

**Special Commission of Inquiry  
into Healthcare Funding**

**Before: The Commissioner,  
Mr Richard Beasley SC**

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

**Monday, 27 November 2023 at 10.00am**

**(Day 001)**

<b>Mr Ed Muston SC</b>	<b>(Senior Counsel Assisting)</b>
<b>Mr Ross Glover</b>	<b>(Counsel Assisting)</b>
<b>Mr Ian Fraser</b>	<b>(Counsel Assisting)</b>
<b>Dr Tamsin Waterhouse</b>	<b>(Counsel Assisting)</b>

**Also present:**

**Mr Richard Cheney SC with Mr Hilbert Chiu for NSW Health**

1 THE COMMISSIONER: This is the first public hearing of  
2 this Special Commission of Inquiry into the funding of  
3 health services in New South Wales, and what I will for now  
4 simply call many other related matters.  
5

6 I don't intend to read out or have read out any of the  
7 nine terms of reference, many of which themselves have  
8 multiple subparts. They are available on the Inquiry's  
9 website and will no doubt be shortly referred to in opening  
10 by counsel.  
11

12 Some of what can be called the challenges facing the  
13 health system that are raised in the terms of reference are  
14 not new. They have been looming on the horizon for some  
15 time. Other challenges need to be addressed now.  
16

17 Some of these have been the subject of previous  
18 reviews and reports and, at times, have prompted general  
19 recommendations for change. They have also been the  
20 subject of many meetings with interested parties within the  
21 health system that this Inquiry has had prior to today,  
22 ranging from representative bodies and organisations such  
23 as the many colleges, the AMA, unions such as the Health  
24 Services Union, NSW Nurses & Midwives Association, ASMOF,  
25 representatives of the local health districts, shared  
26 services and pillar organisations within the New South  
27 Wales health structure, and also various experts and  
28 research organisations.  
29

30 There have also been a number of workshops on the  
31 issues raised in the terms of reference facilitated by NSW  
32 Health. I would like to thank all of the people who have  
33 attended these meetings and workshops, not just for their  
34 time, but for the high level of engagement on the issues  
35 and the desire for meaningful change.  
36

37 The only other thing I will say about the terms of  
38 reference is that they currently require a report to be  
39 provided to the governor and to the government on or before  
40 24 August next year.  
41

42 Just before I invite Mr Muston, who is senior counsel  
43 assisting the Inquiry, to deliver an opening statement,  
44 which I understand he will do in conjunction with  
45 Mr Glover, who is also one of the counsel assisting the  
46 Inquiry, as this is the first public hearing, it is  
47 appropriate to acknowledge the Gadigal people of the Eora

1 nation, who are the traditional owners of the land on which  
2 we are holding this Inquiry, and I pay my respects to their  
3 elders, past and present. I extend that respect to any  
4 Aboriginal or Torres Strait Islander peoples here today and  
5 watching online.

6  
7 As one further matter before you begin, Mr Muston,  
8 I might just take appearances from you and from any other  
9 counsel appearing for an interested party today.

10  
11 MR MUSTON: I have been appointed senior counsel to assist  
12 this Inquiry. Three other barristers have been appointed  
13 to assist as junior counsel in the Inquiry, Mr Glover,  
14 Mr Fraser and Dr Waterhouse. I anticipate others might be  
15 called upon to assist during the course of the Inquiry.

16  
17 Before Mr Cheney announces his appearance, I might  
18 also note that the Inquiry benefits from a team of  
19 solicitors and paralegals, although it is not customary to  
20 list them, I think, having regard to the work that they are  
21 doing and the commitment that they have made to this  
22 Inquiry, it is appropriate in this case to do so. It is  
23 Mr Mullane, Ms Hainsworth, Ms Muniz, Ms Ersoy, Ms Lister,  
24 Ms Giulione and Ms Muguntharajah.

25  
26 THE COMMISSIONER: I think I have met them all now.

27  
28 MR MUSTON: Their efforts should not go unrecognised.

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30 THE COMMISSIONER: Of course.

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32 MR CHENEY: May it please the Commission, I appear with  
33 Mr Chiu for NSW Health and all its agencies.

34  
35 THE COMMISSIONER: I understand you want to give a brief  
36 opening after counsel for the Inquiry?

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38 MR CHENEY: If you would permit that, yes.

39  
40 THE COMMISSIONER: That would be fine, thank you.

41  
42 MR CHENEY: We are instructed by Ms Pinnock of the Crown  
43 Solicitor's Office.

44  
45 THE COMMISSIONER: Yes, Mr Muston.

46  
47 MR MUSTON: The logical starting point when introducing

1 the Inquiry is its terms of reference. I also don't  
2 propose to read them out. In recent weeks, we have heard  
3 them described in various ways during our discussions with  
4 people. I'll attempt to put it neutrally and say they are  
5 very broad.

6  
7 In many respects, that's probably a positive thing.  
8 They give the Inquiry real scope in its search for  
9 meaningful recommendations. I don't think it would be an  
10 exaggeration to say, as large as the health system in  
11 New South Wales is, there is probably no facet of it which  
12 is not, one way or another captured, by the terms of  
13 reference.

14  
15 Now, the breadth of the terms of reference also  
16 reflects the fact that we're not here presented with an  
17 adverse incident or a failure, and asked to determine how  
18 it happened or to attribute responsibility; it is  
19 a policy-based inquiry.

20  
21 Policy-based inquiries of this type are not unique  
22 within the health system. This one seeks to build on work  
23 done in other inquiries in the recommendations made - an  
24 example which we have heard of a lot of people within the  
25 health system will well recall is the 2008 Garling Inquiry  
26 into Acute Care Service in NSW Public Hospitals.

27  
28 The fact that this is more of a policy-based inquiry  
29 is probably important to make clear at the outset because  
30 it means it's unlikely to be an adversarial exercise of the  
31 type that people often associate with inquiries or royal  
32 commissions.

33  
34 The fact that those highly adversarial "got you"  
35 moment type inquiries are the ones that sometimes spring to  
36 mind, means that an announcement of an Inquiry often  
37 provokes genuine anxiety within the system that is being  
38 investigated, and I think we should say at the outset,  
39 no-one should feel apprehensive about this Inquiry. No  
40 part of it involves searching for errors made by any  
41 particular person or group of people working within the  
42 wider health system in New South Wales. I think that bears  
43 repeating. This is not about trying to find fault in any  
44 particular individual or group of people within the wider  
45 health system.

46  
47 Rather, the purpose of the Inquiry is to identify the

1 key challenges faced by the health system, now and into the  
2 future, and to search for the best ways for the system to  
3 adapt to meet those challenges.  
4

5 As we'll come to shortly, the submissions that we've  
6 received to date and discussions that we've had across a  
7 wide range of groups within the health system so far,  
8 suggest that there's really little debate about what those  
9 big challenges actually are.

10  
11 There are certainly different views about the scale of  
12 the challenges; there are different views about the order  
13 in which they might be addressed; and there are certainly  
14 different views about how they should be addressed, but all  
15 of that's inevitable, and it is a good thing, because if  
16 conducted well, this Inquiry provides a platform for  
17 a genuine exchange of ideas about how to meet those  
18 challenges going forward.  
19

20 But, herein lies one of the greatest threats posed by  
21 the wide terms of reference. We have very limited time in  
22 which to conduct this Inquiry. The time available, if we  
23 are being realistic, is not enough to identify all of the  
24 challenges in any system, let alone sort out the many  
25 different ways in which those challenges might be met.  
26

27 THE COMMISSIONER: There is an issue about whether there  
28 is sufficient time to address the terms of reference in  
29 totality, I think.  
30

31 MR MUSTON: The work we have done so far, it will come as  
32 no surprise to anyone familiar with health, has revealed  
33 that the health system is a very large and very complex  
34 beast, and its challenges are many and varied. If we, as  
35 an Inquiry, were to roam around within our terms of  
36 reference, seeking to deal with every challenge as we  
37 encountered it, we would seriously risk getting lost.  
38

39 For this Inquiry to have maximum benefit, we really do  
40 need to be targeted in our approach. We need to try to  
41 focus our efforts on the big systemic challenges within the  
42 system, both from a funding and a governance point of view,  
43 and particularly those that might be preventing the very  
44 clever people who work within the health system from  
45 harnessing innovation and pivoting to meet the evolving  
46 health needs of the people of New South Wales.  
47

1           But even if we restrict ourselves to that, the time  
2 frames, at least as we look at them at the moment, feel  
3 like they present a challenge.

4

5           THE COMMISSIONER:    Yes.

6

7           MR MUSTON:    Now, at a conceptual level, all of that,  
8 hopefully, makes sense.  But how do we actually go about  
9 achieving it?  Because it won't have escaped anyone's  
10 attention that this room is predominantly occupied by  
11 lawyers.  And these are not legal problems that we're  
12 dealing with.  Whatever we lawyers might like to think, we  
13 alone don't have the skill set required to identify the key  
14 challenges facing the New South Wales health system, let  
15 alone resolve them.

16

17           So again, I ask rhetorically, how do we go about  
18 achieving this?

19

20           At the most fundamental level, what we do is we  
21 listen.  We listen to the people working within the health  
22 system, we give appropriate weight to their lived  
23 experience and their genuine expertise.  We listen to the  
24 lived experience of people interacting with the health  
25 system and we listen to the people who have skills and  
26 experience needed to properly identify what are the  
27 important systemic road blocks and offer meaningful  
28 evidence-based solutions.  But we don't listen  
29 uncritically.

30

31           As I've already said, there are, and there inevitably  
32 will be, different views about many of these issues, and  
33 the Inquiry's going to have to evaluate those different  
34 views.  But the beauty of a policy-based inquiry like this  
35 is that we don't need to approach those issues or those  
36 different views in a binary fashion.

37

38           What do I mean by this?  Let's say there's a problem  
39 or a challenge that we're confronted with that we've  
40 identified as one we need to address.  Two conflicting  
41 ideas are brought to the table as a means of solving that  
42 problem.  Now, an inquiry of this type doesn't have to  
43 choose between them.  We don't have to say it's either that  
44 one or it's the other.  Rather, we can critically examine  
45 them, we can explore what underpins them, and most  
46 importantly, we can facilitate a meaningful and respectful  
47 dialogue between the people who have brought the ideas

1 forward and by adopting that process, it is open to the  
2 Inquiry to formulate recommendations which seek to  
3 accommodate the important aspects of both to produce an  
4 outcome or a recommendation which we feel best serves the  
5 people of New South Wales and produces the best health  
6 outcomes for the people of New South Wales.

7  
8 Now, again, all of this is very easy to say, but in  
9 order to achieve it, we are going to require deep and  
10 genuine engagement by all of the key stakeholders and  
11 a willingness by all of them to contribute ideas brought  
12 from their own experience and unique perspective.

13  
14 We probably need to be a little bit careful when we  
15 use a term like "stakeholders" because at one level, every  
16 person in New South Wales - even visiting New South Wales -  
17 has a stake in the state's public health system. If they  
18 need it - and at some point in their lives, most people  
19 will - they want it to be the best it can possibly be.

20  
21 But when we're using the term "stakeholders", we're  
22 referring a little bit more generally to the need to bring  
23 together ideas from the numerous groups that comprise the  
24 wider health ecosystem and should contribute to the  
25 discussions about what the key issues might be. For  
26 example, and you have listed some of them already: the  
27 various components of the health ministry itself; the  
28 health workforce in all of its different forms - and by  
29 that I'm not just referring to the medical or clinical  
30 workforce; the medical colleges; trade unions; employer  
31 groups; universities and other training institutions that  
32 feed graduates into the health workforce; consumers of  
33 health services in New South Wales; medical researchers;  
34 academic and other institutions that have a real depth of  
35 knowledge in a relevant areas.

36  
37 These are the stakeholders and the people who we need  
38 to bring together to have this exchange of ideas. It's by  
39 no means a comprehensive list. There will obviously be  
40 individual people who have a particular experience of  
41 either interacting with the health system or working within  
42 the health system who have something very important to  
43 offer, and in many respects, we have received submissions  
44 from a great number of those people who have provided  
45 information to us, but at a general level, one can't hear  
46 from every single person, we need to try to get those key  
47 stakeholder groups together.

1  
2           Fortunately, the huge number of submissions that we  
3 have received to date reveals a wide range of those key  
4 stakeholders have genuinely engaged in a very positive way  
5 with the work of the Inquiry.  
6

7           All of them who we've spoken to, and a large number of  
8 the submissions we have received, point to enthusiasm, if  
9 not excitement, about the opportunity that this Inquiry  
10 presents for bringing about meaningful change and  
11 improvement within the health system.  
12

13           Now, that's probably a convenient place for me to move  
14 to the work that we have done so far. I'm not talking  
15 about the administrative work required to get an Inquiry  
16 like this up and running --  
17

18 THE COMMISSIONER:   Which runs at its own speed.  
19

20 MR MUSTON:   -- of which there is a surprising amount that  
21 has been done by the members of the wider Inquiry team, the  
22 recruiting the team itself, setting up the IT, acquiring  
23 photocopiers, printers, teaching people how to use them and  
24 the like. It is a surprising amount of work. It shouldn't  
25 be underestimated either in its scale or its importance  
26 because without it, and it's largely invisible, but without  
27 it, the Inquiry couldn't have commenced and, if it were to  
28 stop now, the Inquiry similarly would grind to a halt. So  
29 again, the efforts of all of those involved in that side of  
30 things should not go unrecognised.  
31

32 THE COMMISSIONER:   Yes.  
33

34 MR MUSTON:   Coming back to the other type of work that  
35 I was referring to, what I really was meaning to address is  
36 what is being done by the Inquiry team in its attempt to  
37 understand the wider health landscape and work towards  
38 identifying those key challenges that should be the focus  
39 of our efforts going forward.  
40

41           Now, the useful starting point has been the previous  
42 inquiries and reviews which have been conducted in this  
43 area, and as I've mentioned, the health landscape is  
44 littered with previous inquiries and reviews. In fact,  
45 there are several others, in one way or another, which are  
46 being carried out in parallel with ours, particularly at  
47 the federal level.



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But again, that's a good thing. We have reviewed the reports generated by these earlier efforts, we certainly don't intend to repeat the work that they've done, but the work that they have done, and the recommendations made, and findings made, provides a foundation on which this Inquiry can and should build.

