New South Wales

Special Commission of Inquiry into Healthcare Funding

Submission Number: 68

Name: Positive Life NSW

Date Received: 31/10/2023

Monday 30 October 2023

Delivered by email submissions.hfi@specialcommission.nsw.gov.au

Dear Commissioner Richard Beasley SC,

Re: The Special Commission of Inquiry into Healthcare Funding

Positive Life NSW (Positive Life) welcomes the opportunity to provide a submission into *The Special Commission of Inquiry into Healthcare Funding*.

Positive Life NSW (Positive Life) is the leading state-wide peer-based organisation that speaks for and on behalf of people living with and affected by HIV in NSW. We provide leadership and advocacy in advancing the human rights and quality of life of all people living with HIV (PLHIV), and operate to change systems and practices that discriminate against PLHIV, our friends, family, and carers in NSW.

About HIV and PLHIV in NSW

Today HIV is considered a chronic manageable health condition. A HIV diagnosis is no longer a certain death sentence, and PLHIV can expect to enjoy a life span on par with others who do not live with the condition. Consequently, PLHIV are living longer with more than one health condition besides HIV (comorbidities) such as diabetes, heart disease, HIV-associated neurological disorders, impaired renal function, osteoporosis, non-AIDS related cancers, mental health conditions, asthma and arthritis.[1] PLHIV who were diagnosed in the early years of the HIV/AIDS epidemic and experienced side effects from the early HIV medications or those who have been diagnosed late with advanced HIV, live with a comorbidity burden at two to three times the rate of aged-matched HIV-negative patients.[2]

NSW is home to over 11,721 PLHIV[3], representing the largest number of PLHIV jurisdictionally in Australia. Approximately 5,861 PLHIV are over 55 years of age, of which 645 are women. Within these proportions there are a smaller number of transgender and non-binary PLHIV. 79.9%[4] of PLHIV aged in this 50-64 age group report living with at least one comorbidity. PLHIV over the age of 55 years' regularly experience medical complications, polypharmacy, poorer mental health, social isolation, stigmatisation and

[1] Positive Life NSW (2019). Australian people living with HIV and Aged Care, https://www.positivelife.org.au/wp-content/uploads/2020/10/plnsw-sb2020-aged-care-royalcommission.pdf, accessed 26 October 2023.
[2] Ibid.
[3] Wilson, D. (2011). *Mapping HIV Outcomes; geographical forecasts of numbers of people living with HIV in Australia,* UNSW Sydney, https://apo.org.au/node/22949, accessed 26 October 2023.
[4] Power, J., Amir, S., Brown, G., Rule, J., Johnson, J., Lyons, A., Bourne, A. and Carman, M. (2019). *HIV Futures 9: Quality of Life Among People Living with HIV in Australia*, monograph series number 116, The Australian Research Centre in Sex, Health and Society, La Trobe University, Melbourne, Australia

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discrimination along with up to three or more comorbidities.[5] They also find they are often ineligible for services for older people, given they are under 65 years of age.

PLHIV of all ages intersect significantly with the NSW Health system and require regular pathology, specialist clinical care, prescribed s100 HIV antiretroviral medications, and multiple and increasing comorbidity monitoring over and above those without HIV. Even with the innovative NSW Health 'Ending HIV' campaign, ending HIV transmission will not equate with 'ending HIV' for almost 12,000 HIV positive people in NSW.

Lived experience of HIV and Peer Support Model

As a peer-based organisation staffed by people living with or affected by HIV, we work within a peer-based model (peer navigation) that espouses the value and role of people with lived experience of HIV (peer navigators) as an established strategy that fosters active self-management, peer-based health promotion, retention in clinical care, and health system navigation.[6]

Since the 1980s, peer navigation has been shown to strengthen the HIV care and treatment cascade[7] through person-centred approaches to healthcare linkage, adherence, and self-management, which is tailored to the individual and cost-effective.[8]

Peer navigation offers a cost-effective health provision strategy, that meets an individual's needs and preferences in a culturally consonant and respectful fashion, while increasing self-management related to this chronic manageable health condition.[9]

