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)

Mr Ed Muston SC	**(Senior Counsel Assisting)**
Mr Ross Glover	**(Counsel Assisting)**
Mr Ian Fraser	**(Counsel Assisting)**
Dr Tamsin Waterhouse	**(Counsel Assisting)**

Also present:

Mr Richard Cheney SC with Mr Hilbert Chiu for NSW Health

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

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

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

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

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

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

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

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

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

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

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

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

MR MUSTON: Their efforts should not go unrecognised.

THE COMMISSIONER: Of course.

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

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

MR CHENEY: If you would permit that, yes.

THE COMMISSIONER: That would be fine, thank you.

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

THE COMMISSIONER: Yes, Mr Muston.

MR MUSTON: The logical starting point when introducing

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

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

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

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

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

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

Rather, the purpose of the Inquiry is to identify the

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

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

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

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

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

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

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

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

THE COMMISSIONER: Yes.

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

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

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

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

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

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

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

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

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

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

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

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

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

THE COMMISSIONER: Which runs at its own speed.

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

THE COMMISSIONER: Yes.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

remainder --

THE COMMISSIONER: What is promotion?

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

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

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

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

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

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

the population that the health system serves.

What the submissions tell us is that the burden of disease in the community, which is now being faced and is likely to continue and increase over the coming decades, is something that requires a different approach, a different approach to what I described a moment ago as that historical hospital-focused approach to the delivery of health care.

The focus, we are told, needs to shift to keeping people healthy and well and effectively managing their health needs as best as we can, their chronic conditions as best as we can, outside of the hospital setting.

What we are told is that this really requires better integration between the various parts of the health system, the various areas in which health services are delivered. I'll come back to that shortly, but what we have been told repeatedly in submissions and through our discussions is that a key challenge faced by the health system, if we are seeking to move towards that approach of keeping people healthy and well and effectively managing chronic disease in a way that, as best as we can, keeps people out of hospitals - a significant challenge that that objective faces is the fragmented nature of the delivery of health care.

I guess before moving on from that, it's probably also worth noting this, and that is that these demographic changes that we talk about are again not uniformly spread across the state. They affect different parts of the community in different ways. The burden of disease, the incidence of chronic disease, is not evenly distributed. There is no single population-wide solution that we could apply, it would seem, that would address all of these challenges in each of the little areas that they manifest themselves.

We've been told in very clear terms that some groups in New South Wales experience poorer health outcomes than others. First Nations people, people living in rural and remote areas, people in lower socioeconomic status categories, and in some respects, people from culturally and linguistically diverse backgrounds all have difference experiences of the health system and all have different health needs, and the particular demographic that they

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

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

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

MR MUSTON: Housing, levels of education, exactly.

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

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

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

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.

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

MR MUSTON: As we speak.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

THE COMMISSIONER: Yes.

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

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

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

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

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

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

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

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

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

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

THE COMMISSIONER: Depends what's available, yes.

MR MUSTON: -- another matter.

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

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

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

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

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

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

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

So that's the primary health care piece.

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

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

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

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

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

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

this situation.

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

and international jurisdictions.

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

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

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

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

THE COMMISSIONER: Affordable or suitable accommodation.

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

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

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

services.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

THE COMMISSIONER: Yes.

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

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

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

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

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

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

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

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

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

MR MUSTON: I am.

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

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

SHORT ADJOURNMENT.

THE COMMISSIONER: Yes, Mr Muston.

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

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

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

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

THE COMMISSIONER: No worries.

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

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

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

THE COMMISSIONER: Is it a review or a reform?

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

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

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

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

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

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

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

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

THE COMMISSIONER: That's from an expert.

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

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

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

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

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

THE COMMISSIONER: Is errors, yes.

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

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

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

MR MUSTON: I think it may.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

THE COMMISSIONER: Yes.

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

being effectively made.

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

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

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

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

a real challenge.

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

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

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

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

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

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

MR MUSTON: Thank you, Commissioner.

THE COMMISSIONER: Yes, Mr Glover.

MR GLOVER: Thank you, Commissioner.

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

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

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

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

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

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

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

THE COMMISSIONER: Is that what you are after?

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

In that diagram, one can see the component parts of the wider New South Wales health system. This flows from what is set out in the Health Services Act. One can see there the local health districts and specialty networks - we'll come back to these. The Act creates what are known as statutory health corporations and they include the pillars, which you can see on the right.

There are affiliated health organisations, which don't appear on that diagram, but I'll come back to. But importantly, the secretary - and you can see at the top reference to the Health Administration Corporation - is created in that context to have corporate status and delivers statewide and shared services that one sees on the left, including ambulance, health pathology, health protection, et cetera, and we'll hear some more about those as we go forward.

The secretary leads the ministry, and the ministry has a couple of key functions. The first is to support the functions of the relevant ministers who have wider responsibility for the health portfolio. If we can go to document [SCI.0001.0042.0001], that's the Ministry of Health organisation chart, and at the top there, Commissioner, you can see the relevant ministers who currently have wider responsibility for the health portfolio, and each of the relevant departments within the ministry.

You will hear from three of the people in that diagram - Dr Chant, Mr D'Amato and Ms Willcox - over the course of the week, and we will explore with them a little bit more about the functions within those divisions.

The other significant role that the ministry has is what is described as "system manager of the New South Wales public health system". At a general level, that means that the ministry provides strategic oversight and direction for the wider system, develops and implements policy, and sets and monitors activity targets, key performance indicators of the relevant organisations within the system, and sets and administers the NSW Health budget.

The secretary has a number of statutory functions, including the facilitation and achievement and maintenance

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

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

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

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

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

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

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

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

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

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

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

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

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

health of the community.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

THE COMMISSIONER: Efficient cost or efficient price?

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

THE COMMISSIONER: Thank you.

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

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

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

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

THE COMMISSIONER: Yes, please, go ahead.

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

That engagement has included the contributions made by

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

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

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

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

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

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

B

C

D

E

F

G

H

J

K

L

M

N

O

S

T

U

V

W

Y

Z