So an understanding of those findings, an understanding of those recommendations and, importantly, an understanding of the way in which the health system has responded to earlier recommendations, is going to be very important, and assist us in formulating or identifying those big issues and the big challenges that need to be addressed by this Inquiry.

So that's the first thing. The next thing which has been useful in terms of getting to understand in far more detail that health landscape, is the submissions that have been received to date. So far, the Inquiry has received more than 160 submissions, from a wide range of people. We have considered them.

They have come from many organisations that sit within NSW Health, the ministry, many of the local health districts, what have been described as the pillar organisations and specialty networks, in a way which is positive and refreshing, not only do these various submissions engage genuinely with the terms of reference, but they have done so in what might be described as a very independent way. I think, to be fair to the ministry, there is no party line. Each of its various components has put forward its own view on the way in which the system is working and where improvements are required, and those views do not always line up. But again, that is a positive thing.

Other government agencies have contributed submissions: employee representatives; many of the medical colleges have made submissions; research institutes and others; other experts in public health have contributed submissions; NGOs involved in the delivery of health services in New South Wales; members of the community with personal lived experience of the public health system; individuals working within health - all of these people have, through their submissions, presented a very comprehensive picture of the health system and the areas in

1 which they see challenges lying and where they see  
2 improvements might be made.

3  
4 I probably should say at that point, a number of  
5 extensions have been sought and granted, so we anticipate  
6 that some further submissions will come in. I guess it's  
7 probably also worth making the point, although the time for  
8 making submissions has notionally closed, anyone who has  
9 not yet made a submission and feels they have something  
10 meaningful to contribute to the work of the Inquiry should  
11 reach out through the website, because there will come  
12 a point where the Inquiry is so far advanced that it is  
13 difficult to pivot and deal with a new submission that  
14 comes in.

15  
16 But that point has not yet been reached and we do  
17 genuinely want as many people as have something to offer to  
18 engage meaningfully with it, because if they don't, then  
19 that presents a challenge to the Inquiry. As I've said  
20 already, we need people with the experience and expertise  
21 to contribute enthusiastically to the work of the Inquiry  
22 for it to be a success.

23  
24 Now, many of the submissions that have been received  
25 include a detailed consideration of the terms of reference,  
26 as I have said. Others focus on particular little areas of  
27 expertise or interest and seek to highlight issues or  
28 initiatives that the author of the submission believes the  
29 Inquiry should explore.

30  
31 The reality is it's not going to be possible for the  
32 Inquiry to explore in detail every little initiative or  
33 issue that has been identified in the submissions. As I've  
34 said, to be effective, it doesn't need to because, really,  
35 the overall review of the submissions that we've received  
36 so far suggests that there is a high level of agreement, as  
37 I've already said, about the key challenges that face the  
38 health system.

39  
40 If we can find a way of clearing some of those  
41 challenges, then it's the people within the health system  
42 who will be free to deal with the individual and  
43 location-based issues and challenges that they face on  
44 a daily basis and innovate in a way that produces the best  
45 results within the wider health system.

46  
47 So, we've received our submissions. You've already

1 pointed out we've had a number of preliminary meetings with  
2 groups within the wider health system, and they've been  
3 both helpful, but also participated in, in an enthusiastic  
4 way, by all of those groups - NSW Health agencies; medical  
5 colleges; unions and employer groups; groups representing  
6 consumers; Indigenous health organisations; Educational  
7 institutions; researchers; and others with expertise in the  
8 field of public health and health economics.

9  
10 The purpose of those meetings has been to start to  
11 tease out the key issues and themes that should be the  
12 subject of focus during the Inquiry, and might be addressed  
13 in the recommendations at length, and to a large extent, it  
14 has started to do that, but we still have a lot of work to  
15 do on that front.

16  
17 It is probably useful at this point to identify some  
18 of the key themes and issues which have arisen from the  
19 submissions and the discussions we've had to date, because  
20 they will go a long way towards shaping the way in which  
21 the Inquiry approaches its work.

22  
23 Now, in doing so, I probably should make clear that  
24 the issues, these high-level themes that come through, will  
25 not necessarily be the only matters addressed by the  
26 Inquiry, and in respect of each of them, there is going to  
27 be, as we start to explore them in further detail, aspects  
28 and details which emerge which result in a need for the  
29 Inquiry to shift its focus slightly and to pivot in a way  
30 that enables these real issues, the big issues, to be  
31 identified and resolved. But, nevertheless, the emerging  
32 picture suggests that these themes are those that reflect  
33 the challenges that most people within the wider health  
34 system see as requiring attention, and many of them do  
35 overlap.

36  
37 I guess, before turning to the challenges that have  
38 been identified, it is probably important to note two  
39 foundational propositions which have also emerged from the  
40 submissions which we have received and from all of our  
41 discussions to date, and that is that the New South Wales  
42 public health system has demonstrated that it is actually  
43 very resilient, it performs very well when compared with  
44 its interstate and international counterparts, and it  
45 overwhelmingly delivers a very high standard of health care  
46 to a huge number of people in New South Wales every day.  
47 It's not a perfect system, but no system is, and many

1 people have commented on the fact that the system continued  
2 to function and perform to such a high standard throughout  
3 the height of the COVID-19 pandemic, whilst extremely  
4 taxing for all of the health workforce involved, as  
5 something which was nothing short of remarkable. Again, we  
6 shouldn't shy away from that.

7

8 The second foundational proposition that has emerged  
9 is that the people working across the New South Wales  
10 public health system are genuinely dedicated in their  
11 efforts to ensure the best possible standard of care is  
12 delivered to the people of New South Wales, but they face  
13 a range of challenges in doing so.

14

15 I think it is important to highlight these common  
16 observations that have emerged from the submissions and our  
17 discussions, because as a society, we rely very, very  
18 heavily on an efficient and functioning health system, and  
19 we tend to hear about it, in the press and elsewhere when,  
20 things don't go well or when there's an adverse outcome of  
21 some sort.

22

23 Transparency of that kind is, obviously enough,  
24 critically important, however, it does tend to focus on one  
25 side of the story. What we don't often see reporting of  
26 is, for example, how well a particular emergency department  
27 might have performed during a particularly stressful night  
28 or the no doubt daily, many daily, occasions when the  
29 system performs at its best to produce excellent health  
30 outcomes for individual patients - things are picked up  
31 early, they're dealt with appropriately to produce a better  
32 health outcome for an individual patient than might  
33 otherwise have been experienced. These are great things  
34 about the system that no doubt happen every day but we just  
35 don't hear about them, because when the system is working  
36 well, we don't need to hear about it.

37

38 But as a result of that, the impression that one is  
39 left with through this slightly one-sided focus is perhaps  
40 not entirely fair to the people who are delivering health  
41 care within that system. Identifying where the system is  
42 working well is actually something which is going to be  
43 quite important in the context of this Inquiry, because  
44 identifying those areas where the system is working well  
45 will provide fertile ground for identifying ways in which  
46 things might be changed and improved in areas where it's  
47 not. But equally, finding out how people have managed to

1 achieve good and meaningful change or innovation and the  
2 challenges that they have faced at a systemic level, both  
3 from a funding and governance perspective, will hopefully  
4 reveal to us things that might be done in order to oil the  
5 cogs and enable that sort of level of innovation and those  
6 modes of care and the delivery of care, which is working so  
7 well, to be rolled out and scaled up in a more systemic  
8 way, where it's appropriate to do so.

9  
10 But, the system, any system, even a high-performing  
11 one, faces challenges, and the health system is certainly  
12 no exception to that rule, and those challenges really need  
13 to remain the focus of our Inquiry.

14  
15 Which brings us to some of the themes that have  
16 emerged from the submissions. The first overarching theme  
17 that emerges from submissions and our discussions is what  
18 we've been told is one of the largest challenges facing the  
19 health system, both now and into the future, and that is,  
20 the changing demographic of the population that the  
21 healthcare system provides for.

22  
23 The Inquiry will hear evidence about this and its  
24 impact, but it's useful to make some observations, I think,  
25 at this point, about its significance in the future  
26 delivery of health care across New South Wales.

27  
28 We have repeatedly been told in submissions that the  
29 New South Wales population is ageing. Now, for someone who  
30 is not a demographer, that sounds like a truism. We are  
31 all ageing every day. But I understand it to be  
32 a reference to the fact that the average age of the  
33 population within the state is increasing. In short, we're  
34 living longer. So the proportion of the population which  
35 is in the older cohort is growing.

36  
37 Another thing the submissions tell us is that that is  
38 not uniformly distributed. There are some areas of the  
39 state in which the average age of the population is higher  
40 than others. Particularly rural and regional areas, what  
41 we are told, and it's a matter that might need to be  
42 explored, is that there is an increasing tendency for the  
43 population to be in the older end of the spectrum.

44  
45 Now, what we've also been told is that people, at  
46 least in general terms, receive most of their health  
47 treatment towards that later part of their life.

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By way of example, we've been shown some statistics that suggest, as a percentage of their relevant cohort, emergency department presentations are largely constant for that age 6 to 64 bracket, but then we see a significant rise once we get into the 64 and above.

It has also been suggested to us through some of the submissions that people aged 65 and older - it is related to the statistic, I suspect, which I have just referred to, but people aged 65 and older are far more likely to be hospitalised than those in younger age groups

Again, none of that is particularly surprising, but the fact that we do have this increasingly ageing population is starting to present pressures and challenges to the health system.

The other thing that is important, and is referred to in a large number of the submissions, is the fact that the people of New South Wales, and Australians generally, are not only living longer, but they're living with a much heavier burden of disease, and we've seen a real shift, apparently, towards chronic conditions over the last few decades.

That also brings with it a range of pressures that get imposed upon the health system, but then one needs to build into that another little factor, which is the constantly evolving nature of treatment. Now, again, we're looking at something which is quite positive: treatments are evolving, they're getting better, but at the same time, a lot of these treatments that are evolving - and we've been told by one research institution that there's a literal wave of them coming through to the benefit of people who need them - are very, very expensive. All of those things combine to produce a very significant impact or very significant pressures on the health system because, when taken together, not only do they increase the physical demand on the health system, but they also greatly increase the cost associated with delivering it.

NSW Health currently spends over \$30 billion on health care. It is the largest section of the state budget. At the moment, we're told that that is largely concentrated in hospitals - about 85 per cent of it; prevention and promotion account for about 10 per cent; and the

1 remainder --

2

3 THE COMMISSIONER: What is promotion?

4

5 MR MUSTON: The promotion of prevention; the promotion of  
6 good health. And then the remainder, which is about  
7 5 per cent, is invested in community and other care  
8 settings.

9

10 The distribution of costs reflects a historical  
11 hospital-based approach to the delivery of health care.

12

13 THE COMMISSIONER: That 10 per cent on prevention might  
14 depend on what you're counting as prevention.

15

16 MR MUSTON: It might. It certainly might, and there are  
17 others who have suggested in their submissions that the  
18 rate of spend on prevention should be increased to  
19 5 per cent, which does point to the possibility that what's  
20 built into that 10 per cent is not strictly confined to  
21 what others regard as prevention. But these are again  
22 issues we are going to need to tease out, because, as I'll  
23 come to, an increased focus on prevention and the  
24 management of health in a way that ideally reduces hospital  
25 presentations and reduces the need to present at the  
26 hospital is an area where it's being suggested by many that  
27 work needs to be done.

28

29 Dealing with the money side of it again, it has been  
30 predicted by the federal government in its 2023  
31 intergenerational report, that overall government health  
32 expenditure will rise from 4.2 per cent of GDP in 2022-23  
33 to 6.2 in 2062-63. Those projections assume that  
34 historical trends continue as they currently have. It's  
35 hard to say that that is necessarily going to be right in  
36 terms of increasing costs of the delivery of health care.  
37 These are predictions.

38

39 But the important thing about it is what might seem  
40 small, a 2 per cent increase over a long period of time, is  
41 actually a small percentage of a very, very big number.  
42 What that means, and what the submissions tell us fairly  
43 clearly, is that little changes can actually, in terms of  
44 the financial viability of the healthcare system, make very  
45 big differences. But it's not just about the money,  
46 because those very big differences reflect very big  
47 differences which are made to the health and wellbeing of

1 the population that the health system serves.

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1 represent in terms of their chronic illness and the needs  
2 that they have of the health system are unique and  
3 different and they need to be dealt with individually.  
4

5 Because underpinning much of that is what has been  
6 described to us in some of the submissions as the social  
7 determinants of health and we will hear, I suspect, a fair  
8 bit more about that through this Inquiry, because these  
9 social determinants, social aspects about different  
10 populations and groups and individuals, are things that we  
11 are told have the capacity to have a very significant  
12 impact on a person's long-term health trajectory.  
13

14 THE COMMISSIONER: That means things like housing, levels  
15 of education, et cetera.  
16

17 MR MUSTON: Housing, levels of education, exactly.  
18

19 It seems like they're not health-related things but in  
20 fact the impact that those things can have on the long-term  
21 trajectory of an individual's health, we are told, is very  
22 significant, which means part of this is not just working  
23 out how the health system itself needs to be pivoting and  
24 adjusting to deal with these emerging trends and the  
25 developing challenges, but it's a whole of government  
26 issue. We need to be working out how best to deal with all  
27 of the things, the combination of factors, including these  
28 social determinants, in a way that ultimately produces the  
29 best health outcomes for the overall population of  
30 New South Wales.  
31

32 So I guess related to that, we've repeatedly been told  
33 that, as I've said, small changes can make big differences.  
34 Those big differences, as I mentioned a moment ago, are not  
35 only big differences in terms of people's health outcomes  
36 but they're also big differences in terms of the costs and  
37 financial viability of the health system, which probably is  
38 a useful point to move on to funding, which is the next of  
39 the key themes that has emerged from the submissions we've  
40 received.  
41

42 Again, a theme that we will probably return to a lot:  
43 one of the big challenges presented in the funding space,  
44 we are told, is the fragmented manner in which health is  
45 funded in New South Wales. That, I think, is unlikely to  
46 come as a surprise to anyone familiar with the health  
47 system.

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But the centrality of funding to what we're doing is probably best reflected in what we were told by the health minister, Ryan Park, when he announced this Inquiry, and that is the Inquiry is about taking a once in a generation look at how our health system is funded so we can ensure patients and our essential healthcare workers are getting the support they need.