Terms of Reference, A

As peers embedded in community, the role and value of peers in the community-led HIV response offers an undeniable comparative advantage and cost-effective option to support the safe delivery of high quality, timely, equitable, culturally compatible and accessible person-centred care in health promotion and healthcare in NSW.[10]

With a remit since 1988 to provide optimum well-being, information, care and support to all people living with HIV including heterosexual men and women along with gay/bisexual men who have sex with men (MSM), Positive Life peer navigators are already embedded in community to provide culturally applicable services sensitive to the needs of PLHIV. The ongoing funding of this HIV health service organisation effectively supports the safe delivery

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[5] ibid.

[6] Krulic, T., Brown, G., Graham, S., Hoy, J., & Bourne, A. (2023). Revealing an enabling environment: How clinical community and clinical stakeholders understand peer navigation to improve quality of life for people living with HIV in Australia. *Frontiers in public health*, *11*, 1101722. https://doi.org/10.3389/fpubh.2023.1101722

[7] ibid.

[8] ibid.

[9] ibid.

[10] Ayala, G., et al. (2021). Peer- and community-led responses to HIV: A scoping review. *PloS one*, *16*(12), e0260555. https://doi.org/10.1371/journal.pone.0260555

of high quality, timely, equitable and accessible patient-centred care and health services to the people of NSW, now and into the future.

Terms of Reference, B-ii

The engagement and involvement of peers who are already located in local communities are ideal to share in community-based health service development and delivery with an existing knowledge and expertise that complements general health care services contributing to health promotion, retention in care, medication adherence and strengthening mental health and resilience as the need arises.[11]

'Jamilah's' example below demonstrates how peer navigation can advance culturally compatible information and care, where clinical services have been unsuccessful.

> In 2017, 'Jamilah' was a 45-year-old South African woman living with HIV, who had recently migrated to Australia with her husband and their five children. Her clinical team at a NSW Health specialist HIV clinic in Western Sydney had been unsuccessful over the past six months to convince her to commence HIV anti-retroviral medication, as her mental health, energy levels and physical health noticeably declined. She attended a Positive Life social inclusion event, where she met other women living with HIV as peers, who spent time with her discussing a range of matters related to motherhood and family, including their own personal experiences of the benefits of anti-retroviral treatment. Within three weeks, she returned to the clinical team and commenced HIV anti-retroviral treatment. Her mental health, energy levels and engagement with her family recovered and six years later she continues to engage socially with her community, her family and maintain medication adherence.

This kind of example where PLHIV make life-changing decisions that benefit their health occurs regularly during our social inclusion events and retreats for many diverse communities of PLHIV who engage with our peer support and peer navigators.

Peer navigation consistently demonstrates considerable success with shorter timeframes than a clinical setting, from accepting and incorporating a HIV diagnosis, to critical decisions for early or immediate commencement of HIV anti-retroviral medication, confirming the imperative for ongoing medication adherence, and reducing social isolation which improves mental health and ongoing resilience.

[11] Øgård-Repål, A., Berg, R. C., & Fossum, M. (2023). Peer Support for People Living With HIV: A Scoping Review. *Health promotion practice*, *24*(1), 172–190. https://doi.org/10.1177/15248399211049824

Terms of Reference, B-iv and F

The impact of privatisation, the sharp decline in bulk-billing, decreased numbers of s100 prescribers[12] and HIV specialists, coupled with the increasing cost of living, means PLHIV are finding it progressively difficult to access their clinical care in a timely cost-effective manner. Cuts to health funding also have a direct impact on access to sexual health services, which reduces timely access to care, HIV testing and treatment, access to medication and prevent of onward HIV transmission.

Furthermore, as s100 prescribers and HIV specialists come into retirement age, Positive Life is critically aware this reduced specialised workforce is facing a workforce shortage, especially in regional and rural NSW. While PLHIV in metropolitan Sydney see a preponderance of s100 providers, there are very few to no s100 prescribers in the outer metropolitan areas where HIV transmissions have started to rise. In rural and regional areas of NSW, the severe shortage of s100 prescribers exacerbates the difficulties and barriers for PLHIV to access timely clinical care providers and forces some PLHIV to travel great distances at considerable cost. Positive Life is also aware that the post COVID-19 NSW Health staffing levels have also negatively impacted the health outcomes for PLHIV, along with an impact on sexual health services particularly where there has been an increase in new HIV notifications in the Greater Western Sydney area.

