that impact their health and wellbeing. Secondly, to drive system change by guiding how health systems are planned, delivered and monitored, drive shared decision making, be culturally responsive and safe to achieve health equity and eliminate racism in all aspects of health care."

14.78 The Centre for Aboriginal Health and Ministry have commenced the process for development of an Implementation Plan to cover the period July 2025 to July 2027.[476]

14.79 This is intentionally a separate process, as the *Aboriginal Health Plan* is necessarily a high-level document with a strategic focus across the entire health system. Having a separate Implementation Plan will allow greater opportunity to capture more finely detailed actions, including local solutions. The Implementation Plan will be accompanied by a measurement framework.[477]

14.80 However, NSW Health is not waiting for the Implementation Plan to begin further work on improving Aboriginal health outcomes. There is ongoing work now across NSW to improve outcomes in partnership with the Aboriginal community-controlled sector.

14.81 As to consequences for "failing to act", there are robust accountability measures to monitor performance across the system. This includes quarterly performance reporting by Local Health Districts to Ministry and associated meetings to address any risks.

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[475] Exhibit N.3.30, Joint Statement of Ashley Brown, Nathan Jones and Phillip Bannon (10 December 2024) [23] [MOH.0011.0096.0001 at 0005].
[476] Exhibit N.3.30, Joint Statement of Ashley Brown, Nathan Jones and Phillip Bannon (10 December 2024) [25] [MOH.0011.0096.0001 at 0005].
[477] Exhibit N.3.30, Joint Statement of Ashley Brown, Nathan Jones and Phillip Bannon (10 December 2024) [25] [MOH.0011.0096.0001 at 0005].

ANNEXURE: TABLE OF FACTUAL CORRECTIONS

Paragraph in CA submissions	Error	Correction
[2]	13 January 2024	13 November 2024
[53], Section 4.5	Organisation chart in [53] and description of Health Administration Corporation entities in Section 4.5 do not refer to the Single Digital Patient Record Implementation Authority established in May 2024.	See organisational chart at Exhibit N.3.27, *NSW Health Annual Report 2023-24* [SCI.0011.0717.0001] which includes the Single Digital Patient Record Implementation Authority at 0016, 0013 and 0166
[19], [536]	John Hunter Childrens Hospital	John Hunter Children's Hospital
[19], [151](f), [189], [193], [194], [196] [532], [536] (also footnotes)	Sydney Childrens Hospital Network or Sydney Children's Hospital Network	Sydney Children's Hospitals Network
[65]	Mental Health Visitors Program	Mental Health Official Visitors Program
[74]	The Ministry of Health organisational chart at [74] is no longer current	The current organisation chart of Ministry of Health is linked here
[91]	NSW Health Pathology was established in 2019	NSW Health Pathology was established in 2012 See Exhibit B.10, Statement of Vanessa Janissen (28 February 2024), at [6] [MOH.9999.0008.0001]
[106]	[HI] has the following core functions … (d) To support and oversee asset management by public health organisations	HI no longer has the function identified in (d).
[148], [495]	Intensive Care Services – adult [148] Adult Intensive Care Units [495(a)]	Intensive Care services – adult (selected). Selected Adult Intensive Care Units. Not all adult ICU services are supra-LHD, selected ones are identified in the Service Agreement
[189]	The St Vincent's Health Network is also referred to as a Specialty Health Network	The St Vincent's Health Network is also referred to as a networked Affiliated Health Organisation See section 62B of the *Health Services Act 1997*
[269]	[The National Health Reform Agreement] was first entered into in 2012	[The National Health Reform Agreement] was first entered into in 2011

Paragraph in CA submissions	Error	Correction
		See Exhibit N.3.17, Mid-Term Review of the National Health Reform Agreement Addendum 2020-2024 Final Report (24 October 2024) [SCI.0011.0585.0001 at 0022]
[275]	Independent Hospital and Aged Care Pricing Authority	Independent Health and Aged Care Pricing Authority
[307]	State Purchasing Branch	System Purchasing Branch
[311]	The State Efficient Price reflects the average cost of providing the weighted unit of care	The State ~~Efficient~~t Price reflects the average cost of providing the weighted unit of care See Exhibit CE.32, NSW Activity Based Funding Activity Based Management Compendium (2023-2024), p.26 [MOH.0100.0295.0001 at 0026]
Footnote 350 at [313] [331] and footnote 383	Stuart Dowrick	Stewart Dowrick
[502]	Royal Prince of Wales Hospital	Prince of Wales Hospital
[614]	16,597	16,957
[627](a) and (b), [649](a), [712](f), [715], [727](d), [753]	Australian Medical Association	Australian Medical Association (NSW) Limited Note: Dictionary, *Health Services Act 1997*
[672]	This unit has recently expanded to 400 FTE staff and the Ministry plans to expand it further.	This unit has recently had funding approved to expand to 400 FTE over the next three years.
[869]	Prevention and Response to Violence, Abuse and Neglect Branch	Prevention and Response to Violence, Abuse and Neglect Unit
[997]	"Based on a program piloted in the Murrumbidgee Local Health District, [the NSW Rural Generalist Single Employer Pathway] has now been expanded to 80 training places per year in other rural and regional areas through collaborative trials and a memorandum of understanding with the Commonwealth".	The 80 places includes Murrumbidgee Local Health District, and the sentence is correct if "other" is removed. See statements of Exhibit C.33.1, Statement of Jill Ludford (12 March 2024), [150] [MLH.0001.00016.0001]; and Exhibit D.6, Statement of Luke Sloane (3 October 2024), [55] [MOH.0011.0079.0001].

Paragraph in CA submissions	Error	Correction
[1071]	Footnote 1567 refers to the Inquest into the death of Ricky Hampson as being an example of how "race based decisions (conscious or otherwise) create the potential for serious misdiagnoses".	The Deputy State Coroner expressly stated that she did not find that "there was any specific racial bias influencing the treatment of Dougie, either conscious or unconscious": see Findings of Deputy State Coroner Kennedy at [236].
[1097]	"In 2022-23 these grants totalled in excess of $20 million"	The total amount provided to non-government organisations for the purposes of Aboriginal health in 2022-2023 was approximately $43 million. See NSW Health Annual Report 2022-2023, pp 105-126, [SCI.0001.0059.0001 at 01114-0135].