Funding is obviously a central component of the Inquiry. The way in which the funding is arranged can have very significant impacts on the way in which the health care is delivered, but it's not the only issue, as we will come to.

Once we move through it, if we can get the funding structures right, that's terrific. To the extent that the funding structures are something that, by reason of issues I'll come to in a moment, we can't easily change, we do need to look at how best to work within those funding arrangements to produce the change in the delivery of health care that we are told in the submissions is needed.

But, as I say, examining the funding, that's key to this Inquiry, and it's something that we're going to have to look at.

There are a few different aspects to it. The first that we've been told about a lot is the Commonwealth/state divide. So funding of health care in New South Wales is shared between the Commonwealth and the state governments, and to some extent, is contributed to also by private health insurers.

Unfortunately, we're not just dealing with a simple allocation of a big bucket of money. The fragmented nature of the existing funding arrangements, as I've indicated, also reflects the fragmented way in which different aspects of the health system delivers care to people. But let's start with the funding.

The existing Commonwealth and state arrangements are set out in a series of agreements, including what has been described as the National Health Reform Agreement. We will hear a lot more about that shortly, and the current addendum to that agreement covers a period 2020 to 2025.

1 THE COMMISSIONER: That's an agreement in relation to  
2 which there's what's called a mid-term review taking place  
3 now?

4  
5 MR MUSTON: As we speak.  
6

7 Now, we will return to some of the detail around that  
8 in a while, but at a very high level, the effect of the  
9 agreement is that the Commonwealth Government is  
10 responsible for the funding of - primarily responsible for  
11 the funding of primary care services through Medicare and  
12 the PBS, and the Commonwealth and states and territories  
13 share responsibility for the funding of public hospitals.  
14 The Commonwealth Government is also largely responsible  
15 outside of that for the funding of the aged care sector and  
16 the NDIS.  
17

18 Throughout an individual's life, all of these systems  
19 are likely to overlap in one way or another, sometimes  
20 simultaneously, in the delivery of care.  
21

22 What the Inquiry has been told in many submissions is  
23 that the fragmented nature of the arrangements and how they  
24 operate in a practical sense gives rise to some real  
25 challenges in terms of the delivery of efficient and  
26 effective patient-centred care, and that has a range of  
27 consequences which feed into a number of the other themes  
28 that we'll come to look at in a moment.  
29

30 One example is the suggestion that the episodic or  
31 treatment-based nature of the Medicare funding - that is,  
32 you go to the doctor with a problem, the GP, the GP gets  
33 paid by Medicare to deliver a treatment for that problem -  
34 is a form of funding which promotes the delivery of  
35 treatment over long-term health outcomes. Now, it's  
36 undoubtedly a lot more complex than that, but these are  
37 complexities that will need to be explored by the Inquiry.  
38

39 The same little issue has been raised in relation to  
40 what's described as "ABF funding". Again, we'll hear a lot  
41 about that, I suspect, through the course of this Inquiry,  
42 but what is said is ABF, or activity based funding, which  
43 is the way in which at the outset, money flows from the  
44 Commonwealth down to the states and beyond - unpack that in  
45 a moment - has some limitations which might be standing in  
46 the way of the delivery of greater health outcomes as  
47 opposed to efficient delivery of health services.

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Again, in very broad terms, though, the Commonwealth contributes to the funding of the public hospital system through the activity based funding. Under the system, the Commonwealth's contribution to the funding of public hospitals in New South Wales is assessed in a rather complicated way by reference to the activity undertaken in those hospitals across the state.

Again, I won't try and tease out exactly how that activity based funding is assessed at the moment. That's a separate session in and of itself. But what I probably should say about it is, the activity based funding model is said by many to be a good thing. It offers a level of transparency in the funding model as between the Commonwealth and the states, which is, by and large, positive.

What we've been told is that that same funding model, the activity based funding model, is, at least to some extent, being used as the means of allocating funds by the state to each of its constituent parts, the local health districts.

Again, we'll hear in a little while about how all of those constituent parts fit together, but for the purpose of introducing this theme, we assume hospitals provide a range of treatment to patients, each little bit of treatment that is provided to a patient is calculated or identified as an activity, which, grouped together in the state, is fed up to the Commonwealth. Based on that bundle of activity, the Commonwealth identifies the amount of its contribution to the public health hospital system, gives it to the state. The state then, in distributing the money amongst its local health districts, is, in some respects we're told, using this same model of activity delivered through the hospitals in each local health district, driving the funding of each of those local health districts.

Again, there's a level of transparency that is associated with that, which is a positive thing. To some extent the activity which is being delivered in different health districts and the differences between it means that distributing the money by reference to that, at least in some health districts, has its advantages. But it's by no means a perfect system, and the submissions that we've

1 received to date, including submissions from the various  
2 LHDs, or local health districts, tell us that there are  
3 issues with that activity based funding model when it's  
4 applied at that level, at least.

5  
6 It has been suggested - and these are all matters, of  
7 course, we will need to explore through the Inquiry - that  
8 the ABF model inhibits the development and implementation  
9 of innovative models of care, or at least can. It's  
10 suggested that it lacks the flexibility needed to enable  
11 local health districts to respond quickly to the needs  
12 within their district.

13  
14 I guess unpacking that, a facet of it is the activity,  
15 against which funding is assessed is past activity, not  
16 necessarily current or future activity. That's an inherent  
17 weakness, possibly, in the system. The system potentially  
18 fails to promote and appropriately fund models of care that  
19 cover the full spectrum of primary health care within  
20 a hospital, hospital care, community care. Again if we're  
21 in a position --

22  
23 THE COMMISSIONER: It's not designed to do that, though,  
24 is it?

25  
26 MR MUSTON: It's not designed to do that. So the fact  
27 that it's not designed to do that means that, as a funding  
28 model, it doesn't promote it. What it promotes is, we're  
29 told, the efficient delivery, technically efficient  
30 delivery - we'll come to technical efficiency in a moment -  
31 but the technically efficient delivery of treatment within  
32 hospitals.

33  
34 THE COMMISSIONER: There may be innovation in becoming  
35 more efficient in delivery of services so that would be  
36 a benefit of ABF.

37  
38 MR MUSTON: It would be. It would be. But to the extent  
39 that our goal as a health system, we're told, should be  
40 looking to delivering health outcomes which, as best as  
41 possible, keep people out of hospital. If the public  
42 health system and the hospital system, the funding that  
43 surrounds the hospital system is going to be a part of  
44 delivering that, then a model which focuses on the delivery  
45 of services within the hospital as a basis for funding  
46 presents some challenges. The main one, and it's an  
47 obvious one, is that it promotes activity over outcomes.

1  
2           So I mentioned technical efficiency a moment ago, but  
3 some of the submissions that we've received draw the  
4 distinction between technical and allocative efficiency.  
5 Technical efficiency is how efficiently can we deliver the  
6 services that we are delivering. A day in a hospital bed,  
7 what's the most efficient way that we can deliver that to  
8 make sure that the money which is being applied to the  
9 health system is used as efficiently as possible? And that  
10 is not unimportant.

11  
12           But there's another way of looking at it, or another  
13 facet to it, which is what has been described to us as  
14 "allocative efficiency", and that is, to what extent is the  
15 money you are spending on the healthcare system delivering  
16 the best available health outcomes for the people who are  
17 interacting with that system? The Inquiry is going to hear  
18 a lot more about that.

19  
20           In simple terms, what we're told is that the ABF  
21 funding model is very good for technical efficiency but may  
22 not be great for allocative efficiency, and that, as  
23 a health system across the board, not just the hospital  
24 system but the wider health system, consistent with the  
25 themes that came through the changing demographic and the  
26 impact that that has on the pressures and costs of  
27 maintaining the health system, it needs to shift its focus,  
28 at least to some extent, from technical efficiency to  
29 allocative efficiency. We need to be producing health  
30 outcomes, which means the money being spent on health care  
31 is producing the best health outcomes and, as best as  
32 possible, is reducing the amount of demand, financial and  
33 other, that individuals are placing on the health system  
34 throughout their lives.

35  
36           There's a whole lot of other funding issues which have  
37 been identified in the submissions. Some examples that  
38 probably bear mentioning, because they have been referred  
39 to more than once, are the challenges associated with the  
40 annual nature of budgetary cycles.

41  
42           It has been suggested by some that needing to work to  
43 a 12-month budget can prevent LHDs and health organisations  
44 from planning and implementing long-term strategies. It  
45 has been suggested by some that it doesn't allow sufficient  
46 time for innovative models of care to be tested and proved  
47 worthy of scaling up because you've got that 12-month

1 ability to fund it and if you don't have a capacity to  
2 demonstrate that it's worthy of further funding because it  
3 hasn't yet properly proved itself, then it potentially  
4 falls away. But again, whether that's right or wrong is  
5 something we're going to have to look into.

6

7 THE COMMISSIONER: I think we've heard most of their costs  
8 are predictable, but it's at that new program end of the  
9 spectrum where 12 months is said to be problematic,  
10 perhaps.

11

12 MR MUSTON: Yes. The other challenge is - we have heard  
13 that there is a predictable amount of money that each  
14 health district will receive, as you pointed out, but  
15 there's also a predictable amount of spend that will be  
16 associated with that - the demands on the public hospital  
17 system are not going down.

18

19 THE COMMISSIONER: Yes.

20

21 MR MUSTON: So whilst it is true that there is  
22 a predictable amount that most health districts will, year  
23 to year, assume they'll get, they also have a demand being  
24 placed on them that year to year they can expect to see and  
25 perhaps will see increasing. So it is just that little bit  
26 at the top and the ability to have that spare portion which  
27 can be devoted to innovation and devoted to changing models  
28 of care in a way which produces better outcomes which, if  
29 it works in the longer term, can result in, potentially, a  
30 reduction in that baseline of demand being placed on the  
31 public hospital system. It's by no means that simple, but  
32 what we are told is the 12-month nature of the budgetary  
33 cycles is a challenge, and these and other issues will need  
34 to be examined.

35

36 Moving on from funding, the next issue, which is a  
37 little bit related - and again, it's going to become  
38 a recurring theme - is what we're told are challenges  
39 associated with the access to primary health care and other  
40 forms of care, which again draws on this theme of the  
41 fragmented nature of the delivery of health care and other  
42 forms of care within the hospital system, the primary  
43 health care system and other forms of community based care.

44

45 Now, what we're told in submissions is that particular  
46 challenges are being presented at the moment by reduced  
47 access to a lot of the healthcare services which are funded

1 primarily by the Commonwealth, including general  
2 practitioners, aged care and the NDIS. Again, these  
3 challenges are not spread uniformly across the state. In  
4 some areas, we are told they're particularly acute; in  
5 other areas, less so, but everyone is experiencing  
6 a problem of some sort in relation to accessing all of  
7 these various levels of care.

8  
9 Again, all of this emerges in part from the fragmented  
10 nature of the funding of health care and the fragmented way  
11 in which it's delivered because one single system, the  
12 New South Wales public health system, for example, at the  
13 moment doesn't have complete control over all of them and  
14 can't be diverting its resources easily into filling voids  
15 as and where they see them, because that's, in part,  
16 something that's being dealt with by another funding  
17 source, and in part being dealt with by the private market.

18  
19 So all of these challenges interact in a way that is  
20 producing, we're told, some deficiencies in other areas of  
21 care across the state, which present challenges. Some  
22 examples that we've been given are: there was a General  
23 Practice: Health of the Nation 2023 report published by the  
24 Royal Australian College of General Practitioners, which  
25 indicated that, I think, 29 per cent of GPs intend to  
26 retire within the next five years, and we're told that this  
27 coincides with a significant reduction in the number of  
28 medical graduates who are entering general practice  
29 training programs, and the long-term effect of that is, if  
30 that trend continues, a reduction in the number of general  
31 practitioners available to the community and a consequent  
32 reduction in the availability of primary health care, the  
33 predominant form of primary health care in its current  
34 form.

35  
36 Another thing we've been told, but we will really need  
37 to look into exactly whether this is empirically based, is  
38 that this trend has also resulted in an increase in  
39 presentation to emergency departments, particularly of  
40 patients who perhaps are presenting with issues that might  
41 more traditionally have been dealt with in the primary  
42 health network by GPs.

43  
44 It has also been suggested - and again, we will need  
45 to look into how empirically based this is, it may just be  
46 an impression, but we've been told that patients presenting  
47 to the emergency department, in some areas where there are



1 real challenges in accessing primary health care, are  
2 presenting to emergency departments with a high level of  
3 acuity, ie, they're sicker than might traditionally have  
4 been the case.

5

6 Now, again, whether or not that's actually right might  
7 actually be difficult for this Inquiry to assess. That's  
8 a big statistical exercise. It's very important, I  
9 imagine, for NSW Health to be looking into those  
10 statistics. But whether this Inquiry can make its own  
11 assessment of it is --

12

13 THE COMMISSIONER: Depends what's available, yes.

14

15 MR MUSTON: -- another matter.

16

17 But again, that probably doesn't matter, because  
18 what's important from the point of view of this Inquiry is  
19 a recognition of primary health care, as we've been told by  
20 the overwhelming majority of people who have made  
21 submissions, is really important, and if there are problems  
22 with the availability of primary health care, and those  
23 problems can't easily be solved by magic-ing up some more  
24 GPs in particular locations, the health system, the public  
25 health system in New South Wales, might need to look at  
26 ways of addressing that problem, that challenge, and it  
27 might need to look at ways of adjusting the funding models  
28 or engaging with the Commonwealth in a way that produces  
29 a solution to that problem which is actually real and  
30 achievable.

31

32 One example that we have been given in one of the  
33 submissions is what is described as the "single employer  
34 model" being implemented by the Murrumbidgee LHD.  
35 I suspect we will hear a little bit more about that through  
36 the course of the Inquiry, but that seems to be a way in  
37 which the public health system has pivoted in an attempt to  
38 deal with what was perceived to be some problems in the  
39 availability of primary health care within the area covered  
40 by that local health district. But ultimately we will need  
41 to explore it.