PLHIV and the NSW HIV sector are facing a current reduction in the capacity and capability of the NSW Health workforce to maintain the world-renowned successes of NSW since the 1980s to curb the HIV/AIDS epidemic.[13] Coupled with the current reduced access to NSW health services and outdated assumptions about HIV transmission that assumes a risk profile of men who have sex with men, PLHIV not only risk dropping out of care, and can also experience considerable barriers to access timely health monitoring, consultation and access to our s100 antiretroviral medication. The broader NSW community also risks access to timely diagnosis such as 'Sarah's' example illustrates below:

> 21-year-old 'Sarah's' graduation celebrations included a night out with friends, and a night with a young man she'd met only that evening. On parting ways in the morning, he departed with the enigmatic, 'you'll never forget me'. Over the next few days, Sarah began to experience flu-like symptoms. As a true Gen-Z, she investigated her symptoms online, and requested a HIV test from her family GP. It took her three different appointments with three different GPs before she found one who would

[12] HIV anti-retroviral medicines are classed as a section 100 (s100) highly specialised drug. Only s100 prescribers can prescribe HIV anti-retroviral medication which is critical to supressing the HIV virus in the body, thus ensuring HIV cannot be passed onto sexual partners.

[13] Di Giallonardo, F., et al. (2021). Subtype-specific differences in transmission cluster dynamics of HIV-1 B and CRF01_AE in New South Wales, Australia. *Journal of the International AIDS Society*, *24*(1), e25655. https://doi.org/10.1002/jia2.25655

provide her with a HIV test, ultimately receiving the news she had seroconverted and was now HIV positive for the rest of her life.

'Sarah's' story is not a singularity. Positive Life has heard instances of similar experiences, especially in the case of young women. Other regularly reported experiences from cis and trans women living with HIV, include clinical staff assumptions that they are sex workers, or have history of injecting drug use as 'Elizabeth's' example below demonstrates. These assumptions pose significant barriers to all women living with HIV accessing healthcare, and threaten their access to timely, effective healthcare.

> 'Elizabeth' is a 55 year old woman living long term with HIV for over 25 years. When she began to experience age-related osteoarthritis and cartilage damage, including early onset frailty due to a previously compromised immune system, she sought medical care from an orthopaedic registrar at a major metropolitan NSW Health teaching hospital. Once he recommended surgery, she disclosed her HIV status. His immediate response was to inquire how she contracted HIV. When she was not forthcoming to his satisfaction, he clearly assumed she had a history of intravenous drug use and sex work. Horrified and embarrassed 'Elizabeth' left the consultation and avoided follow-up appointments with that particular public NSW health service. 'Elizabeth' delayed seeking further medical advice for a number of years, and prolonged her pain and further cartilage damage out of fear and concern for further stigmatisation and inappropriate assumptions and questions from clinical staff.

To meet the current needs of the NSW community, and sustainability of the NSW workforce to meet future demands delivering efficient, equitable and effective health services, the capacity and capability of the NSW Health workforce requires urgent attention and training to maintain NSW's world-renowned record of success regarding the HIV/AIDS epidemic.

Terms of Reference, C and F

Currently, HIV testing follows an 'opt-in' model, which conducts HIV testing according to risk factors, clinical indication or by patient request. HIV 'opt-out' testing models have been proven to support a cost-effective preventative health initiative. An 'opt-out' approach identifies HIV infection earlier, enables earlier antiretroviral treatment, contributes to a reduction in onward transmissions while destigmatising and normalising HIV testing in the broader community.