42

43 The extent to which any little adjustments or changes  
44 made in the public health system result in a shifting of  
45 the funding burden, as between the state and the  
46 Commonwealth, is again something that we're going to have  
47 to be mindful of, but also we'll have to look at ways of

1 dealing with, because it's just not an answer, not  
2 a satisfactory answer, to say on either side of that  
3 ledger, "This is funded by us, that's funded by them,  
4 therefore, they'll deal with it."  
5

6 That's something that is often heard in this space,  
7 and I think the beauty of an inquiry like this is it has  
8 the capacity to cut through some of that and look for ways  
9 in which changes can be made, systemic ways in which  
10 changes can be made, to deal with the problems which might  
11 have multiple funding sources.  
12

13 THE COMMISSIONER: You can't say "This patient is  
14 a New South Wales patient"; "This one is a Commonwealth  
15 patient".  
16

17 MR MUSTON: No. And what we're overwhelmingly told is  
18 that every patient is a patient which is navigating their  
19 way through the wider health system, and to produce the  
20 best outcomes for that patient, which, in turn, will result  
21 in the best outcomes, both financially and in terms of  
22 demand for the wider health system, is to deal with them,  
23 what we're told repeatedly, in a patient-centred way - that  
24 is, to meet the needs of that patient at every stage of the  
25 process and to interact and cooperate with one another in a  
26 way that makes sure that the needs of that patient are  
27 identified and best addressed.  
28

29 So that's the primary health care piece.  
30

31 The next thing we're told in a number of our  
32 interactions, particularly with the local health districts  
33 and in a number of the submissions which we've seen, is the  
34 challenges presented by the difficulty in accessing beds in  
35 residential aged care facilities, which again are the  
36 responsibility of the Commonwealth. But what that means in  
37 terms of the state health system is, we're told, elderly  
38 patients might be living in their home, they have a fall,  
39 they might break an arm, for example. They are presented  
40 to an emergency department, they are admitted to a public  
41 hospital in an orthopaedic ward. They have their arm  
42 treated, at which point they are fit to be released from an  
43 acute care setting, they are well enough to be released  
44 from that setting, but they're not quite well enough to go  
45 home. In the case of that patient - and this is just  
46 a hypothetical patient, there are across the state  
47 obviously a great many patients, but in the case of that

1 hypothetical patient - the challenge presented to the  
2 public health system is: where can they go if they can't  
3 go home? The logical answer is a residential aged care  
4 facility where they can receive the care that they need,  
5 the rehabilitation that they need, the level of support  
6 that they need in order to get well quickly.

7  
8 But if there's not a bed available in a residential  
9 aged care facility, the default or fall-back is they remain  
10 in a hospital, and that has a range of problems associated  
11 with it. The most important one, before I'll come to the  
12 bed blocks and the things that we sometimes hear about in  
13 the press, the most important consequence of that is,  
14 counterintuitive though it may sound, being in a hospital  
15 is not the best place - or a hospital is not the best place  
16 for these people to be, from the point of view of their  
17 health.

18  
19 The patient who is well enough to leave an acute  
20 setting but remains there actually becomes exposed, we're  
21 told, to a range of other risks and problems - a risk of  
22 contracting an illness, risks associated with a general  
23 decline in wellbeing because you're not up and mobilised in  
24 a way that you might be if you were in a rehabilitation  
25 facility.

26  
27 All of these things, in the case of an aged and frail  
28 person, can combine, we're told, to very quickly produce  
29 health outcomes which are very much inferior to those which  
30 would have been achieved if that patient was quickly moved  
31 out of the acute care setting and into a more appropriate  
32 place for them to have that much lower level of care but,  
33 nevertheless, very important care, delivered appropriately.  
34 Again, I've mentioned it now, one can't really talk about  
35 this problem without mentioning the bed blocks.

36  
37 What we're told - again, I think the sense one gets  
38 reading the submissions is that this is not a uniform  
39 problem across the state, but one of the challenges that  
40 having patients staying in hospital longer than they need  
41 to be there presents to the hospital system is,  
42 a difficulty to move patients through that system in a way  
43 which maximises the number of patients that you can see and  
44 admit, treat and move on as quickly as practicable, and  
45 that presents its own challenges. We hear a lot about  
46 them, they really, in our minds, probably should be  
47 secondary to the health outcomes which are associated with

1 this situation.

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Again, without needing to go into the detail of it, there has been some suggestion in some of the submissions that similar issues can emerge in terms of the interaction between a public health system and the NDIS system. Again, we can explore that in more detail but it doesn't really bear repeating with another hypothetical example for present purposes.

All of these issues are issues the Inquiry is going to have to look at. They have been raised sufficiently frequently in the submissions for it to be clear, even at this stage, that they're an issue we need to look at.

The next big issue or theme that is recurring in the submissions and our discussions is workforce. This is, some might say, one of the bigger issues because the overwhelming majority of people who've made submissions have talked about it, but they each bring to it their own perspective, and they are not uniform.

What has been said by many, in terms of these workforce challenges - some of them are common themes. We're told by many that there is a genuine shortage of clinicians and other medical staff in some areas and in some areas of practice, and that presents obvious challenges to the delivery of health care in those areas or within those areas of practice where the shortages present themselves.

We're told that related to that might be a range of challenges or problems arising in connection with the training of staff, clinical staff, medical staff, and the way in which that training operates and the way in which those who are trained feed in to the wider health workforce. Again, we'll have to look at that in a little bit more detail, but training is definitely an issue which has been raised by a great many people.

The apparent maldistribution of the health workforce and the particular challenges that that presents, especially in regional and rural areas, is something that has been raised.

A number people have raised the disparity in rates of remuneration between New South Wales and other Australian

1 and international jurisdictions.

2

3 THE COMMISSIONER: We're not an industrial relations  
4 commission, but where it's relevant on that is whether the  
5 rates of pay are affecting the provision of health services  
6 in New South Wales, including the difficulty of filling  
7 spaces - filling spots for the workforce.

8

9 MR MUSTON: Yes. We have been told that New South Wales  
10 is part of a broad international market, which is currently  
11 competing for the existing clinical and medical workforce,  
12 which is not actually large enough to fill all of its  
13 needs. Whilst New South Wales has, we're told,  
14 historically been a place, quite understandably, where  
15 people do want to live and work, where real challenges  
16 start to present - I will come to this in a moment, but  
17 where real challenges start to present, one looks to other  
18 states and other jurisdictions, for example, New Zealand or  
19 the UK, and looks at the level of remuneration in those  
20 areas and asks oneself, "Do I really want to work here or  
21 do I want to go and work there?" It's for that potentially  
22 slightly greater level of remuneration, and it's an issue  
23 we have to confront.

24

25 It is a particular issue in New South Wales in the  
26 border regions. So to extent those perhaps living close to  
27 the Queensland border are faced with the decision, "Do  
28 I want to work in the hospital on this side of the  
29 artificial line or that side of the artificial line", where  
30 there's a pay differential, if it's a significant one, one  
31 can readily see how that could make a big difference to the  
32 ability of the New South Wales health system in that little  
33 area, that microcosm, to attract and retain staff. It's by  
34 no means the only issue, but it's definitely an issue that  
35 people have raised and we will need to consider it.

36

37 It relates with other issues that feed in to this  
38 workforce piece. For example, it has been suggested that  
39 the inability to obtain or to secure adequate and  
40 affordable accommodation in certain areas is, in itself,  
41 creating problems from a workforce point of view, and one  
42 need only scratch the surface to realise that things like  
43 remuneration matter when it comes to identifying what is  
44 and isn't affordable accommodation. These are not issues  
45 that are unique to remote or rural regional areas --

46

47 THE COMMISSIONER: Affordable or suitable accommodation.

1  
2 MR MUSTON: -- these are issues which are system wide,  
3 whether you are talking about staffing a hospital in the  
4 eastern suburbs of Sydney, where one might take notice of  
5 the fact that accommodation is eye-wateringly expensive, or  
6 whether one is seeking to attract a workforce in a regional  
7 and remote area where the available accommodation might  
8 also be expensive but it can also be very scarce, and other  
9 pressures, state pressures, are being brought to bear on  
10 that same scarce accommodation. There's a whole range of  
11 other services which are delivered in these places -  
12 education, policing; there might be mines in these areas;  
13 private industry might be placing a demand on the  
14 accommodation. The bottom line is, if we are seeking to  
15 deal with maldistribution of the workforce, one thing we  
16 are told we will need to give consideration to is an  
17 ability to accommodate that workforce in the areas where it  
18 needs to be.

19  
20 So the next little issue that sort of ties in to all  
21 of this that we've heard a lot about is the fact that in  
22 some parts of the state a very heavy reliance is being  
23 placed on what is described in the submissions as "premium  
24 labour". Premium labour we understand to mean essentially  
25 locums, medical locums, and agency nurses, to staff  
26 facilities.

27  
28 Locums and agency nurses are not, as a concept,  
29 problematic. They are an important part of the health  
30 landscape. They allow hospitals to top up their workforce  
31 in times of high demand, surge periods. They enable the  
32 workforce, the existing and permanent workforce, to have  
33 holidays and do all of those sorts of things which are  
34 fundamentally important. But if one shifts to a point  
35 where one is placing very, very heavy reliance on this  
36 premium labour, as a central means of providing your  
37 day-to-day health care, we are told that that raises  
38 a number of pretty significant issues, not the least of  
39 which being spiralling costs. We're told that there is  
40 potentially competition which emerges, not directly but  
41 indirectly between the various different health districts  
42 who are trying to access this network. Again, you've got  
43 a lot of spots to fill, or if you have a lot of spots to  
44 fill and there's a limited number of locums who are looking  
45 to fill those spots, then inevitably, there's going to be,  
46 whether it's direct or indirect, some competition between  
47 the various health districts who are trying to secure their

1 services.

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10 THE COMMISSIONER: Morale, we're told.

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But it also has another impact, which is a greater reliance on the premium labour workforce results in a largely transient workforce within certain areas, and that has an impact on the way care is delivered but it also has an impact on the way in which the workforce operates as a happy and harmonious unit.

THE COMMISSIONER: Morale, we're told.

MR MUSTON: Morale, yes, exactly.

THE COMMISSIONER: We have had a lot of submissions on this, and it's clearly not a new issue, because Justice Garling raised it in 2008 his report 15 years ago, and suggested - well, he made a recommendation about how to deal with it, but it didn't seem to get picked up for reasons I don't think we know yet. I think the last submission I read was 200 and something, so we might have gone past the figure you suggested. I'm not sure we've had a submission from an agency yes, have we?

MR MUSTON: I'm not aware of one from a locum agency.

THE COMMISSIONER; no.

MR MUSTON: We will obviously need to explore what was done in response to the recommendation along these lines made in the Garling report, and why we are still in the position we are in in relation to this issue.

THE COMMISSIONER: Which was some sort of centralisation which was suggested, yes.

MR MUSTON: Because there may well be a logical, or perhaps logical but not necessarily clearly visible, reason why what seemed to those responsible for the Garling report to be an obvious answer to the problem, which, when it was attempted to be rolled out in practice just hasn't worked, but we will need to get to the bottom of what that is. All of these issues are inherently related, these workforce issues. One can't pick one of them off and say, "Let's solve that one because that one's going to solve all of our problems." They interact with one another in a way which means a systemic look at all of them and ways in which bringing about a systemic improvement that will

1 harness all those issues, bring them closer together in a  
2 way that produces a good outcome, is going to be important.

3  
4 THE COMMISSIONER: There are multiple complaints about the  
5 use of locums - "complaints" might be the wrong word. It's  
6 raised a lot as an additional cost that maybe could be  
7 avoided. Maybe it can't be. But I think we're told it  
8 might require a national approach to deal with it. But  
9 I don't think it has been explained to us yet what that  
10 national approach might look like.

11  
12 MR MUSTON: No. Consistent with the exchange we had in  
13 relation to the pay differential, the issue, particularly  
14 with a medical locum workforce that New South Wales faces  
15 is, we're told, it is trading in an international market.  
16 The locums that are available to fill positions in, say,  
17 western New South Wales, are equally available,  
18 potentially, to fill positions in any other state or in  
19 New Zealand.

20  
21 Perhaps when we're dealing with the locum market it's  
22 somewhat more regional than the overall workforce, but  
23 still, for those short-term placements, it is very quick to  
24 fly to New Zealand, for example, and if there's a good  
25 placement being offered there for a locum and it's, for  
26 whatever reason, more desirable to that locum and fits in  
27 better with their life than something that's offered  
28 somewhere in New South Wales, then one can readily see why  
29 they might go there, but how one deals with the push and  
30 pull factors is something that we will have to have a look  
31 at.

32  
33 All of those things, we're told, can have a real  
34 spiralling effect in particular locations, and at a very  
35 general level. You might have workforce challenges in a  
36 location or a particular department at a location that  
37 produces more pressure on the department or on the  
38 workforce and a less satisfied workforce.

39  
40 Now, sometimes there are little human things that fit  
41 into that which are very hard to control, but when you get  
42 that increase in pressure, reduction in satisfaction in a  
43 workforce, those less satisfied workers tend to be a little  
44 bit more inclined to leave for what increasingly start  
45 looking like greener pastures, which in turn manifests  
46 itself within that location or department as recruitment  
47 and retention challenges, potentially, a higher level of



1 reliance on a transient workforce, which in turn can lead  
2 to a further increase in the pressure, can lead to  
3 a further increase in that general decline in morale, and  
4 what flows from that is a further increase in those  
5 problems.

6  
7 We don't pretend it's simple, but one thing that we  
8 have seen, in comparing the submissions and in our  
9 discussions with various LHDs, is that it's hard to predict  
10 where these problems will emerge. But once they do emerge,  
11 they can become entrenched and very hard to deal with.

12  
13 One might sort of look to things that feel like they  
14 might be a logical cause of some of these problems. You  
15 might look to a very remote location and say, "It is  
16 obviously going to be very hard to staff that very remote  
17 location", and so you might expect to see some of those  
18 problems there.

19  
20 But in fact, what we might be told in relation to that  
21 location is there is a really happy and engaged workforce,  
22 which is collaborating really well with other local health  
23 providers, the Aboriginal health providers, the LHD, the  
24 hospitals, the Royal Flying Doctor Service, to produce  
25 a workforce which is actually really happy and engaged and  
26 they don't have those problems there. Whereas you might  
27 come to somewhere which is far less remote and in many  
28 respects seems like it should be less bedevilled by these  
29 problem, but it has them, and trying to work out why these  
30 problems emerge is going to be difficult, and I think  
31 perhaps impossible in some cases, because of the human  
32 element that I'm going to come to in a moment. But trying  
33 to work out whether there are aspects of the system which  
34 might be adjusted to try and turn them around I think is  
35 going to be an important part of what we can do through  
36 this Inquiry.

37  
38 In terms of what we can do on that front - again, it's  
39 easy to say, but we need to actually look at what it is we  
40 can do. What we can do is have a look at what is happening  
41 in various parts of the state and things that are working  
42 well, because we've been told about a whole lot of ways in  
43 which the health system, in certain places and in some  
44 areas, has adapted in response to these issues. Existing  
45 models of care have been described, which we're told really  
46 harness the full capability of the local health workforce  
47 and utilise technology in a safe and effective way to

1 overcome gaps in the medical workforce. So it would be  
2 useful for the Inquiry to look at areas in which that has  
3 worked well, because the reality might be that that's a far  
4 better and more realistic solution to some of these  
5 problems than trying to conjure up a workforce which just  
6 does not exist. Maybe there are better ways of delivering  
7 health care that overcome these problems and maybe they, in  
8 fact, deliver better health care.

9  
10 We've heard about partnerships which have been  
11 developed between local health districts and training  
12 institutions, which we're told facilitate the training of  
13 local people within that local health district setting, as  
14 part of the nursing workforce, as part of the other  
15 workforce, and to some extent, as part of the medical  
16 workforce, and it has been suggested that strategies like  
17 that greatly increase the chance of the people, once they  
18 have completed their training, staying where they are.

19  
20 One of the things that has been mentioned a few times  
21 to us in our discussions and through submissions is the  
22 fact that a lot of the training of the medical workforce  
23 tends to happen in the larger tertiary hospitals, which are  
24 predominantly located in areas of high population. But  
25 once trained in those areas, and training of the medical  
26 workforce is not a quick process, the individuals who are  
27 located in those areas, they train, they become established  
28 personally in those areas, and even those who might have  
29 come from the rural and regional areas to do their  
30 training, often don't go back, in part because, at  
31 a perfectly human level, they become settled.

32  
33 Are there ways in which things could be changed which  
34 would perhaps adjust that cycle a little bit? We can look  
35 at that. But again, we look at it by examining ways in  
36 which it has been done well in other areas.

37  
38 Again, like everything else, there's no single  
39 solution to these problems, but what we should do is look  
40 more broadly at the funding and governance arrangements and  
41 identify how well suited they are to evaluate and harness  
42 the appropriate scope of practice in all members of the  
43 health workforce, and to ensure that all members of the  
44 health workforce are being utilised to their greatest  
45 ability and capacity.

46  
47 That's important for a few reasons - first, it makes

1 sure that as much genuine value care is being delivered  
2 across the state as can be by the existing workforce; but  
3 it also has the real capacity to address some of these  
4 issues around work satisfaction and morale. If people are  
5 able to work to their full capacity, then they, one would  
6 hope, are going to be happier in their work, and these  
7 little things - keeping people happy and satisfied and  
8 challenged in their work - as we see, can make a big  
9 difference. They can stop that spiral from occurring or  
10 they can potentially turn it around.

11  
12 We should look at the existing arrangements for the  
13 training of the clinical workforce and consider whether,  
14 and, if so, how any aspects of those arrangements might be  
15 contributing to the workforce challenges. We should  
16 examine the extent to which existing recruitment  
17 arrangements operating across the public health system  
18 might be contributing to workforce challenges or might be  
19 adapted to better meet those challenges, and consistent  
20 with an exchange we had a moment ago, we might include in  
21 this examination another look at the way in which  
22 that premium labour workforce, including locums and agency  
23 nurses, are being engaged across the state.

24  
25 We can also examine the way in which the medical staff  
26 practising in the private sector, the VMOs about which the  
27 Inquiry will hear a lot, are being utilised to deliver  
28 health care throughout the public health system and ensure  
29 that it's being done in a way that best serves the users of  
30 that system.

31  
32 What we have been told is that VMOs provide a critical  
33 and important component of the delivery of care within the  
34 public health system and they are, for that - and for what  
35 they bring to it - a great asset. But equally, one needs  
36 to look at the way in which they're being utilised in order  
37 to understand whether that is in any way contributing to  
38 any of these workforce issues and, if so, what adjustments  
39 need to be made to deal with that.

40  
41 Can I move on from the workforce issues and come back  
42 to this recurring theme of the fragmented nature of the  
43 health system, this time through the lens of information  
44 sharing.

45  
46 Another theme that has emerged from some of the  
47 submissions, and a challenge which we've said arises, is

1 a lack of information sharing between the various fragments  
2 or parts of the health system that contribute to the  
3 provision of care for a particular patient.  
4

5 Even within the New South Wales public health system -  
6 that is, between local health districts - we're told that  
7 patient information is not particularly well shared at the  
8 moment. It may come as a surprise to hear that we're told  
9 that there is no single computer system holding patient  
10 records which applies across the whole of the public health  
11 system as matters stand.  
12

13 Now, work is being done by NSW Health, we're told, to  
14 deal with this through a project which is being described  
15 as the "single patient record". We will probably hear a  
16 little bit more about that through the course of the  
17 Inquiry. But the importance of that information sharing  
18 really can't be underestimated, and we can't stop in our  
19 little search for ways of improving the information sharing  
20 at the boundaries of the New South Wales public health  
21 system, because information sharing from one public  
22 hospital to another, obviously enough, is going to be very  
23 important.  
24

25 Any patient who presents at one public hospital and  
26 then presents at another, in terms of their best care,  
27 needs to be in a position where those who are providing  
28 their care know exactly what has happened at the other  
29 hospital. Patients that are transferred from one hospital  
30 to another in a different LHD, equally, you would like to  
31 think have the benefit of full transparency of exactly what  
32 has been done at the first hospital so that work can be  
33 seamlessly picked up in the second hospital to provide the  
34 best care for them without unnecessary repetition or  
35 wastage.  
36

37 But equally, the sharing of information between the  
38 primary care sector and the public hospital system is  
39 something we've been told is particularly challenging.  
40 Challenges, we're told - those challenges impact on the  
41 ability of those providing care to a patient at hospital to  
42 provide the best care.  
43

44 Let me unpack that a little bit because I perhaps  
45 haven't been as clear as I should have been. A patient who  
46 has been receiving a particular course of treatment in the  
47 primary health sector, say through their GP, presents in

1 the middle of the night at an emergency department with an  
2 acute episode. Ideally, the hospital and the medical and  
3 clinical staff treating that patient in that hospital  
4 setting would need to know, or would like to know, exactly  
5 what this patient's history is and what might have brought  
6 them to hospital on that night, and where one relies  
7 largely on the health literacy of the patient and the  
8 patient's ability to deliver a full and accurate history of  
9 their health care, there is inevitably going to be problems  
10 in terms of a seamless transition from one health service  
11 to the next, which will result, potentially, in the patient  
12 receiving care that they don't need; potentially, the  
13 patient receiving care that they should not get; and,  
14 potentially, the patient receiving care which is  
15 repetitious of care that they've received already, or  
16 resulting in inefficiencies and all those things, which  
17 could and should be avoided not only for the financial  
18 consequences but also for the benefit of that patient who  
19 shouldn't be subjected to any more tests or treatment than  
20 they absolutely require.

21  
22 But the challenges also go in the other direction.  
23 We're told of challenges faced by general practitioners who  
24 have had patients admitted to a hospital or presented at  
25 a hospital and delivered with a particular type of care or  
26 treatment at that hospital, and then discharged from the  
27 hospital, that patient presents to their GP, there are  
28 discharge summaries which are provided. The extent to  
29 which those discharge summaries find their way to the GP  
30 who has been providing the care is imperfect, because,  
31 again, a lot of that depends on the ability of the person  
32 who presents at hospital to provide the right information  
33 about who that information should be sent to. But, equally,  
34 in big systems, things sometimes just don't work, where it  
35 actually involves a conscious decision to take a piece of  
36 information and deliver it to some external source.

37  
38 The content of that information again, where one is  
39 taking a piece of information and consciously deciding to  
40 package a bit of it up and deliver it to another external  
41 source, like a GP - say, the hospital taking a bundle of  
42 the information from within its records and delivering it  
43 to that GP - involves a decision being made by someone as  
44 to what information needs to be passed on, and that again -  
45 there are human issues that intervene there to mean that it  
46 can sometimes be imperfect.  
47

1 All of these things combine to produce real problems  
2 in terms of, we're told, the integrated care which is  
3 provided to individual patients. Again, one can readily  
4 see the problems that that can present, if our overall  
5 focus is to provide for each individual patient the best  
6 form of patient-centred care which delivers in an efficient  
7 way, the best health outcomes for them.

8  
9 That's something that we're going to have to examine  
10 in the course of the Inquiry because it's not enough to  
11 talk about problems with the fragmented nature of the  
12 funding and the fragmented nature of the delivery, if some  
13 or other of those things can't be changed. One thing that  
14 can be changed is trying to remove some of the problems  
15 associated with those different fragments to bring them  
16 together in a slightly more cohesive way so that the care  
17 that they provide individual patients is more seamless.

18  
19 THE COMMISSIONER: It's not clear to me yet, and this  
20 could be because of me not anyone else, but the interface  
21 between what is proposed as the single digital patient  
22 record and primary care.

23  
24 MR MUSTON: As we understand it, at the moment, there's no  
25 immediate proposal as part of the single patient record  
26 project, to roll out a full integration across all of these  
27 parts of the health system.

28  
29 THE COMMISSIONER: Yes.

30  
31 MR MUSTON: What we are told, I anticipate we will be told  
32 in evidence, is that as a starting point, by centralising  
33 the system operated by the public health system, by the  
34 public hospital system, we greatly improve the ability for  
35 that system to engage with the various forms of software  
36 routinely used within the primary health sector for the  
37 keeping of patient records there. So as a starting point,  
38 clearly, getting one single system which contains all of  
39 a patient's information within the health ministry is going  
40 to make it a lot easier for that single system to then  
41 start talking to the handful of systems which are used by  
42 the overwhelming majority of primary care providers across  
43 New South Wales.

44  
45 Now, we are told that there is a degree of information  
46 sharing which is happening. So where a patient presents at  
47 hospital there are discharge summaries which are presented,

1 and to the extent they can be provided based on the  
2 information which is given by the patient, they are, and  
3 I'm sure in many cases, that's adequately perfect.  
4

5 There is also informing sharing, we are told, in terms  
6 of some statistical analysis conducted by the state, to try  
7 and look at health trends and look at ways in which, the  
8 delivery of health care, might be shifted. The state is  
9 able to harvest information from its own health systems,  
10 albeit at the moment various systems, to look at trends and  
11 look at these changes, but equally we are told that there  
12 is a high degree of collaboration between those parts of  
13 the ministry which collect the information and some of the  
14 larger primary health providers. The groups of, say, GP  
15 practices that cover a wide area, they use single point  
16 software and have a greater ability and a willingness,  
17 we're told, to provide high level, obviously anonymised,  
18 information about health trends and the like which can be  
19 useful in terms of formulating changing approaches to the  
20 delivery of health care.  
21

22 That raises two other issues, which we probably should  
23 touch on. The first is, obviously where we are looking to  
24 improve the nature of the delivery of health care from an  
25 outcomes point of view and perhaps target our focus on  
26 outcomes, it's critically important that the system has  
27 a proper visibility of what those outcomes are, because as  
28 a silo, the public health system, delivering care  
29 predominantly through hospitals, struggles to work out what  
30 is best in terms of long-term, outcome-based care if it  
31 doesn't have visibility of what a patient's longer-term  
32 outcomes are once they leave the hospital system and find  
33 their way back into the primary health network, to the  
34 extent that it's not being delivered by the public health  
35 system.  
36

37 That's really important, we're told, in relation to  
38 things like identifying what has been described as "low  
39 value care", a concept I will come to in a moment. Low  
40 value care, a form of treatment which it's said is not  
41 actually justified having regard to the clinical outcomes  
42 it produces. I won't name any particular type of care. It  
43 is a controversial area. But the reality is, the ability,  
44 at least at an evidentiary level, to identify whether the  
45 long-term benefits of a particular form of care,  
46 a particular treatment, or a particular medication or a  
47 particular mode of delivering health care to someone - to

1 work out whether they are providing genuine value in terms  
2 of good health outcomes, one needs to see that patient all  
3 the way through the full trajectory of their health journey  
4 to identify - and not just that patient but all of the  
5 patients who are receiving it, in order to get enough  
6 information and to harvest enough information about them to  
7 work out whether things are working well or not and, if  
8 they are not working well or not producing good health  
9 outcomes, what adjustments need to be made in order to  
10 adjust that.

11  
12 But the other thing that probably needs to be  
13 mentioned, at this point, when we're talking about this,  
14 and particularly when we use a phrase like "harvesting  
15 data", there is an issue around the integrated nature of  
16 people's healthcare records which raises concerns. People  
17 are concerned and alarmed sometimes by the prospect that  
18 people might - others, people across a wider health system,  
19 might be able to view their health records. They are an  
20 intensely personal thing. So real care needs to be taken  
21 in managing that side of it, because inevitably it needs to  
22 be an opt-in system, and to encourage people to opt in they  
23 need to be assured that it's safe and that the benefits,  
24 both for them and at a systemic level, overwhelmingly  
25 favour a more open and shared approach of health data.

26  
27 THE COMMISSIONER: Sure. Are you moving to another issue?

28  
29 MR MUSTON: I am.

30  
31 THE COMMISSIONER: We might have a break. We will have  
32 a break until 5 to 12.

33  
34 Just for moving forward, it's a minor matter, there is  
35 no need for people to stand when I walk in or leave this  
36 Inquiry. I'm sure, when I come in, you will generally fall  
37 into silence for a while, but there's no need to stand. We  
38 will adjourn until 5 to 12.

39  
40 **SHORT ADJOURNMENT.**

41  
42 THE COMMISSIONER: Yes, Mr Muston.

43  
44 MR MUSTON: I should probably come back very quickly to  
45 one issue, Commissioner. You asked whether we'd received  
46 any submissions from agencies. I think, having had a quick  
47 look at it over the adjournment, we have received one brief



1 submission from an organisation called E3 which is  
2 involved in - I am sorry, the submission number is E3.  
3 It's from a group who supply some agency nurses. The  
4 submission, helpfully, doesn't give a name. But they are  
5 involved in the provision of agency nurses, which is  
6 presumably why neither you nor I were able to bring it  
7 immediately to mind when we were having an exchange about  
8 that topic a little bit earlier.