> A 2022 UK opt-out testing trial for HIV, hepatitis B and hepatitis C in 33 UK accident and emergency departments (EDs), identified 282 new HIV diagnoses and 144 PLHIV who had been lost to care in the first 9 months.[14] *The Lancet* reported the trial was "particularly effective at identifying those disproportionately affected by a late

[14] Editorial, *Lancet HIV* (2023), Vol 10, e351 https://www.thelancet.com/action/showPdf?pii=S2352-3018%2823%2900117-0, accessed 25 October 2023.

diagnosis, including women, older people, and those from Black African communities, all groups who are less likely to access sexual health services."[15]

Furthermore, reported estimated savings of £6–8 million in care costs were based on a £2 million cost to the UK National Health Scheme (NHS). An open letter from UK AIDS trusts and foundation CEOs calling for opt-out testing to be permanent across a range of local area health areas, cited an example from Croydon University Hospital where the average hospital stay for a newly diagnosed HIV patient dropped 32.5 days from 34.9 days to 2.4 days.[16]

In the USA, routine opt-out HIV testing has been recommended by the Centers for Disease Control and Prevention (CDC) for all people aged between 13-64 years of age in EDs and other healthcare settings since 2006.[17] The World Health Organisation (WHO) has recommended HIV opt-out testing since 2007 for all patients in healthcare settings such as STI and TB services, antenatal, childbirth and postpartum services, surgical services and reproductive health services.[18] Opt-out HIV testing in EDs have been found to identify people living with HIV who have been previously diagnosed but 'lost to care', and successfully re-engage them into care, so preventing onward transmission once they've engaged in HIV antiretroviral treatment.

Australia already offers universal voluntary opt-out HIV testing as an established and routine practice for pregnant women as part of their antenatal care. Opt-out testing for other STIs such as chlamydia, gonorrhoea, hepatitis B and syphilis are cost-effective strategies that are already acceptable to Australian patients and clinicians. The Australian experience has demonstrated that opt-out HIV testing has been found to be acceptable to patients in GP settings, increase HIV testing in sexual health clinics settings, to be a feasible strategy for identifying people with previously undiagnosed HIV infection who might normally access HIV testing.[19]

Terms of Reference, G and H

The Australasian Society for HIV, Viral Hepatitis and Sexual Health Medicine (ASHM) administers the s100 certification programs for HIV and hepatitis B prescribers *of* highly

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[15] ibid.

[16] Open Letter to fund opt-out testing in more A&E departments (2022). https://www.nat.org.uk/expandtesting/letter, accessed 25 October 2023.

[17] Making Opt-Out HIV Testing Routine in the Emergency Department, *Centers for Disease Control and Prevention (CDC), U.S. Department of Health & Human Services, Division of HIV Prevention*. https://www.cdc.gov/endhiv/action/stories/east-baton-rouge-hiv-testing.html, accessed 25 October 2023.

[18] World Health Organization and Joint United Nations Programme on HIV/AIDS (2007). *Guidance on provider-initiated HIV testing and counselling in health facilities*, https://iris.who.int/bitstream/handle/10665/43688/9789241595568_eng.pdf?sequence=1, accessed 26 October 2023.

[19] HIV Testing Policy Update: Opt-out Testing (2023). Australasian Society for HIV, Viral Hepatitis and Sexual Health Medicine (ASHM), https://ashm.org.au/about/news/hiv-testing-policy-update-opt-out-testing/ accessed 25 October 2023.

specialised drugs, as well as trains and supports this expert and critical medical workforce. It is critical that this workforce is sustained and incentivised, and GPs are provided with current information about this sexually transmitted infection (STI) to counter assumptions about who is at risk or who should be tested for HIV.

Equipping GPs with a current understanding of the ongoing HIV transmission rates and increased risks for people from culturally and linguistically diverse backgrounds, heterosexual men and women along with gay/queer men of contracting this STI, will support HIV preventative strategies through increased regular testing and reduce long term health spending. In 2023, more than half (51%) of HIV notifications attributed to heterosexual sex were diagnosed 'late'. These 'late HIV diagnoses' are patients who have been 'frequent fliers' in and out of Emergency Departments (EDs) over many years with an increasing burden of illness through opportunistic infections until they are ultimately admitted with an AIDS-defining condition. The overall proportion of people diagnosed 'late' in 2021 (48%) was the highest since 1990.