9

10 THE COMMISSIONER: I've still got a couple to read. Maybe  
11 that's one of them.

12

13 MR MUSTON: It has been brought to my attention. We will  
14 endeavour to bring it to your attention.

15

16 THE COMMISSIONER: No worries.

17

18 MR MUSTON: Can I turn to the next topic, which is a theme  
19 that sort of travels through some of the submissions, and  
20 that is inefficiencies and waste, as a very broad category.

21

22 There are a number of submissions that refer to  
23 inefficiencies as an issue or a challenge being faced by  
24 the health system. In any big system, there's always going  
25 to be inefficiencies, but equally, in any big system, small  
26 inefficiencies can have large financial consequences and,  
27 where there is, as has been predicted, an increase in  
28 demand being placed upon that system, as that demand  
29 increases, so, too, does the capacity of those  
30 inefficiencies to produce significant and important  
31 consequences, and where even a well-delivered health system  
32 is always going to be working with a challenging budget,  
33 because delivering health care is very, very expensive,  
34 trying to work out those inefficiencies as best as is  
35 possible is obviously going to be to the best benefit of  
36 the system.

37

38 They operate at a few levels. There are probably only  
39 two that are worth touching on at this stage. The first is  
40 inefficiencies that arise through procurement. Again,  
41 we've been told that NSW Health is undertaking  
42 a significant review of its procurement processes across  
43 the system and looking to introduce some new and fairly  
44 sophisticated procurement arrangements.

45

46 THE COMMISSIONER: Is it a review or a reform?

47

1 MR MUSTON: I suppose you would call it a reform. That's  
2 probably a better way of characterising it.  
3

4 The important thing about that is we probably need to  
5 keep in mind that things like procurement and identifying  
6 inefficiencies in areas like procurement really need to be  
7 looked into at a systemic level, because what might be  
8 perceived as an inefficiency in one area, and we have  
9 heard, in submissions and discussions, about what are  
10 perceived to be inefficiencies in certain areas, might  
11 actually be producing significant benefits at a system-wide  
12 level.  
13

14 Come up with a hypothetical example, a particular  
15 service which is used in all hospitals across the state,  
16 a health district close to an industrial area might find  
17 that the provision of this particular service is able to be  
18 obtained more cost-effectively than it is currently being  
19 provided through a centralised procurement service. We  
20 have been told that sometimes those who are providing the  
21 service in that area will actively reach out to the local  
22 health district and encourage them to the view that they  
23 could be getting it more cost effectively, and where  
24 a local health district is managing a tight budget, that's  
25 understandably enticing.  
26

27 But if one then steps back and looks at that same  
28 service as it's delivered across all of the health  
29 districts, you might find that what is a little bit more  
30 expensive in that little LHD, when one goes out to some of  
31 the more remote LHDs, is actually very significantly  
32 cheaper than they could obtain it locally, and system-wide  
33 it produces very great savings for the health system.  
34

35 I raise that only because when we're looking at  
36 procurement and trying to examine what health is doing,  
37 what we probably should have a careful eye to is the extent  
38 to which the wider health system is actually looking at the  
39 systemic effect of inefficiencies or perceived  
40 inefficiencies and wastage, because that's, from  
41 a budgeting and funding point of view, what really matters  
42 the most.  
43

44 The other form of inefficiency which I have already  
45 addressed briefly, but it is touched on in a number of  
46 submissions, is this concept of low value care health, and  
47 I probably don't need to develop that in any more detail

1 than I really have. It's treatment which is perceived to  
2 be of limited clinical benefit.

3

4 I probably should point out that at least one of the  
5 submissions we've received suggests that low value care can  
6 represent up to about 30 per cent of all care delivered  
7 within the health system, and --

8

9 THE COMMISSIONER: That's from an expert.

10

11 MR MUSTON: Professor Braithwaite, I think, has pointed to  
12 that. That's very significant, in the context of the  
13 overall size of the health budget, 30 per cent. It's  
14 obviously not 30 per cent of that total budget but  
15 30 per cent of the component of that budget that relates to  
16 the delivery of health care in a direct way can make a big  
17 difference. But again --

18

19 THE COMMISSIONER: Big cost, low value in health outcomes  
20 or not necessarily ideal health outcomes for huge expense?

21

22 MR MUSTON: Yes. And that, I suppose, feeds in to  
23 a number of these other themes that we've already looked  
24 at, including things like information sharing, identifying  
25 and changing practices in relation to that low value care -  
26 all of these things interact. But the way that they will  
27 interact point to, when we actually get to that pointy end  
28 in this little example of the low value care, the capacity  
29 of these changes or changes that you might make to actually  
30 produce very significant results in terms of the way in  
31 which health care is delivered but equally in terms of the  
32 way in which it's able to be sustainably funded.

33

34 THE COMMISSIONER: I think that 60-30-10 figure you had in  
35 mind with the 30 being low value care, it is  
36 Professor Braithwaite, but just to be accurate, I think it  
37 is the work of the institute that he is part of, which is  
38 the Australian Institute of Health Innovation at Macquarie  
39 University.

40

41 MR MUSTON: Rounded out, again unless I have  
42 mis-remembered it, 60 per cent of the health care is  
43 useful, valuable care; 30 per cent is low value care; and  
44 10 per cent is positively harmful.

45

46 THE COMMISSIONER: Is errors, yes.

47

1 MR MUSTON: To the extent that we could, through any  
2 recommendations or systemic changes, strip back, obviously,  
3 the 10, but equally if we can reduce that 30 down, that  
4 would make a big difference.  
5

6 We have heard examples of a lot of work that has been  
7 done already by the health ministry and by individual LHDs  
8 in relation to these areas, by gathering data, by changing  
9 practices within the community of clinicians, and if we can  
10 look at ways in which that has worked, we've probably got  
11 a greater capacity to identify ways in which the system  
12 could be adjusted to best facilitate that and, in fact,  
13 encourage it.  
14

15 THE COMMISSIONER: I just used the term "error" in  
16 relation to the 10 per cent. Does that also involve  
17 hospital acquired complications like infections?  
18

19 MR MUSTON: I think it may.  
20

21 THE COMMISSIONER: Because that may not involve error;  
22 that might just be, even with best practice --  
23

24 MR MUSTON: I think we might, out of an abundance of  
25 caution, take that question on notice.  
26

27 THE COMMISSIONER: It doesn't matter for now but I just  
28 want to be careful about saying there's 10 per cent errors  
29 because that might be wrong, because there are, you know,  
30 hospital acquired infections that even with absolute best  
31 practice, may not all be avoidable. Anyway, we can pick  
32 that up later.  
33

34 MR MUSTON: What we're told - having raised it we should  
35 probably be more fulsome about it - around 60 per cent of  
36 care is in line with evidence or consensus based  
37 guidelines; 30 per cent of care is some kind of waste  
38 including ineffective care that could have been avoided or  
39 the misuse of resources; 10 per cent of patients are harmed  
40 when receiving care ranging from minor mistakes with  
41 medication administration to errors resulting in death or  
42 disability.  
43

44 THE COMMISSIONER: Okay. It might still require some  
45 drilling down as to what all that means.  
46

47 MR MUSTON: I think it will require quite a bit of

1 drilling down. To the extent we need to actually really  
2 get into what that 10 per cent is, what we need to  
3 understand for the purpose of the Inquiry is ways in which  
4 a system can be adjusted, potentially, to increase the  
5 60 per cent. That may be more important than looking at  
6 ways of trying to cut out the 30 or the 10. But they are  
7 obviously all closely related.

8  
9 In saying that, obviously enough, it's not the role of  
10 this Inquiry to form a view about the clinical value of any  
11 particular procedure. Whilst it may well be that we  
12 identify a case study that is a useful vehicle --

13  
14 THE COMMISSIONER: As you said, a group of lawyers  
15 couldn't do that for a start.

16  
17 MR MUSTON: No. But, more importantly, it would be an  
18 enormous and potentially impossible task, because --

19  
20 THE COMMISSIONER: It might take you 12 months just on one  
21 particular procedure.

22  
23 MR MUSTON: If one were to work through all of the  
24 procedures with a view to identifying low value care, a  
25 little bit like painting the Harbour Bridge, you would get  
26 to the other end and you would find that medical practice  
27 and the understanding of it had moved on in a way which  
28 meant you had to start again, and even then, you might  
29 still have quite a period where low value care is being  
30 delivered, which is why the very best way for it to be  
31 dealt with is by those small individual groups who are  
32 actually delivering each type of care and facilitating  
33 a system which enables a ministry and the health system  
34 generally to assist in pulling together information and  
35 guiding the delivery of care, but always informed by those  
36 practitioners at the coalface who know most about it and  
37 are best capable, through their academic studies or through  
38 the delivery of the care, of identifying where change needs  
39 to be made.

40  
41 But what this Inquiry can do is work out whether or  
42 not there are any impediments to that happening at the  
43 moment and, if so, what might be changed in order to clear  
44 those roadblocks, because at the end of the day, it's also  
45 going to be a patient-specific exercise. What is and is  
46 not low value care is probably something that can't be  
47 stated as a matter of generality. There will be procedures

1 which, delivered to a large number of the patients who are  
2 currently receiving them, might be low value care, but to  
3 a small cohort of those patients, might actually be very  
4 valuable. So it's a nuanced issue.  
5

6 That, I suppose, leads nicely into what really is one  
7 of the largest challenges faced by the health system, and  
8 that is the fact that at every level, the system is  
9 populated by a largely autonomous group of human beings.  
10

11 Now, I characterise that as a challenge. It's  
12 actually its greatest strength. We're told repeatedly that  
13 patient autonomy - there is one group of human beings, the  
14 patients - is a centrepiece of good delivery of health  
15 care. Patients need to be able to make decisions about  
16 their own health care in a properly informed way. That's  
17 really important.  
18

19 The autonomy of clinicians and those managing the  
20 health system is also really important. They need to be  
21 reasonably free to apply their skills and exercise their  
22 professional judgment in order to provide effective and  
23 efficient patient-centred care to all of their patients.  
24 Autonomy within that group and all of the individuals  
25 within that group is critically important, and at a high  
26 level, it goes almost without saying that political  
27 autonomy is a fundamental tenet of democracy.  
28

29 But the fact that autonomy operates at all of these  
30 levels and that the health system, from the patient all the  
31 way up to those who are making political decisions about  
32 how the health system should be shaped are autonomous human  
33 beings, presents real challenges.  
34

35 Our work, our early work, has suggested that even the  
36 most positive change requires more than a compelling  
37 evidentiary foundation. The community, the health  
38 workforce and everyone else associated with that particular  
39 area, whatever the particular area is that might be being  
40 changed, need to be engaged and need to be supportive of  
41 that change.  
42

43 I will give you a hypothetical example: change to  
44 a service being provided at a particular location. I'm not  
45 going to identify a particular service or a particular  
46 location. Submissions and discussions we have had have  
47 talked about a whole range of them. It is undoubtedly

1 contested ground, which exactly why - contested ground for  
2 the reasons that I'm about to articulate.

3

4 But let's say, in this hypothetical example,  
5 a particular facility, a hospital, is performing  
6 a particular procedure very infrequently. Let's say the  
7 cost associated with keeping that facility ever ready to  
8 perform that procedure, should the need arise, are actually  
9 vast. Now, let's add to that the fact that empirical  
10 evidence might comfortably show it is safer and more  
11 effective for patients requiring that procedure to travel  
12 to a nearby facility which performs it all the time. That  
13 almost bears repeating - it's safer and more efficient and  
14 effective for patients to travel to that nearby facility.  
15 There might be a world of empirical evidence that shows  
16 that.

17

18 It would seem logical in that circumstance that the  
19 facility, facility number 1, let's call it, should cease  
20 performing that procedure and patients should, to the  
21 extent they need it, go to the nearby facility and have  
22 that done there. But, if local clinicians and the local  
23 community are not brought along, the sense one gets from  
24 what we have read and what we have been told is that  
25 bringing about such a change will be very, very challenging  
26 and very, very slow.

27

28 What we're told is similar issues and forces impact on  
29 the ability to scale up innovation and to deliver care in  
30 new and innovative ways. What we're also told is if any of  
31 these things - questions about delivering care in a new  
32 way, changing the services available at a particular  
33 location because evidence suggests it is far better for  
34 patients and the system that it be delivered elsewhere -  
35 if any of those things develop a political dimension, we're  
36 told that change can be almost impossible.

37

38 THE COMMISSIONER: Yes.

39

40 MR MUSTON: That's a simple reality. It's a human  
41 reality, and I guess it's unavoidable in a human system.  
42 But it's an aspect of this system, the health system, that  
43 we are really going to have to grapple with and factor in  
44 to our thinking around recommendations that the Inquiry  
45 ultimately makes, because there is little point in making  
46 recommendations about change which don't take that into  
47 account because they are centrally important to that change

1 being effectively made.

2

3 THE COMMISSIONER: I don't think you are being coy by not  
4 being more specific than you are, because I think this  
5 issue can only be dealt with properly in the form of  
6 evidence, because there will be an element of disagreement  
7 and controversy in relation to this, but we've certainly  
8 had, in a general sense, let's just call it, feedback from  
9 some saying, "But for politics, we would be putting  
10 money" - and by "politics", I'm not, by any means, talking  
11 necessarily about past or present ministers, but, "But for  
12 politics generally, we might be diverting funding to  
13 another area from an area that politics might be forcing us  
14 to keep going with."

15

16 MR MUSTON: We've also been told about change which has  
17 been made in a way that properly harnesses or engages the  
18 clinical community providing care in a particular area, the  
19 community to whom that care is being provided, where they  
20 have been brought along in a really effective way to drive  
21 change, which has been really effective. So there are  
22 certainly areas where, if it's done well and if the  
23 community who the health system serves are brought along  
24 and the clinicians who provide that care are brought along,  
25 it can be very effective. But equally we have been told  
26 of situations in which what seem to be obvious improvements  
27 have not been possible because of human forces.

28

29 But it's also not entirely simple, because, if I were  
30 to have identified a particular procedure, in one little  
31 geographic location, it might have made perfect sense to  
32 have a discussion about it; in another geographic location,  
33 because of challenges associated with getting from one  
34 facility to another during times of the year when roads are  
35 icy, or whatever it might be, a completely different set of  
36 considerations might apply. It's going to be very much  
37 procedure specific, location specific. It needs to be  
38 driven by not only the evidence around the pros and cons of  
39 delivering the procedure but the evidence around the need  
40 for the procedure just in this hypothetical example to be  
41 delivered at a particular location and the capacity for it  
42 to be moved to another location in a way that still serves  
43 the health needs of the community.

44

45 But the issue really that we're trying to tease out is  
46 that evidence of all of those things is not enough. You  
47 need to harness the human factors as well, and that's



1 a real challenge.

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I think we've probably covered off most of the general themes which have emerged from the submissions. I don't suggest by any means that we've covered all of the issues. There are many of them, and for present purposes, it's probably not appropriate to traipse through them. Look, at best, we've probably only given you the corner pieces of the jigsaw which is the health system. We would say at this stage, that's entirely appropriate, because a search for the big systemic challenges that can and should be addressed, and a search for recommendations relating to them, is something which has to be informed by the people with skills and long experience in the health system to provide those insights and answers.

As I said at the outset, we're a group of lawyers. We can find the corner pieces in the box because they've got a right angle. But as to what we do with the rest of the pieces, the discussions we have had with people so far, the submissions we have received, have started to help us to see the picture that we are working towards in the Inquiry. But first and foremost, we have to try to harness that on the ground knowledge and that expertise in order to direct us in the work we do in the Inquiry.

What we're doing in relation to that, at least as a first step, is we're populating an expert panel from people who have made submissions across a wide spectrum of areas - academic institutes which have a range of disciplines which feed in to health, economists, health economists, obviously clinicians - pulling together an expert panel which it's anticipated will meet routinely throughout the course of the Inquiry, will assist us in guiding the Inquiry and the direction that it takes in relation to some of these big themes that we've outlined, and equally might contribute in one way or another periodically to the evidence that the Inquiry gives.

Exactly how we'll utilise that panel might vary from issue to issue. We'll obviously be needing to harness those people on the panel who have the key knowledge and the key area to deal with particular issues, but by and large, they will be a significant part of informing the way forward.

We will conduct hearings in public and, to the extent

1 necessary and appropriate, closed hearings, in relation to  
2 the gathering of evidence. We might gather some evidence  
3 through roundtables. Again, the beauty of an inquiry,  
4 a policy-based inquiry like this, is it doesn't need to  
5 restrict itself to old fashioned witnesses in the witness  
6 box type evidence; it can very effectively gather evidence  
7 and have this exchange of ideas through a roundtable,  
8 formal roundtable process, and importantly, all of these  
9 things, both the public/private hearings and roundtables,  
10 will happen not only here in Sydney but around in the  
11 regions, so that the issues that are raised in other parts  
12 of the state and are unique, and perhaps particularly acute  
13 in other parts of the state, can be properly examined  
14 there, where they're happening, and can be informed by  
15 people on the ground who have a real lived experience of  
16 them with a view to searching for some solutions to the  
17 challenges.

18  
19 Which really brings us to the evidence that is going  
20 to be given this week. What we intend to do this week  
21 really is lay some foundations. The Inquiry will be  
22 hearing some evidence from individuals within the New South  
23 Wales health system, which will identify just what that  
24 system is, exactly how it operates, how it is funded, how  
25 it perceives the funding arrangements as between itself and  
26 the Commonwealth and how that funding is distributed within  
27 the health system, with a view to giving us some building  
28 blocks to use to start to build our Inquiry.

29  
30 The first part of that is going to be a panel of  
31 senior individuals from the health ministry, who you'll be  
32 introduced to shortly, and thereafter, there will be  
33 a separate little panel session dealing with the funding  
34 and budgeting arrangements.

35  
36 Before we do that, Mr Glover is going to give you  
37 a brief introduction to, if I could put it generally, what  
38 is NSW Health, with a view to giving you a little bit of an  
39 outline of exactly what these structures are and how they  
40 all fit together, so that when this evidence is delivered,  
41 you might have a slightly better ability, and those  
42 watching the Inquiry will have a slightly better ability,  
43 to understand exactly what the evidence means and where it  
44 fits in to that broader landscape. Unless there's anything  
45 else I can assist you with immediately, I might hand it  
46 over to Mr Glover.

47

1 THE COMMISSIONER: No, thank you. You are excused until  
2 Wednesday morning. Good luck.

3  
4 MR MUSTON: Thank you, Commissioner.

5  
6 THE COMMISSIONER: Yes, Mr Glover.

7  
8 MR GLOVER: Thank you, Commissioner.

9  
10 The terms of reference make multiple references to  
11 NSW Health, so it's important to spend a little time in  
12 understanding what falls within, as Mr Muston described,  
13 the "complex beast". The words "complex" and "complexity"  
14 are words that you will hear frequently, including during  
15 the little burst I will give you, and we will hear much  
16 about the detail about the system and how it gets its  
17 funding contribution from the Commonwealth over the coming  
18 days, so what I propose to do is address it at a relatively  
19 high level to introduce those concepts, and allow those  
20 with far better knowledge and who are in a far better  
21 position than me to explain the detail to you.

22  
23 In terms of NSW Health, there are two key pieces of  
24 legislation that establish the component parts of the  
25 New South Wales public health system and identify their  
26 respective roles and functions. They are the Health  
27 Services Act and the Health Administration Act.

28  
29 Chapter 2 of the Health Services Act establishes and  
30 sets out the structure of the New South Wales public health  
31 system. It creates the component organisations. They are  
32 best viewed diagrammatically, so if I can ask the operator  
33 to call up [SCI.0001.0003.0001], and we will go to page 5  
34 in that document, please.

35  
36 THE COMMISSIONER: You want page 5, not (iii); is that --

37  
38 MR GLOVER: Yes, that's my error. I've already fallen  
39 over at the first attempt.

40  
41 THE COMMISSIONER: I have a structure in front of me, if  
42 it assists, but you want it on the screen.

43  
44 MR GLOVER: It is page 17 internally, page 5 of the PDF.

45  
46 THE COMMISSIONER: Is that what you are after?

47

1 MR GLOVER: Yes. If we can scroll down, thank you.

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1 of adequate standards of care within hospitals, the  
2 provision of governance, oversight and control of the  
3 public health system and the statutory health organisations  
4 within it, and to facilitate the efficient and economic  
5 operation of the public health system.

6  
7 Much of the care delivered in the public health system  
8 we will hear about is at the local health district and  
9 specialty health network level.

10  
11 The local health districts are each unique in the  
12 sense of the populations they serve, their demographics and  
13 some of the challenges they face, although there are  
14 degrees of commonality between them.

15  
16 To get a sense of the breadth of some of the areas  
17 covered by the local health districts, it may be useful to  
18 look at the local health district map which is at  
19 [SCI.0001.0001.0001].

20  
21 There, Commissioner, you can see the 15 local health  
22 districts. The metropolitan districts are in focus down  
23 the bottom right of the map, but on immediate observation  
24 one can start to get a sense of the challenges of  
25 delivering health care in some of the regions in the vast  
26 state that is New South Wales. We can look at, for  
27 example, Western NSW, Murrumbidgee and Far West, and  
28 including Hunter New England, and the areas covered by just  
29 those four LHDs is a significant portion of the area of the  
30 state.

31  
32 We will hear, I suspect, some evidence about the  
33 unique challenges that come from servicing and providing  
34 health care to populations in those rural and remote areas,  
35 not limited to workforce but also the tyranny of distance,  
36 the particular demographics and population make-up of those  
37 regions.

38  
39 However, as I indicated a moment ago, some of the  
40 challenges are common. It may be useful at this early  
41 stage, just by way of comparison from some of the  
42 statistics that are in the NSW Health Annual Report, to do  
43 a short analysis of some of the issues that those health  
44 districts see as being their challenges, and if we can pull  
45 up pages [SCI.0001.0003.0304] and [SCI.1001.0003.0305] next  
46 to each other, please.

47

1 Now, these are snapshots. One has to be careful in  
2 not getting too distracted by summaries, but this is  
3 a comparison between Sydney Local Health District and  
4 Western NSW Local Health District. Some of the differences  
5 are immediately obvious. Sydney Local Health District has  
6 an area of 126 square kilometres, faced with 247,000 square  
7 kilometres for Western NSW. The population density is also  
8 vastly different - 740,000 residents in a 126 kilometre  
9 square area, against 283,000 residents across 247,000  
10 square kilometres. I expect you will hear some evidence  
11 about the differences in approach required to deliver  
12 healthcare services across those different profiles.  
13

14 The demographics of the residents in those health  
15 districts are also vastly different. However, some of the  
16 common themes, the common challenges that we have heard  
17 about in the submissions and I expect you will hear  
18 evidence about, including the ageing population - both  
19 areas predict that, as a proportion of population, those  
20 above 70 will continue to increase. Another constant theme  
21 that Mr Muston touched on earlier was the prevalence of  
22 chronic conditions - again, some common challenges.  
23

24 So that whilst the individual LHDs will, I expect,  
25 tell you more about the unique features that are common to  
26 them, unique features and challenges that they are dealing  
27 with, it is already starting to emerge that some of the  
28 challenges are not limited to those rural and regional  
29 areas but are, indeed, common across all of them.  
30

31 That ties in to one of the significant issues that are  
32 raised by the submissions that we have received - that is  
33 whether the current funding models are best equipped to  
34 deal with challenges not only unique to particular areas  
35 but also that are running common throughout.  
36

37 The legislation identifies the statutory purpose and  
38 functions of the LHDs, and I'll touch on them briefly,  
39 because they are important to bear in mind when  
40 understanding the nature and services that are to be  
41 delivered, and including their future planning.  
42

43 Fundamentally, the LHDs are responsible for managing  
44 the public hospitals and health institutions within their  
45 area, but their primary purpose remains to provide relief  
46 to sick and injured persons through the provision of care  
47 and treatment and to promote, protect and maintain the

1 health of the community.

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The common theme coming through our discussions with the LHDs and in the submissions is that they take those roles and functions incredibly seriously, notwithstanding the challenges that they face in meeting them.

The secretary has ultimate oversight of the LHDs and related to that oversight and control by the secretary, one of the issues and considerations that is raised in the submissions is the mix between centralised decision making, on the one hand, and devolved decision making, on the other, and where on the spectrum the best possible balance can be struck to achieve the best health outcomes for the population.

LHDs deliver services in their areas pursuant to service agreements that are entered into between the LHDs and the secretary. I expect you'll hear some evidence over the coming days about the service agreements and how they're negotiated. They have a significant role in the provision of health services across the state. They identify the services that are to be provided in the LHDs, but they also set and identify activity targets which have an important role in budgeting and Commonwealth funding contributions.

Other organisations within the wider New South Wales health framework also have services agreements - for example, the specialty networks and ambulance have service agreements, the pillars have performance agreements and HealthShare and NSW Health Pathology have statements of service. Their function, although not entirely common, is as one would expect, to identify performance expectations and levels of service across those organisations.

I touched on the Health Administration Corporation earlier - that is, the secretary in her corporate status. That is the statutory vehicle through which ambulance services are provided and other support services to the wider New South Wales health system.

Within the Health Administration Corporation, or HAC as it is sometimes referred to, sit eHealth, Health Infrastructure, HealthShare, Health Protection and NSW Health Pathology. We'll hear some more about what each of those organisations does in the wider network over the

1 coming days, and as I have said, NSW Ambulance is also  
2 within the health administration, although it is created by  
3 a different part of the Health Services Act.

4  
5 The statutory health corporations - they are created  
6 in chapter 4 of the Health Services Act - are organisations  
7 that provide statewide health and health support services.  
8 They include the two specialty health networks, Justice  
9 Health and Forensic Mental Health Network, and the Sydney  
10 Children's Hospitals Network. They also include the  
11 pillars.

12  
13 The pillars flowed from recommendations made in the  
14 Garling report, and the pillars are the Agency for Clinical  
15 Innovation, the Bureau of Health Information, the Clinical  
16 Excellence Commission, the Health Education and Training  
17 Institute, and the Cancer Institute of New South Wales,  
18 although it is created by its own individual piece of  
19 legislation. Again, I expect we will hear more about the  
20 work that the pillars do and the specialty health networks  
21 do in the coming days.

22  
23 Finally, the affiliated health organisations. They  
24 are, in general terms, health organisations managed by  
25 religious and other charitable groups who provide health  
26 services through their facilities - the St Vincent's  
27 network is an example. There are others across the state.  
28 We will hear in the coming days how those organisations  
29 provide their services as part of the wider NSW Health  
30 network.

31  
32 In order to get a sense of just how vast the operation  
33 of NSW Health is, it's useful to have a look at some  
34 headline statistics. These are coming from the most recent  
35 NSW Health Annual Report, which was for the period  
36 2021-2022. If we can go to [SCI.0001.0003.0005] please.  
37 Thank you.

38  
39 This is a snapshot of some statistics but it really  
40 does give one an immediate sense of the vast amount of care  
41 and interactions the community has with the New South Wales  
42 health system. Approximately 178,000 people employed  
43 across NSW Health; 3 million emergency department  
44 attendances; 1.8 million inpatient episodes; almost 300,000  
45 surgeries performed in a year; 72,507 babies born in a  
46 public hospital in a year, 24 million meals served.  
47 Although these statistics are headline numbers, it does



1 give a sense of, to use the word, the complexity and  
2 breadth of the services provided by NSW Health and that  
3 they touch a vast number of the population throughout the  
4 course of a single year.

5  
6 Workforce is a significant issue that has been raised,  
7 as Mr Muston has touched upon, and it's important to  
8 recognise that workforce isn't just limited to medical or  
9 nursing or other clinical staff. There's a range of  
10 employees within the system that are all vital to its  
11 functioning. If we can go to [SCI.0001.0003.316], please.  
12 Just scroll down, thank you.

13  
14 On the left there, Commissioner, you can see a summary  
15 of the number of full-time equivalent staff, and not only  
16 are the numbers vast, 131,866 in total, but the range of  
17 staff that are all necessary and vital to the functioning  
18 of the New South Wales health system. So when one speaks  
19 of workforce and the challenges of workforce, particularly  
20 in rural and remote areas, it's not just limited to medical  
21 or nursing workforce, there is a range of other important  
22 inputs into the system.