When PLHIV are diagnosed 'late', we present with greater damage to our immune systems, place greater demand on the health system due to this illness burden, are sicker, longer and require more attention from clinicians compared with someone who is diagnosed quickly and commences early antiretroviral treatment. 'Late' diagnosis represents multiple missed clinical opportunities to diagnose and treat HIV infection as well as missed clinical opportunities to prevent onward HIV transmission. These missed opportunities consequently exacerbate long term health spending on this relatively small group of NSW residents.

Opt-out HIV testing in sexual health and ED settings would offer a cost-effective strategy to reduce the proportion of 'late' HIV diagnoses as well as normalise HIV testing in the community. In 2022, ASHM updated their HIV testing policy recommending opt-out testing in STI services settings, and TB services.[20]

Expanding this into EDs, as a new model of care similar to that which has occurred in the US since 2006, will increase the ability of NSW Health to reduce 'late' HIV diagnoses and prevent subsequent HIV transmissions, complications and costs to NSW Health.

ASHM's 2022 guidelines also highlight that only 53% of gay and bisexual men who attend high gay caseload GP practices have received a HIV test in the previous 12 months. Additionally, a third of patients from a culturally and linguistically diverse (CALD) background are unaware that a HIV test is not part of a standard pathology STI test.[21]

Positive Life's Positive Speakers Bureau (PSB) regularly provides speakers with lived experience to complement NSW Health HIV and Related Programs (HARP) workforce training and forums, and ASHM's HIV, viral hepatitis and sexual health workforce training. This lived experience resource could be utilised by NSW Primary Health Networks (PHNs) to

[20] ibid.
[21] ibid.

supplement their ongoing professional training of GPs and other health professionals to support the capacity of the health workforce to deliver improved understanding and awareness about this STI, its prevention and transmission rates.

Positive Life regularly participates in medical students' lectures about HIV. 'Steven's' feedback is unfortunately all too familiar as illustrated below:

> 'Steven' is a 23-year-old medical student who attended a Positive Life presentation about the epidemiology and transmission rates of HIV in NSW. This presentation provided information and statistics about the demographic profile including the diagnosis of women. 'Steven' expressed concern and surprise to the Positive Life CEO after the presentation, stating 'In medicine we are taught that HIV affects *only men who have men with men,* and this is the *only risk profile we are told to be aware* of as graduates and practitioners.'

This example underscores the importance for PLHIV to be included not only in ASHM and NSW Health HARP clinical training environments, but also NSW PHN Continuing Professional Development (CPD) training for GPs and other health professionals **to** improve health outcomes for the people of NSW.

Terms of Reference, H

As discussed above, opt-out HIV testing has been shown to save money over the long term by early diagnosis and treatment. An acknowledged danger with opt-out HIV testing in EDs is the heightened risk for poor linkage to care and a lack of integration of cultural competency for patients diagnosed with HIV.[22] Embedding peer navigators within this model of care would ensure a strong linkage to care and integration of cultural competency for patients diagnosed with HIV to contribute to health outcomes for the people of NSW and maintain the world-renowned NSW Health achievements in the HIV response to curb the HIV/AIDS epidemic.[23]

A clinical innovation to improve health outcomes, would be updating the sexual health screening guidelines, positioning HIV testing as part of a general health check up to reach people who would not consider themselves at risk for HIV. The current priority on MSM overlooks the fact that the HIV transmission rates in heterosexual women and men HIV are slowly increasing, as are new diagnoses in CALD communities, and gay/bisexual men who were born overseas.

Patients from CALD backgrounds often assume that HIV has been eliminated in Australia and are unaware of the multiple HIV prevention strategies (free condoms, anonymous free

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[22] Soh, Q.R., Oh, L.Y.J., Chow, E.P.F. *et al.* (2022). HIV Testing Uptake According to Opt-In, Opt-Out or Risk-Based Testing Approaches: a Systematic Review and Meta-Analysis. *Curr HIV/AIDS Rep* **19**, 375–383. https://doi.org/10.1007/s11904-022-00614-0

[23] Di Giallonardo, F., et al. (2021). Subtype-specific differences in transmission cluster dynamics of HIV-1 B and CRF01_AE in New South Wales, Australia. *Journal of the International AIDS Society*, *24*(1), e25655. https://doi.org/10.1002/jia2.25655

sexual health HIV testing on request, pre-exposure prophylaxis (PrEP), post-exposure prophylaxis (PEP), and free HIV antiretroviral medication for all NSW residents regardless of Medicare eligibility), innovations which contribute to HIV being well managed in this country.

Patients with CALD backgrounds are often unaware that NSW Health clinics are free and available to anyone to access regardless of Medicare eligibility, can be accessed anonymously and are typically a-political environments. People of CALD backgrounds from countries with authoritarian political systems or other politically conservative cultures are often suspicious of NSW Health government services, and assume they are surveilled and their personal sexual health situations or requirements are shared to their detriment with other organisations or immigration departments.

A recent HIV prevention strategy has seen one HIV self-test kit approved by the Therapeutic Goods Administration (TGA), the Atomo HIV Self-Test. It is available online, over-the-counter in pharmacies and organisations that work with the HIV at-risk communities, predominantly gay and bisexual MSM. Currently each test is sold between $25 to $30 making this an expensive purchase. Exploring options to make them more readily available and/or subsidising them would increase this HIV prevention strategy and reduce barriers to access for the average consumer.

Recommendations

1. Ensure the ongoing engagement of peers who are already embedded in communities with existing knowledge and expertise to complement the health service development and delivery as a comparative advantage and cost-effective strategy to support the safe delivery of high quality, timely, equitable, culturally compatible and accessible person-centred care in HIV health promotion, prevention, retention in care, medication adherence and strengthening mental health and resilience and healthcare in the NSW community-led HIV response.
2. The capacity and capability of the clinical NSW HIV workforce requires urgent attention, incentivisation and support to maintain the world-renowned successes of NSW regarding the HIV/AIDS epidemic and meet the current needs of the NSW community, and sustainability of the NSW workforce to meet future demands delivering efficient, equitable and effective health services,. It is critical that GPs are provided with current information about this STI to counter assumptions about who is at risk or who should be tested for HIV, potentially through ASHM which trains and supports this expert and critical workforce and administers the s100 certification programs for HIV and hepatitis B prescribers *of* highly specialised drugs.
3. Introduce opt-out HIV testing in ED and sexual health settings as a long term, cost-effective, acceptable strategy to both patients and clinicians, to reduce the stigma associated with requesting a HIV test and normalise HIV testing, re-engage people lost to care, and ultimately prevent onward HIV transmissions.

4. Increase the education and training programs for specialist HIV clinicians and their sustainability to meet and sustain future needs. Incentivise and attract HIV clinical care providers to reverse the workforce shortage drain that is already apparent in the NSW HIV sector, while building the capacity and capability of the NSW Health workforce to combat outdated assumptions about HIV transmission, improve current understanding of ongoing HIV transmission rates and increased risks, HIV preventative strategies and better serve the health needs of the NSW population.
5. Expand the engagement opportunities for PLHIV to participate, shape and deliver training opportunities through the PSB speakers program to NSW Health HARP workforce, ASHM HIV, viral hepatitis and sexual health workforce training and NSW PHNs CPD training for GPs and other health professionals **to** improve health outcomes for the people of NSW.
6. Update the sexual health screening guidelines to ensure all heterosexual women and men from Anglo-Australian and CALD backgrounds, are offered opt-out HIV testing as part of their general health check-up.
7. Ensure HIV Self-Test kits are more readily accessible to the community and/or subsidise for NSW residents.
8. Increase the promotion of NSW Health sexual health clinics as free, anonymous and respectful options to all NSW residents, regardless of Medicare eligibility. Accordingly, the sexual health workforce capacity and capability in these clinics must be increased, supported, and incentivised to ensure the ongoing sexual health of the entire NSW population.
9. Increase opportunities for funding to be redistributed through community organisations, with embedded peer navigators who are well positioned to provide prevention messaging, and nuanced culturally appropriate community support training for healthcare providers.