23  
24 That's all I wanted to say by way of general remarks  
25 as to what is the complex beast that is NSW Health in  
26 opening. I was proposing to touch very briefly on the  
27 funding model and, in particular, the funding model in  
28 relation to its operation of the Commonwealth contribution  
29 to public hospital services.

30  
31 Again, I propose to do this at a fairly general level,  
32 because you will have some evidence about it in more detail  
33 over the coming days.

34  
35 Public hospital services are, as Mr Muston said,  
36 funded jointly by the Commonwealth and state governments,  
37 although, of course, to the extent that funding comes from  
38 governments, there is an anterior consideration that is the  
39 taxpayer. The taxpayer ultimately is the source of the  
40 government's contributions. Additional funding is received  
41 from private health insurance payments, patient payments,  
42 and there are some opportunities within the system for  
43 self-generated revenue through retail arrangements and car  
44 parking.

45  
46 The overall expenditure on public hospitals in  
47 Australia is a significant portion of budgets of the

1 Commonwealth and each of the states and territories. The  
2 Australian Institute of Health and Welfare reported that in  
3 2021-2022, state and territory governments contributed  
4 \$42.6 billion towards public hospital spending; the  
5 Commonwealth contributed between 29.9 and 31.5 billion,  
6 depending on the particular measure being looked at; and  
7 non-government entities contributed 4.7 billion.

8  
9 Overall, spending on health has been a consistent  
10 upward trend in the last decade, and Mr Muston touched on  
11 some of the projections from the Commonwealth  
12 intergenerational report that predict that spending will  
13 increase at a rapid rate over the period of that report.

14  
15 The division of responsibility between the  
16 Commonwealth and state and territory governments is  
17 currently outlined in the National Health Reform Agreement.  
18 That agreement was first entered into in 2011, and there  
19 have been two addenda to it since, the first in 2017 and  
20 the second, which is the addendum that currently operates  
21 in 2020.

22  
23 Prior to the commencement of that agreement, the  
24 states and territories were paid a contribution for public  
25 hospital services by the Commonwealth by way of grants  
26 under what was described as the national healthcare  
27 specific purpose payment arrangements. At a high level,  
28 they were calculated based on historical costs, rather than  
29 by reference to the services that were actually provided  
30 and undertaken. We will hear a little bit more about that  
31 in the coming days.

32  
33 In August 2011, the Council of Australian Governments  
34 agreed to changes as to how public hospitals were to be  
35 funded by the Commonwealth and the state and territory  
36 governments, and that it was a move to activity based  
37 funding. Those changes were reflected in the agreements  
38 that I've just mentioned.

39  
40 In accordance with the National Health Reform  
41 Agreement, the Commonwealth's contribution to public  
42 hospital services comprises funding in relation to hospital  
43 services provided to public patients in a range of  
44 settings, hospital services provided to eligible private  
45 patients in public hospitals, hospital services provided to  
46 patients in public hospitals but funded through block  
47 grants not by ABF, and I will come back to block funding,

1 teaching and training functions, research funded by states  
2 and other public health activities.

3

4 That contribution takes three forms. We heard a  
5 little earlier about activity based funding. I've just  
6 mentioned block funding. They are, as the name describes,  
7 block amounts of money applied to particular facilities or  
8 purposes. I will come back to that. And another source of  
9 funding is what is called public health funding, and I will  
10 come back to that in a moment.

11

12 In New South Wales there are 228 public hospitals.  
13 100 receive activity based funding; 110 of the smaller  
14 hospitals are block funded as they do not generate  
15 sufficient activity to make activity based funding  
16 appropriate; and not only are small hospitals block funded,  
17 others that provide particularly specialist services or  
18 care are also block funded.

19

20 Activity based funding operates to fund hospitals  
21 whereby they get paid based on the number and mix of  
22 patients they treat. It seeks to operate by measuring  
23 activity levels and taking into account the complexity of  
24 the particular procedure or patient.

25

26 It does that by allocating a standard weighting - that  
27 is, a national weighted activity unit, or an NWAU. You  
28 will hear lots about this over the coming months. One NWAU  
29 is a standard unit of care in the public hospital system.  
30 It is intended to be a point of relatively for the pricing  
31 of hospital services.

32

33 The other input into this rather complicated  
34 calculation is what is known as the national efficient  
35 price. That's a price which seeks to identify what the  
36 efficient cost of one NWAU is. They are the two main  
37 inputs --

38

39 THE COMMISSIONER: Efficient cost or efficient price?

40

41 MR GLOVER: Efficient price, sorry, of one national  
42 weighted activity unit. Those are the two main inputs that  
43 go into the calculation.

44

45 Of course, not everything is worth one NWAU: some  
46 things will be worth less, so they will be priced at  
47 a fraction of an NWAU; some things are worth many, many

1 multiples. The determination of that ultimate NWAU figure  
2 is subject to adjustments for remoteness, complexity and  
3 the features of the individual patient, and I expect we'll  
4 hear something over the coming days, and certainly  
5 throughout the Inquiry, as to whether the measure of what  
6 is in those adjustments and the calculation of the national  
7 efficient price is actually doing the job that it is  
8 intended to do.

9

10 How that works in practical terms. At the start of  
11 each period, NSW Health provides its estimates of the  
12 activity that it intends to carry out over the coming  
13 period under the National Health Reform Agreement. The  
14 Commonwealth's contribution is paid in accordance with the  
15 formula, which is far more complicated than I have  
16 described it, and the reconciliation against the amounts  
17 paid and those estimates is undertaken, and there may be  
18 adjustments either up or down at the end of the period.

19

20 That funding is then distributed to the LHDs and the  
21 specialty health networks in accordance with budgets set by  
22 NSW Health, as Mr Muston touched on earlier this morning.  
23 It follows a similar but not identical process.

24

25 Some overall numbers, so one can get a sense of the  
26 amount of money that we're speaking of. If we can go to  
27 [SCI.001.0028.0101]. This is from the annual report of the  
28 National Health Funding Pool. The National Health Funding  
29 Body has responsibility for calculating the Commonwealth's  
30 contribution and then ensuring that it is paid in  
31 accordance with the NHRA. You can see there, Commissioner,  
32 that for the period 2022 to 2023, the Commonwealth's  
33 contribution to activity based funding was about  
34 \$6.7 billion, whereas New South Wales's contribution was  
35 \$8.1 billion.

36

37 Activity based funding does not cover every aspect of  
38 a service provided in a public hospital. It covers what  
39 are referred to as "in-scope activities" only. What is in  
40 scope is determined by IHACPA, another acronym.

41

42 What is generally in scope are all admitted services,  
43 including hospital in the home programs; all emergency  
44 department services provided by a recognised emergency  
45 department service; and other outpatient, mental health,  
46 subacute services and other services that could be  
47 reasonably considered to be a public hospital service in

1 accordance with the provisions of the NHRA. That is  
2 a general description that comes from the agreement.

3  
4 What ultimately happens is that IHACPA provide a list  
5 of in-scope services, the states and territories can make  
6 submissions to IHACPA to include services on that list, and  
7 we'll hear a little bit about that process and whether it  
8 is effective in responding to new and emerging models of  
9 care over the coming days.

10  
11 The Commonwealth's contribution under ABF, as you can  
12 see from the summary on the screen, does not cover the  
13 entire cost. The Commonwealth's contribution is what is  
14 referred to as a "growth model". In general terms, it  
15 starts by funding a base amount and then 45 per cent of the  
16 growth on that base amount year on year. It is subject to  
17 an overall growth cap of 6.5 per cent, so if the growth  
18 from the previous year is above 6.5 per cent, the risk or  
19 the cost of that additional growth is borne by the state or  
20 territory.

21  
22 We've been told that the effect of that agreement is  
23 that, overall, the Commonwealth's contribution to public  
24 health costs in New South Wales sits at about 40 per cent,  
25 presently.

26  
27 One of the other types of funding under the NHRA is  
28 block funding. As I have introduced, that's a funding  
29 mechanism that applies to services that are not readily  
30 amenable to activity based funding. Some services that are  
31 provided, or activities, I should say, undertaken, even in  
32 large metropolitan hospitals, still receive block funding,  
33 like training and research and things like that.

34  
35 The range of activities supported by block funding  
36 arrangements under the NHRA include, as I have indicated,  
37 small regional hospitals, teaching, training and research,  
38 various mental health services and also highly specialised  
39 therapies. Block funded services are also a growth model -  
40 that is, the previous year's block funding amount plus  
41 45 per cent of growth, determined in accordance with the  
42 formulas in the NHRA, and are also subject to the  
43 6.5 per cent growth cap.

44  
45 Finally under the NHRA the Commonwealth also  
46 contributes amounts for what is called public health  
47 funding. That funding relates to activities such as

1 national public health programs, youth health services and  
2 essential vaccination programs.

3

4 If we go to page 85 in the document that's on the  
5 screen, these are the overall amounts contributed by the  
6 Commonwealth Government under the NHRA for the period  
7 2022-2023 - about \$7.9 billion in that period out of an  
8 overall revenue budget of about \$30 billion.

9

10 The NHRA also contemplates that the states and  
11 territories may enter into arrangements with the  
12 Commonwealth directly for other sources of funding, for  
13 other activities that fall outside those three. There are  
14 such agreements that have been entered into by New South  
15 Wales with the Commonwealth and we will hear some evidence  
16 about those over the coming days.

17

18 That's all I wish to say about the structure of NSW  
19 Health and a general overview of the funding arrangements  
20 by way of opening, and unless there is anything that I can  
21 further assist with, that completes what I wanted to say.

22

23 THE COMMISSIONER: Thank you.

24

25 We may as well adjourn and have you after, Mr Cheney.

26

27 MR CHENEY: I will be about three minutes, if that bears  
28 on your decision, Commissioner.

29

30 THE COMMISSIONER: We might as well hear from you now.

31

32 MR CHENEY: It was planned to be a very short  
33 contribution, if I may, Commissioner.

34

35 THE COMMISSIONER: Yes, please, go ahead.

36

37 MR CHENEY: As we hope might be apparent from the  
38 assistance that NSW Health has provided in the weeks since  
39 this Inquiry was announced, NSW Health welcomes the Inquiry  
40 and sees it as an opportunity to examine the operation of  
41 health care in New South Wales with a view to improving it,  
42 and we thank you, Commissioner, and counsel assisting, for  
43 acknowledging this morning that engagement and the efforts  
44 that have been made by NSW Health to assist you and your  
45 team with your unenviable task.

46

47 That engagement has included the contributions made by

1 the 15 local health districts and the other health  
2 entities, including the various statutory health  
3 corporations comprising the pillars that have made  
4 submissions to this Inquiry and have participated in  
5 briefings with you and those assisting you, and  
6 Commissioner, you may be assured that those various  
7 entities have not been constrained in any way in their  
8 participation: as Mr Muston correctly put it, there is no  
9 party line here.

10  
11 NSW Health, as the largest public health system in  
12 Australia, provides what we consider to be high-quality,  
13 safe care to communities across New South Wales, but  
14 nevertheless, as counsel assisting's very fair openings  
15 have explained today, the system does encounter some  
16 challenges and has had to adapt to those over recent years.  
17 As Mr Muston in particular observed, the burden of disease  
18 has changed significantly over the last 20 years, with an  
19 increased prevalence of conditions associated with ageing  
20 and mental health issues, and escalating numbers of those  
21 with chronic diseases, and that has placed increasing  
22 pressure on health and social care systems which, we have  
23 to acknowledge, are not sufficiently connected or  
24 coordinated in the provision of care.

25  
26 The funding models must enable the system to respond  
27 to these changing conditions, and as we have candidly put  
28 in our initial written submission, the current operation of  
29 funding models does not effectively support the delivery of  
30 innovative and new models of care. The current models too  
31 often leave NSW Health as a provider of last resort, with  
32 failures in primary care, in aged care and in disability  
33 care, and as we see it, risk and responsibility should be  
34 shared.

35  
36 Commissioner, NSW Health sees this Inquiry as an  
37 opportunity to drive further reform to ensure a health  
38 system that is fit for the future and can meet the needs of  
39 New South Wales communities, and the Commission may be  
40 assured of NSW Health's continued support and engagement  
41 throughout this important Inquiry. Thank you.

42  
43 THE COMMISSIONER: Thank you. All right. We will adjourn  
44 until 10am tomorrow. Thank you.

45  
46 **AT 1.00PM THE SPECIAL COMMISSION OF INQUIRY WAS ADJOURNED**  
47 **TO TUESDAY, 28 NOVEMBER 2023 AT 10AM**

<p><b>\$</b></p> <hr/> <p><b>\$30</b> [2] - 14:43, 62:8</p> <hr/> <p><b>0</b></p> <hr/> <p><b>001</b> [1] - 1:25</p> <hr/> <p><b>1</b></p> <hr/> <p><b>1</b> [1] - 47:19  <b>1.00PM</b> [1] - 63:46  <b>1.8</b> [1] - 56:44  <b>10</b> [10] - 14:47, 15:13, 15:20, 43:44, 44:3, 44:16, 44:28, 44:39, 45:2, 45:6  <b>10.00am</b> [1] - 1:23  <b>100</b> [1] - 59:13  <b>10am</b> [1] - 63:44  <b>10AM</b> [1] - 63:47  <b>110</b> [1] - 59:13  <b>12</b> [4] - 23:9, 40:32, 40:38, 45:20  <b>12-month</b> [3] - 22:43, 22:47, 23:32  <b>121</b> [1] - 1:19  <b>126</b> [2] - 54:6, 54:8  <b>131,866</b> [1] - 57:16  <b>15</b> [3] - 31:16, 53:21, 63:1  <b>160</b> [1] - 9:21  <b>17</b> [1] - 51:44  <b>178,000</b> [1] - 56:42</p> <hr/> <p><b>2</b></p> <hr/> <p><b>2</b> [3] - 1:19, 15:40, 51:29  <b>20</b> [1] - 63:18  <b>200</b> [1] - 31:20  <b>2008</b> [2] - 4:25, 31:16  <b>2011</b> [2] - 58:18, 58:33  <b>2017</b> [1] - 58:19  <b>2020</b> [2] - 18:46, 58:21  <b>2021-2022</b> [2] - 56:36, 58:3  <b>2022</b> [1] - 60:32  <b>2022-2023</b> [1] - 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