We are comfortable with the publication of this submission in full on the website under the name of Positive Life NSW.

Yours respectfully

Jane Costello

Positive Life NSW Chief Executive Officer

October 2023

Terms of Reference

NEW SOUTH WALES

CHARLES THE THIRD, by the Grace of God, King of Australia and His other Realms and Territories, Head of the Commonwealth.

TO

Mr Richard Beasley SC

GREETING

By these Our Letters Patent, made and issued by Our Governor under the authority of the *Special Commissions of Inquiry Act 1983* with the advice of the Executive Council, We hereby authorise you as Commissioner to inquire into and report to Our Governor of the said State on:

A. The funding of health services provided in NSW and how the funding can most effectively support the safe delivery of high quality, timely, equitable and accessible patient-centred care and health services to the people of NSW, now and into the future;

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

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

   ii. the engagement and involvement of local communities in health service development and delivery;

   iii. how governance structures can support efficient implementation of state-wide reform programs and a balance of system and local level needs and priorities;

   iv. the impact of privatisation and outsourcing on the delivery of health services and health outcomes to the people of NSW;

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

C. The way NSW Health funds health services delivered in public hospitals and community settings, and the extent to which this allocation of resources supports or obstructs access to preventative and community health initiatives and overall optimal health outcomes for all people across NSW;

D. Strategies available to NSW Health to address escalating costs, limit wastage, minimise overservicing and identify gaps or areas of improvement in financial management and proposed recommendations to enhance accountability and efficiency;

E. Opportunities to improve NSW Health procurement process and practice, to enhance support for operational decision-making, service planning and delivery of quality and timely health care, including consideration of supply chain disruptions;

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

   i. the distribution of health workers in NSW;

   ii. an examination of existing skills shortages;

   iii. evaluating financial and non-financial factors impacting on the retention and attraction of staff;

   iv. existing employment standards;

   v. the role and scope of workforce accreditation and registration;

   vi. the skill mix, distribution and scope of practice of the health workforce;

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

   viii. the relationship between NSW Health agencies and medical practitioners;

   ix. opportunities for an expanded scope of practice for paramedics, community and allied health workers, nurses and/or midwives;

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

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

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

   i. placements;

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

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

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

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

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

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

AND FURTHER, WE authorise you to make recommendations to address the issues raised including in relation to National structures or settings, including the National public hospital funding model and/or National Health Reform Agreement and the impact of aged and disability care in NSW public hospitals, where such recommendations would support or enhance any changes recommended by the Special Commission.

AND hereby establish a Special Commission of Inquiry for that purpose. The Special Commission may be assisted by one or more experts on matters that you consider require expert opinion.

AND We direct you, in conducting the inquiry:

J. To have regard to existing reviews, reports and recommendations in relation to the national public hospital funding model and other national settings insofar as they impact on the delivery of high quality, timely, equitable and sustainable public hospital and community health services in NSW, in particular co-payments, oversight of compliance and influence of private capital on the health services market; and
K. That you are not required to inquire, or to continue to inquire, into a particular matter to the extent that you are satisfied that the matter has been or will be sufficiently and appropriately dealt with by another review, inquiry or investigation.

AND pursuant to section 21 of the *Special Commissions of Inquiry Act 1983* (NSW) it is hereby declared that section 24 shall apply to and in respect of the Special Commission issued to you by Our Letters Patent.

AND OUR further will and pleasure is that you do, as expeditiously as possible, but in any case on or before 24 August 2024, deliver your final report in writing of the results of your inquiry to the offices of the Premier and Our Governor in Sydney.

IN WITNESS, We have caused these Our Letters to be made Patent and the Public Seal of Our State to be hereunto affixed.

WITNESS Her Excellency the Honourable Margaret Beazley, Companion of the Order of Australia, King's Counsel, Governor of the State of New South Wales in the Commonwealth of Australia.

Dated this 23rd day of August 2023.

[signed]

Governor of NSW
By Her Excellency's Command

[signed]

Premier

https://healthcarefunding.specialcommission.nsw.gov.au/about/terms-of-reference/